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MISSION STATEMENT DEPARTMENT OF OPHTHALMOLOGY

The Department of Ophthalmology of Saint Louis University recognizes its mission to provide excellence of patient care, teaching of residents and students, furthering research and knowledge in the field of Ophthalmology, and to provide future leaders in Ophthalmology, both in the community and academia.

WHO WE ARE:

Saint Louis University Eye Institute (WWW.SLUEI.SLU.EDU) is the Department of Ophthalmology of Saint Louis University School of Medicine in St. Louis, Missouri, USA.

Address:
1755 South Grand Ave.
St. Louis, MO 63104
USA
(314) 256-3200

AFFILIATED HOSPITALS

SAINT LOUIS UNIVERSITY HOSPITAL

Primary Teaching Site:  Main Hospital:
Anheuser-Busch Institute  3635 Vista Avenue
1755 South Grand Blvd  St. Louis, MO 63104
St. Louis, MO 63104  314-577-8000
314-256-3200

CARDINAL GLENNON CHILDREN'S HOSPITAL

1463 South Grand
St. Louis, MO 63104
314-577-5600

AFFILIATED PRIVATE PRACTICE OFFICES

ILLINOIS EYE SURGEONS
ST. LOUIS EYE SURGERY & LASER CENTER
Educational Goals

PROGRAM EDUCATIONAL GOALS & OBJECTIVES

DEPARTMENT EDUCATIONAL GOALS & OBJECTIVES

The Department of Ophthalmology at Saint Louis University School of Medicine strives to balance its primary missions of providing excellence in patient care while simultaneously providing excellence in residency teaching and education. The residency program is currently under the guidance of the program director, Dr. Gabriela Espinoza. Dr. Oscar Cruz serves as chairman of the department. The goal of the program is to provide for the education of physicians in a progressive, mentored and accredited graduate medical education environment leading to the graduation of trainees competent in all areas of general ophthalmology and competent to achieve board certification from the American Board of Ophthalmology.

The chairman’s major focus is to provide a coordinated, clear leadership and develop a positive synergy between these clinical and academic goals and responsibilities as the department recruits new faculty, expands its clinical operations, and continues to achieve faculty development. This includes oversight of our distinct educational activities which include didactic lectures, journal club reviews, procedural lab sessions, clinical conferences, grand rounds presentations, hospital consult rounds, rotations and lectures with community physicians, resident teaching of peers as well as rotating non-ophthalmology residents and medical students.

The program director’s role is to strive to achieve the necessary balance in the program curriculum to allow for optimal resident experience during clinical responsibilities, teaching activities, and research. The program director also ensures that the program is compliant with all ACGME regulations, and continually evaluates processes and procedures involving the residents to improve deficiencies when possible and identify areas for innovation. The residents and faculty are encouraged and actively recruited to be active in the management of their program to implement changes that continue to strengthen and enhance our program.

Clinical schedules are designed to be well within the maximum duty hours to encourage residents to read and study independently, as well as prepare meaningful research projects. Educational needs are balanced with service needs through dedicated, mandatory conferences that take precedent over clinical responsibilities. For example, every Wednesday morning until 9:00 AM is set aside for resident education meetings, Grand Rounds case discussions, and during weeks that the department hosts visiting professors, clinical responsibilities are suspended on Thursday afternoons for case discussions and lectures by the visitor.
Educational Goals

It is recognized that residency education and teaching occurs in many venues, with participation in direct patient care providing the most critical component of residency education. During the three years of training, residents are taught and evaluated in multiple healthcare delivery settings and systems:

- Our primary teaching setting is the Tenet outpatient facility at Anheuser-Busch Institute of Saint Louis University Hospital. Here we provide exposure to patients comprising a full range of ages, races and socioeconomic background in a for-profit (Tenet) and not-for-profit (University Medical Group) partnership.
- Cardinal Glennon Children’s Hospital (Sisters of St. Mary Network) provides both outpatient and inpatient settings exclusively focused on pediatric patients in a not-for-profit hospital system.
- Saint Louis University Hospital (Tenet for-profit facility) provides our adult inpatient and emergency room setting patients.
- The residents rotate with affiliated private-office practitioners at the offices Illinois Eye Surgeons and St. Louis Eye Surgery & Laser Center.

Through a variety of indirect (e.g., role modeling by attending, nurses and administrators; outpatient and inpatient management; surgical scheduling) and direct (e.g., Grand Rounds case discussions; mandatory compliance workshops), residents develop competence in coordinating care of their patients in a broad range of healthcare settings, including the development of effective skills to contain cost, reduce risk, advocate for quality patient care, optimize delivery systems and become an effective team member to enhance the safety and care of the patients that they serve.

RESIDENCY EDUCATIONAL GOALS

- To develop a residency program curriculum that covers all aspects of ophthalmology with enough didactic instruction and clinical experience to obtain American Board of Ophthalmology (ABO) certification.
- To train ethical, comprehensive, and compassionate ophthalmologists.
- To provide residents with the fundamental scientific background in ophthalmology to prepare them to become life-long learners.
- To provide residents with skills to practice evidence-based medicine.
- To develop evaluation tools that adequately assess the resident’s performance in the six competencies as set forth by the ACGME: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.
- To prepare evaluation tools that adequately assess the resident’s progression in the ophthalmic milestones
- To enhance all areas of residency education by increasing faculty participation and response to resident feedback.
Educational Goals

RESIDENCY EDUCATIONAL OBJECTIVES

- To provide residents with clinical skills in all subspecialties of ophthalmology
- To provide residents with a strong scientific understanding of the fundamentals of ophthalmology
- To provide residents with broad surgical experience in all subspecialties of ophthalmology
- To encourage residents to perform literature reviews and use critical thinking skills to make informed patient care decisions
- To provide residents with an understanding of ethical, legal, and moral issues involved in eye care and medical care.
- To provide residents with the fundamental business and managerial skills for a systems-based practice.
- To provide residents with a greater appreciation of ancillary services that are available to provide non-physician services to the ophthalmic patient.
- To support attendance at medical conferences both financially and with time allowed.

Specific Educational Goals and Objectives by rotation and year of training are detailed by rotation further in this manual.
Educational Goals

OVERVIEW OF THE PROGRAM

- **First Year** - The first year of training emphasizes mastery of comprehensive eye examinations on well patients and triage of walk-in patients during business hours and initial response to after-hours emergencies and phone calls while on-call. Residency begins with two weeks of introductory lectures and demonstrations of the basic skills and knowledge needed to fulfill their role on the team. First year residents also are exposed to subspecialty practices including contact lens clinic, retina, cornea, oculoplastics, pediatrics, neuro-ophthalmology, low vision and glaucoma, providing them a basis for developing more in-depth skills in these areas when they rotate through these services again during their second and third years. Residents also receive time for gross and microscopic examination of pathology specimens during their first year.

- **Second Year** - Second year residents continue to be part of the on-call team for the first month of their second year in residency to mentor and work side-by-side with the new first year residents until the new first year residents are competent to function as first responders on-call. Thereafter, second year residents are free of call responsibilities, providing time for more in-depth reading and becoming involved in meaningful research with one or more of the faculty members. The second year emphasizes in-depth knowledge of four specialties (retina, neuro-ophthalmology, pediatric ophthalmology and oculoplastics) during the four, three-month blocks of the second year. Responsibilities and expectations increase during the second year, becoming effectively the second in command under the attending while on these assignments. Second year residents are the primary surgeon on a significant number of cases during this year.

- **Third Year** - Third year residents have the highest responsibilities and expectations among the residents. Aside from the attending on-call, third year residents are viewed as the leader of the on-call team and guide the first year residents in how to respond to a variety of urgent and emergent problems. The third year residents are primarily involved in the following four, three-month rotations: cornea, retina, glaucoma and comprehensive ophthalmology. The emphasis on anterior segment and comprehensive ophthalmology during these rotations provides third year residents with in-depth experience as primary surgeons and refractionists. Nearly all of the residents’ cataract surgery experience as primary surgeons occurs during the third year.

Because comprehensive ophthalmology experience occurs throughout the three years of training, there is good balance between subspecialty and general ophthalmology training. In the St. Louis area, comprehensive ophthalmology patients are derived from within a 10 to 15 mile radius of the city, whereas patients served in the subspecialty clinics travel up to three hours to seek subspecialty care.
Educational Goals

RESIDENCY EDUCATIONAL GOALS & OBJECTIVES BY ROTATION AND YEAR OF TRAINING

The major rotations of our program are listed in the table below. The resident should be able to competently demonstrate the following objectives upon completion of each rotation as follows.

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<td>Ophthalmic Pathology</td>
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<td>Officer of the Day</td>
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<tr>
<td>Pediatric Ophthalmology and Adult Strabismus</td>
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<td>Retina and Vitreous</td>
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**COMPREHENSIVE OPHTHALMOLOGY**

**Overall Goal:** To equip residents with adequate competence to independently conduct a comprehensive ophthalmology practice following graduation.

**Preceptors:**
Sangeeta Khanna, MD
Sweta Tarigopula, MD

**Comprehensive Ophthalmology Rotation PGY-2**

**Patient Care**

**Goal:** To provide care for ophthalmic patients that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

**Objectives:**
1. Determine the patient’s specific and general eye concerns.
2. Obtain complete and accurate history from both the patient and the chart.
3. Perform an eight point eye examination on healthy normal patient presenting for routine eye examination.
   - External exam
   - Vision
   - Pupils
Educational Goals

- Motility
- Confrontation Visual Fields
- Slit Lamp Examination
- Tonometry by Goldman applanation and Tonopen®
- Indirect fundus examination

4. Perform appropriate physical examination for patient with refractive errors.
5. Perform appropriate physical examination for patient with visual disturbance.
6. Perform appropriate physical examination for patient with cataract.
7. Perform appropriate physical examination for patient with blepharitis.
8. Perform appropriate physical examination for patient with dry eye syndrome.
9. Perform appropriate physical examination for patient with conjunctivitis.
10. Perform appropriate physical examination for patient with viral keratitis.
11. Perform appropriate physical examination for patient with drusen.
12. Perform appropriate physical examination for patient with stye or chalazion.
13. For simple problems, formulate a focused differential diagnosis ranked from most likely to least likely.
14. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
15. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
16. For common diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
17. Develop appropriate treatment plans or follow-up plans for common conditions.
18. Demonstrate efficiency in clinic.
19. Perform initial refraction on patients before verification by senior residents or attendings.
21. Explain dry eye care to patients.
22. Explain appropriate application of eye drops to patients.
23. Follow up on all laboratory/visual study results and communicate results back to patients in a timely fashion.

Medical Knowledge

Goal: To acquire knowledge in comprehensive ophthalmology, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.
Educational Goals

Objectives:
1. Learn the normal appearance of the eye and common variations of normal expected on routine eye examination.
2. Learn ophthalmic terminology to describe eye findings.
3. Learn sufficient fundamentals of optics and refraction to perform routine refractions.
4. Prescribe and manage therapy for common ophthalmic conditions including knowledge of important and common side effects.
5. Demonstrate knowledge of current developments in diagnosis and treatment of common ophthalmic conditions.
6. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
7. Integrate knowledge of basic science and pathophysiology with patient care.
8. Explain the underlying basic science mechanism of common ophthalmic disorders, including cataract formation, dry eye syndrome, keratitis, and infections.
9. Participate in supervised and unsupervised simulator exercises and wet lab exercises to learn the initial steps of cataract surgery.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching general ophthalmology knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of ophthalmic conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students, optometry students, and resident rotators basic ophthalmic exam skills.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.
Educational Goals

Interpersonal Communication

**Goal:** To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

**Objectives:**
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

**Goal:** Develop a commitment to excellence, integrity, and sensitivity in the care for ophthalmic patients and in the interactions with other health professionals and staff.

**Objectives:**
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Demonstrate ethical behavior with pharmaceutical representatives.

Systems Based Practice

**Goal:** Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

**Objectives:**
1. Practice cost-effective medicine.
Educational Goals

2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Begin to understand principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.

Comprehensive Ophthalmology Rotation PGY-3

Patient Care

Goal: To provide care for ophthalmic patients that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

Objectives:
1. Determine the patient’s specific and general eye concerns and elicit an appropriate review of systems based on these concerns.
2. Obtain complete and accurate history from both the patient and the chart.
3. Perform an eight point eye examination on healthy normal patient presenting for routine eye examination.
   - External exam
   - Vision
   - Pupils
   - Motility
   - Confrontation Visual Fields
   - Slit Lamp Examination
   - Tonometry by Goldman applanation and Tonopen®
   - Indirect fundus examination
4. Recognize presence of all major abnormal exam findings on routine eye examination.
5. Perform appropriate physical examination for patient with refractive errors.
6. Perform appropriate physical examination for patient with visual disturbance.
Educational Goals

7. Perform appropriate physical examination for patient with cataract.
8. Perform appropriate physical examination for patient with blepharitis.
9. Perform appropriate physical examination for patient with dry eye syndrome.
10. Perform appropriate physical examination for patient with conjunctivitis.
11. Perform appropriate physical examination for patient with viral keratitis.
12. Perform appropriate physical examination for patient with drusen.
13. Perform appropriate physical examination for patient with stye or chalazion.
14. Perform appropriate physical examination for patient with early glaucoma.
15. Perform appropriate physical examination for patient with iritis.
16. Perform appropriate physical examination for patient with corneal edema.
17. Perform appropriate physical examination for patient with optic neuropathies.
18. Perform appropriate physical examination for patient with motility disturbances.
19. Perform appropriate physical examination for patient with vitreous detachments.
20. Perform appropriate physical examination for patient with diabetic retinopathy.
21. Perform appropriate physical examination for patient with retinal vein occlusions.
22. For simple and difficult problems, formulate a focused differential diagnosis and an expanded differential diagnosis rank ordered from most likely to least likely that includes uncommon/rare ophthalmic conditions.
23. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
24. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
25. For common and uncommon diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
26. Develop appropriate treatment plans or follow-up plans for common and uncommon conditions.
27. Selection of diagnostic tests is appropriate, evidence-based and cost-effective.
29. Use results of diagnostic tests to narrow down the differential diagnosis.
30. Perform refraction on patients with more advanced knowledge of glasses prescriptions including single vision and bifocal prescriptions.
32. Perform chalazion incision and drainage procedures.
33. Prescribe and manage blepharitis therapy.
34. Prescribe and manage dry eye therapy.
35. Explain dry eye care to patients.
36. Explain appropriate application of eye drops to patients.
Educational Goals

37. Follow up on all laboratory/visual study results and communicate results back to patients in a timely fashion.

Medical Knowledge

Goal: To acquire knowledge in comprehensive ophthalmology, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Learn the normal and abnormal appearance of the eye and common variations of normal expected on routine eye examination.
2. Learn ophthalmic terminology to describe eye findings.
3. Learn sufficient fundamentals of optics and refraction to perform routine refractions.
4. Prescribe and manage therapy for common ophthalmic conditions including advanced knowledge of important, common and uncommon adverse effects.
5. Demonstrate knowledge of current developments in diagnosis and treatment of common and less common ophthalmic conditions.
6. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
7. Integrate knowledge of basic science and pathophysiology with patient care, clinicopathologic correlation, and journal review and discussion.
8. Explain the underlying basic science mechanism of common ophthalmic disorders, including cataract formation, dry eye syndrome, keratitis, and infections.
9. Explain the underlying basic science mechanism of less common conditions such as autoimmune conditions, neuropathies, and manifestations of systemic diseases such as diabetes and hypertension.
10. Participate in simulator exercises and wet lab exercises to learn all of the steps of cataract surgery.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching general ophthalmology knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of ophthalmic conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
Educational Goals

3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students, optometry students, and resident rotators basic ophthalmic exam skills and treatment of common ophthalmic conditions.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify in journal club or other presentations when new evidence, guidelines or information should change how they or the department function (ordering tests, selecting therapies, etc.)
9. Identify process for incident and error reporting in the institution.
10. Maintain accurate and timely procedure logs.
11. Maintain a portfolio that contains patient care encounters that demonstrate mastery of the core competencies.

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for ophthalmology patients and in the interactions with other health professionals and staff.
Educational Goals

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Effectively lead the team of residents and technicians that are working with you in the care of a patient.
8. Do not push off responsibilities on other staff members.
9. Demonstrate ethical behavior with pharmaceutical representatives.
10. Respect patient confidentiality.

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

Objectives:
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Increased understanding and application of principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.
15. Delegate tasks appropriately to members of the health care team.
16. Articulate understanding of how cost-benefit analysis is applied to patient care (i.e. via principles of screening tests and the development of clinical guidelines).
17. Identify the role of various health care stakeholders including providers, commercial and government payers, pharmaceutical industry and medical device companies, and their varied impact on the cost of and access to health care.
Educational Goals

**Comprehensive Ophthalmology Rotation PGY-4**

**Patient Care**

**Goal:** To provide care for ophthalmic patients that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

**Objectives:**
1. Determine the patient’s specific and general eye concerns and elicit an appropriate review of systems based on these concerns.
2. Obtain complete and accurate history from both the patient and the chart.
3. Examine uncooperative patients, or patients otherwise difficult to examine, and arrive at accurate information about the state of the eye.
4. Perform an eight point eye examination on healthy normal patient presenting for routine eye examination.
   - External exam
   - Vision
   - Pupils
   - Motility
   - Confrontation Visual Fields
   - Slit Lamp Examination
   - Tonometry by Goldman applanation and Tonopen®
   - Indirect fundus examination
5. Recognize presence of all major abnormal exam findings on routine eye examination and catch minor abnormal exam findings.
6. Perform appropriate physical examination for patient with refractive errors.
7. Perform appropriate physical examination for patient with visual disturbance.
8. Perform appropriate physical examination for patient with cataract.
9. Perform appropriate physical examination for patient with blepharitis.
10. Perform appropriate physical examination for patient with dry eye syndrome.
11. Perform appropriate physical examination for patient with conjunctivitis.
12. Perform appropriate physical examination for patient with viral keratitis.
13. Perform appropriate physical examination for patient with drusen.
14. Perform appropriate physical examination for patient with stye or chalazion.
15. Perform appropriate physical examination for patient with early glaucoma.
16. Perform appropriate physical examination for patient with iritis.
17. Perform appropriate physical examination for patient with corneal edema.
18. Perform appropriate physical examination for patient with optic neuropathies.
19. Perform appropriate physical examination for patient with motility disturbances.
Educational Goals

20. Perform appropriate physical examination for patient with vitreous detachments.
21. Perform appropriate physical examination for patient with diabetic retinopathy.
22. Perform appropriate physical examination for patient with retinal vein occlusions.
23. For simple, difficult, and complex problems, formulate a focused differential diagnosis and an expanded differential diagnosis rank ordered from most likely to least likely that includes uncommon/rare ophthalmic conditions.
24. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
25. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
26. For common and uncommon diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
27. Develop appropriate treatment plans or follow-up plans for common and uncommon conditions.
28. Selection of diagnostic tests is appropriate, evidence-based and cost-effective.
29. Demonstrate efficiency in clinic.
30. Use results of diagnostic tests to narrow down the differential diagnosis.
31. Perform refraction on patients with more advanced knowledge of glasses prescriptions including single vision and bifocal prescriptions.
32. Perform advanced refractive correction of complex refractive states and in patients with loss of vision due to diseased states of the eye (including high myopia, high astigmatic corrections, and rudimentary low vision aids).
33. Neutralize a patient’s glasses with a manual lensometer including progressive lenses.
34. Perform chalazion incision and drainage procedures.
35. Perform dilation and irrigation of the nasolacrimal duct system.
36. Prescribe and manage blepharitis therapy
37. Prescribe and manage dry eye therapy
38. Explain dry eye care to patients.
39. Explain appropriate application of eye drops to patients.
40. Follow up on all laboratory/visual study results and communicate results back to patients in a timely fashion.
41. Appropriately recognize and refer patients to subspecialty clinics.
42. Understand and explain cataract procedure to patients along with risks, benefits and alternatives of surgery.
43. Perform cataract surgery under the supervision of your attending, gaining the ability to perform routine cataract extractions without assistance.
44. Explain post-operative care to patients.
45. Manage operative and post-operative complications of cataract surgery.
Educational Goals

Medical Knowledge

**Goal:** To acquire knowledge in comprehensive ophthalmology, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

**Objectives:**
1. Learn the normal and abnormal appearance of the eye and common variations of normal expected on routine eye examination.
2. Learn ophthalmic terminology to describe eye findings.
3. Learn sufficient fundamentals of optics and refraction to perform routine refractions.
4. Prescribe and manage therapy for common ophthalmic conditions including advanced knowledge of important, common and uncommon adverse effects.
5. Demonstrate knowledge of current developments in diagnosis and treatment of common and less common ophthalmic conditions.
6. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
7. Integrate knowledge of basic science and pathophysiology with patient care, clinicopathologic correlation, and journal review and discussion.
8. Explain the underlying basic science mechanism of common ophthalmic disorders, including cataract formation, dry eye syndrome, keratitis, and infections.
9. Explain the underlying basic science mechanism of less common conditions such as autoimmune conditions, neuropathies, and manifestations of systemic diseases such as diabetes and hypertension.
10. Learn common risk factors for complicated cataract surgery (e.g. use of tamsulosin, pseudoexfoliation syndrome, etc.)
11. Participate in simulator exercises and wet lab exercises to refine all of the steps of cataract surgery.

Practice-Based Learning and Improvement

**Goal:** Develop skills in acquiring, analyzing, applying and teaching general ophthalmology knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

**Objectives:**
1. Demonstrate knowledge of current developments in diagnosis and treatment of ophthalmic conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
Educational Goals

4. Use review of surgical videos with attendings and during Cataract Club to further identify opportunities for improvement in cataract surgery.
5. Teach medical students, optometry students, and resident rotators basic ophthalmic exam skills and treatment of common ophthalmic conditions.
6. Identify areas in own practice that need improvement and implement needed changes.
7. Identify specific areas of interest.
8. Investigate areas of interest where certain clinical questions are left unanswered.
9. Identify in journal club or other presentations when new evidence, guidelines or information should change how they or the department function (ordering tests, selecting therapies, etc.)
10. Identify process for incident and error reporting in the institution.
11. Maintain accurate and timely procedure logs.
12. Maintain a portfolio that contains patient care encounters that demonstrate mastery of the core competencies.
13. Identify alternative resources to answer clinical questions (e.g. Medicare policies, CDC reporting requirements, etc.)
14. Maintain a portfolio that contains patient care encounters that demonstrate mastery of the core competencies.

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.
Educational Goals

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for ophthalmology patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Effectively lead the team of residents and technicians that are working with you in the care of a patient.
8. Do not push off responsibilities on other staff members.
9. Demonstrate ethical behavior with pharmaceutical representatives.
10. Respect patient confidentiality.

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

Objectives:
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Regularly apply principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.
15. Delegate tasks appropriately to members of the health care team.
16. Articulate understanding of how cost-benefit analysis is applied to patient care (i.e. via principles of screening tests and the development of clinical guidelines).
Educational Goals

17. Identify the role of various health care stakeholders including providers, commercial and government payers, pharmaceutical industry and medical device companies, and their varied impact on the cost of and access to health care.
18. Identify gaps and shortfalls in health care systems broadly.
19. Articulate understanding off the intersection of the legal system and health care system in the context of medical error.
20. Articulate an awareness of current debates/issues of health care financing and how it will affect patients, providers, third party payers and other stakeholders.

CONSULT SERVICE

Overall Goal: To provide residents with experience managing acute and subacute inpatient consults in a major teaching hospital.

Preceptors:
- Sophia Chung, MD
- Matthew Council, MD
- Gabriela Espinoza, MD
- Sangeeta Khanna, MD

Hospital Consult Rotation PGY-2

Patient Care

Goal: To provide care for ophthalmic inpatients that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

Objectives:
1. Obtain complete and accurate history from the primary team, the nurses, the patient and the chart (including previous ophthalmology notes if SLU ophthalmology patient).
2. Perform appropriate physical examination for a floor inpatient.
3. Perform appropriate physical examination for an ICU inpatient.
4. Perform appropriate physical examination for an emergency room patient that may or may not become an inpatient.
5. Perform appropriate physical examination for patient with suspected ruptured globe.
6. Perform appropriate physical examination for patient with eyelid lacerations.
7. Perform appropriate physical examination for patient with facial and orbital trauma.
8. Perform appropriate physical examination for patient with suspected endogenous fungal ocular infections.
Educational Goals

9. Perform appropriate physical examination for patient with vision changes in stroke.
10. Perform appropriate physical examination for patient with acute vision change.
11. Perform appropriate physical examination for pre- and post-operative evaluation of neurosurgical patients.
12. For simple problems, formulate a focused differential diagnosis ranked from most likely to least likely.
13. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
14. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
15. For common diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
16. Perform relevant textbook/literature searches prior to attending rounds.
17. Develop appropriate treatment plans or follow-up plans for common conditions.
18. Demonstrate efficiency on rounds.
19. Perform Goldman visual field tests and interpret results when appropriate.
20. Explain ophthalmic care and application of eye drops or ointment to patients and nursing staff.
21. Explain wound care to patients and nursing staff.
22. Maintain consultation patient list and follow patient hand off protocol regularly.
23. Arrange for patient’s ophthalmic follow-up after hospital discharge.
24. Selection of diagnostic tests is appropriate, evidence-based, and cost-effective.
25. Follow up on all laboratory/visual study results and communicate results back to patients and attendings in a timely fashion.
26. Use results of diagnostic tests to narrow down the differential diagnosis.

Medical Knowledge

Goal: To acquire knowledge in inpatient and emergency ophthalmology, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Use ophthalmic terminology to describe eye findings.
2. Identify and appropriately triage ophthalmic emergencies (e.g. ruptured globe, endophthalmitis, foreign bodies, etc.).
3. Prescribe and manage therapy for common acute ophthalmic conditions including knowledge of important and common side effects.
4. Demonstrate knowledge of current developments in diagnosis and treatment of common ophthalmic conditions.
Educational Goals

5. Understand and communicate the relevance of ophthalmic findings to underlying medical conditions.
6. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
7. Integrate knowledge of basic science and pathophysiology with patient care.
8. Explain the underlying basic science mechanism of less common ophthalmic disorders, including endogenous endophthalmitis, visual loss in cases of stroke, and motility disorders related to trauma.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching general ophthalmology knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of ophthalmic conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students and resident rotators about pertinent exam findings and disease processes on hospital rounds.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Investigate areas of interest where certain clinical questions are left unanswered.
7. Identify process for incident and error reporting in the institution.
8. Coordinate and organize hospital rounds with fellow residents and attendings.

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Accept consults from primary team in a polite and respectful manner.
3. Demonstrate respect and courteousness to fellow residents.
4. Demonstrate respect and courteousness to attending physicians.
5. Be attentive to staff needs.
Educational Goals

6. Communicate effectively with primary team and other consulting physicians.
7. Communicate effectively with outside ophthalmologist or optometrist and primary care physicians when necessary.
8. Explain things at an appropriate level for patients to understand.
9. Provide written materials to patients when necessary.
10. Use translators appropriately.
11. Develop skills with phone triage and accurately document these interactions in the medical record.
12. Instill confidence in patients.
13. Create an environment in which patients are comfortable to ask questions.
14. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for ophthalmic patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Respond to consults in a timely and polite manner.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Do not push off responsibilities on other staff members.
7. Respect patient confidentiality, especially in hospital common areas (e.g. elevators, waiting rooms, etc.).

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

Objectives:
1. Practice cost-effective medicine.
2. Demonstrate knowledge and manageability of insurance issues.
3. Act as a patient advocate for coverage of treatment/diagnostic procedures.
4. Communicate with primary team, other consulting physicians, and primary care physicians.
5. Understand the relevance of the ophthalmic findings to underlying medical conditions.
6. Obtain appropriate consultations and laboratory testing for patients.
7. Explain the nuances of insurance to patients.
8. Understand and address how social situations impact patient compliance and accessibility to health care systems.
Educational Goals

9. Understand the importance of continuity of care and help to facilitate this.
10. Utilize EMR efficiently and independently.
11. Access support services appropriately.
12. Arrange for specialized ophthalmic pastoral care consultation as indicated.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Begin to understand principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.

Hospital Consult Rotation PGY-3

Patient Care

Goal: To provide care for ophthalmic inpatients that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

Objectives:
1. Obtain complete and accurate history from the primary team, the nurses, the patient and the chart (including previous ophthalmology notes if SLU ophthalmology patient).
2. Perform appropriate physical examination for a floor inpatient.
3. Perform appropriate physical examination for an ICU inpatient.
4. Perform appropriate physical examination for an emergency room patient that may or may not become an inpatient.
5. Perform appropriate physical examination for patient with suspected ruptured globe.
6. Perform appropriate physical examination for patient with eyelid lacerations, recognizing full thickness lacerations, marginal lacerations, and canalicular lacerations.
7. Perform appropriate physical examination for patient with facial and orbital trauma.
8. Perform appropriate physical examination for patient with suspected endogenous fungal ocular infections.
9. Perform appropriate physical examination for patient with vision changes in stroke.
10. Perform appropriate physical examination for patient with acute vision change.
11. Perform appropriate physical examination for pre- and post-operative evaluation of neurosurgical patients.
12. For simple and difficult problems, formulate a focused differential diagnosis and an expanded differential diagnosis that includes uncommon/rare ophthalmic conditions.
13. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
14. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
Educational Goals

15. For all diseases, common and uncommon, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
16. Perform relevant textbook/literature searches prior to attending rounds.
17. Develop appropriate treatment plans or follow-up plans for common conditions.
18. Develop appropriate treatment plans for more uncommon conditions within the constraints of the hospital setting.
19. Demonstrate efficiency on rounds.
20. Perform Goldman visual field tests and interpret results when appropriate.
21. Explain ophthalmic care and application of eye drops or ointment to patients and nursing staff.
22. Explain wound care to patients and nursing staff.
23. Maintain consultation patient list and follow patient hand off protocol regularly.
25. Selection of diagnostic tests is appropriate, evidence-based, and cost-effective.
26. Follow up on all laboratory/visual study results and communicate results back to patients and attendings in a timely fashion.
27. Use results of diagnostic tests to narrow down the differential diagnosis.

Medical Knowledge

Goal: To acquire knowledge in inpatient and emergency ophthalmology, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Use ophthalmic terminology to describe eye findings.
2. Identify and appropriately triage ophthalmic emergencies (e.g. ruptured globe, endophthalmitis, foreign bodies, etc.).
3. Prescribe and manage therapy for common acute ophthalmic conditions including knowledge of important and common side effects.
4. Demonstrate knowledge of current developments in diagnosis and treatment of common and uncommon ophthalmic conditions.
5. Understand and communicate the relevance of ophthalmic findings to underlying medical conditions.
6. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
7. Integrate knowledge of basic science and pathophysiology with patient care.
8. Explain the underlying basic science mechanism of less common ophthalmic disorders, including endogenous endophthalmitis, visual loss in cases of stroke, and motility disorders related to trauma.
Educational Goals

9. Demonstrate knowledge of medical and surgical treatment of common and uncommon conditions, including important, common and uncommon adverse effects.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching general ophthalmology knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of ophthalmic conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students and resident rotators about pertinent exam findings and disease processes on hospital rounds.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Investigate areas of interest where certain clinical questions are left unanswered.
7. Identify process for incident and error reporting in the institution.
8. Coordinate and organize hospital rounds with fellow residents and attendings.
10. Identify in journal club or other educational venues when new evidence, guidelines, or information should change how they or the department function as a consult service.
11. Maintain a portfolio that contains patient care encounters that demonstrate mastery of the core competencies.
12. Demonstrate an ability to educate patients on a disease or treatment using appropriate language for the level of learner.

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Accept consults from primary team in a polite and respectful manner.
3. Demonstrate respect and courteousness to fellow residents.
4. Demonstrate respect and courteousness to attending physicians.
5. Be attentive to staff needs.
Educational Goals

6. Communicate effectively with primary team and other consulting physicians.
7. Communicate effectively with outside ophthalmologist or optometrist and primary care physicians when necessary.
8. Explain things at an appropriate level for patients to understand.
9. Provide written materials to patients when necessary.
10. Use translators appropriately.
11. Develop skills with phone triage and accurately document these interactions in the medical record.
12. Instill confidence in patients.
13. Create an environment in which patients are comfortable to ask questions.
14. If a SLU ophthalmology patient is admitted, communicate hospital course/plan with the patient’s primary ophthalmologist.
15. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for ophthalmic patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Respond to consults in a timely and polite manner
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Do not push off responsibilities on other staff members.
7. Respect patient confidentiality, especially in hospital common areas (e.g. elevators, waiting rooms, etc.).

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

Objectives:
1. Practice cost-effective medicine.
2. Demonstrate knowledge and manageability of insurance issues.
3. Refer appropriately to financial services.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with primary team, other consulting physicians, and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
Educational Goals

8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Arrange for specialized ophthalmic pastoral care consultation as indicated.
15. Regularly apply principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.
16. Identify the role of various health care stakeholders including providers, commercial and government payers, pharmaceutical industry and medical device companies, and their varied impact on the cost of and access to health care.
17. Identify gaps and shortfalls in health care systems.
18. Articulate understanding of the intersection of the legal system and health care system in the context of medical error.
19. Articulates an awareness of current debates/issues of health care financing and how it will affect patients, providers, third party payers and other stakeholders.

CONTACT LENS

Overall Goal: To learn the basics of contact lens fitting and to be able to prescribe contact lenses in routine patients.

Preceptor: Julie DeKinder, OD

Contact Lens Rotation PGY-2

Patient Care

Goal: To provide care for contact lens wearing ophthalmic patients that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

Objectives:
1. Determine the patient’s specific and general contact lens concerns.
2. Obtain complete and accurate history from both the patient and the chart
3. Perform an eight point eye examination on healthy contact lens-wearers presenting for routine eye examination.
   - External exam
   - Vision
   - Pupils
Educational Goals

- Motility
- Confrontation Visual Fields
- Slit Lamp Examination
- Tonometry by Goldman applanation and Tonopen®
- Indirect fundus examination

4. Perform appropriate physical examination for patient with refractive errors.
5. Know the appropriate indications for soft contact lenses.
6. Know the appropriate indications for toric contact lenses.
7. Know the appropriate indications for rigid gas-permeable contact lenses
8. Perform appropriate physical examination for patient with keratoconus.
9. Learn routine fitting and maintenance for soft and hard contact lenses in patients with no astigmatism or regular astigmatism.
10. Develop competence in performing manual keratometry.
12. Perform initial refraction on patients before verification by attending.
13. Develop appropriate treatment plans or follow-up plans for common contact lens issues.
14. Recognize and educate patients on contact lens overuse.
15. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
16. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending.
17. Explain dry eye care to patients.
18. Explain appropriate application of eye drops to patients.

Medical Knowledge

Goal: To acquire knowledge in the art of contact lens fitting, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Learn ophthalmic terminology to describe eye findings.
2. Learn sufficient fundamentals of optics and refraction to perform routine refractions.
3. Prescribe and manage therapy for common ophthalmic conditions including knowledge of important and common side effects.
4. Demonstrate knowledge of current developments in diagnosis and treatment of common contact lens related conditions.
5. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
6. Integrate knowledge of basic science and pathophysiology with patient care.
7. Demonstrate knowledge of common complications due to contact lens use.
Educational Goals

8. Explain the underlying basic science mechanism of common ophthalmic disorders, including keratoconus, dry eye syndrome, keratitis, and infections.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, and applying and teaching contact lens related ophthalmology knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of contact lens related ophthalmic conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students, optometry students, and resident rotators basic contact lens fitting skills.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.
9. Demonstrate an ability to educate patients on contact lens use and care using appropriate language for the level of the learner.
10. Maintain a portfolio that contains patient care encounters that demonstrate mastery of the core competencies.

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow learners (optometry students).
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Explain things at an appropriate level for patients to understand.
7. Provide written materials to patients when necessary.
8. Use translators appropriately.
Educational Goals

10. Create an environment in which patients are comfortable to ask questions.
11. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for contact lens wearing patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Demonstrate ethical behavior with pharmaceutical representatives.

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

Objectives:
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Become comfortable with discussing cost of contact lenses not covered by insurance plans with patients.
10. Understand and address how social situations impact patient compliance and accessibility to health care systems.
11. Understand the importance of continuity of care and help to facilitate this.
12. Utilize EMR efficiently and independently.
13. Access support services appropriately.
Educational Goals

15. Begin to understand principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.

16. Delegate tasks appropriately to members of the health care team.

CORNEA AND EXTERNAL DISEASE

Overall Goal: To provide resident with exposure to the diagnosis and management of advanced tertiary care cornea and external ocular diseases.

Preceptors: Sean Edelstein, MD
Matt Council, MD

Cornea and External Disease Rotation PGY-2

Patient Care

Goal: To provide care for ophthalmic patients with cornea and external disease concerns that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

Objectives:
1. Determine the patient’s specific and general eye concerns
2. Obtain complete and accurate history from both the patient and the chart
3. Gain an in-depth knowledge of the structure and function of the external eye and cornea.
4. Perform appropriate physical examination for patient with ocular surface disorders.
5. Perform appropriate physical examination for patient with infections of the eyelids, conjunctiva, cornea and sclera.
6. Perform appropriate physical examination for patient with immune mediated disorders of the eyelids, conjunctiva, cornea and sclera.
7. Perform appropriate physical examination for patient with neoplasms of the eyelids, conjunctiva, and cornea.
8. Perform appropriate physical examination for patient with congenital anomalies of the cornea and sclera.
9. Perform appropriate physical examination for patient with corneal dystrophies.
10. Perform appropriate physical examination for patient with degenerative disorders of the conjunctiva, cornea and sclera.
11. Perform appropriate physical examination for patient with toxic and traumatic injuries of the anterior segment.
12. For simple problems, formulate a focused differential diagnosis rank ordered from most likely to least likely.
13. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
Educational Goals

14. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
15. For common diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
16. Develop appropriate treatment plans or follow-up plans for common conditions.
17. Demonstrate efficiency in clinic.
18. Perform and interpret special stains of the cornea and conjunctiva.
19. Perform corneal pachymetry.
20. Perform esthesiometry when appropriate.
21. Perform corneal topography when appropriate.
22. Explain appropriate application of eye drops to patients.
23. Observe and perform the role of primary assistant in the operating room during cornea and anterior segment surgery.
24. Know the appropriate indications for a variety of corneal and anterior segment procedures.
25. Demonstrate understanding of common corneal and anterior segment procedures, their expected outcomes and the importance of management of realistic expectations.
26. Know and be able to explain the risks, benefits, options and aftercare of common corneal and anterior segment procedures.
27. Follow up on all laboratory/visual study results and communicate results back to patients in a timely fashion.

Medical Knowledge

Goal: To acquire knowledge in the field of cornea and external disease in ophthalmology, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Learn ophthalmic terminology to describe eye findings.
2. Learn the layers of the cornea.
3. Demonstrate a good knowledge of anatomy of the cornea and anterior segment as it relates to disease, treatment, and surgical intervention.
4. Prescribe and manage therapy for common corneal and anterior segment conditions including knowledge of important and common side effects.
5. Demonstrate knowledge of current developments in diagnosis and treatment of common corneal and anterior segment ophthalmic conditions.
6. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
7. Integrate knowledge of basic science and pathophysiology with patient care.
Educational Goals

8. Explain the underlying basic science mechanism of common ophthalmic disorders, including cataract formation, dry eye syndrome, and corneal dystrophies.
9. Participate in simulator exercises and wet lab exercises to learn all of the steps of cataract surgery.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching corneal and external diseases ophthalmology knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of corneal and external ophthalmic conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students, optometry students, and resident rotators anterior segment ophthalmic exam skills.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
Educational Goals

10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for corneal and external disease ophthalmic patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Learn to effectively utilize support staff.
9. Demonstrate ethical behavior with pharmaceutical representatives.
10. Respect patient confidentiality.

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

Objectives:
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
Educational Goals

14. Begin to understand principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.

Cornea and External Disease Rotation PGY-3

Patient Care

Goal: To provide care for ophthalmic patients with cornea and external disease concerns that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

Objectives:
1. Determine the patient’s specific and general eye concerns
2. Obtain complete and accurate history from both the patient and the chart
3. Exhibit an in-depth knowledge of the structure and function of the external eye and cornea.
4. Perform appropriate physical examination for patient with ocular surface disorders.
5. Perform appropriate physical examination for patient with infections of the eyelids, conjunctiva, cornea and sclera.
6. Perform appropriate physical examination for patient with immune mediated disorders of the eyelids, conjunctiva, cornea and sclera.
7. Perform appropriate physical examination for patient with neoplasms of the eyelids, conjunctiva, and cornea.
8. Perform appropriate physical examination for patient with congenital anomalies of the cornea and sclera.
9. Perform appropriate physical examination for patient with corneal dystrophies.
10. Perform appropriate physical examination for patient with degenerative disorders of the conjunctiva, cornea and sclera.
11. Perform appropriate physical examination for patient with toxic and traumatic injuries of the anterior segment.
12. For simple and difficult problems, formulate a focused differential diagnosis and an expanded differential diagnosis with uncommon or rare diagnoses.
13. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
14. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
15. For common and uncommon diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
16. Develop appropriate treatment plans or follow-up plans for common conditions.
17. Demonstrate efficiency in clinic.
18. Perform and interpret special stains of the cornea and conjunctiva.
19. Perform corneal pachymetry.
Educational Goals

20. Perform esthesiometry when appropriate.
21. Perform corneal topography when appropriate.
22. Explain appropriate application of eye drops to patients.
23. Perform the role of primary assistant and primary surgeon in the operating room during cornea and anterior segment surgery.
24. Know the appropriate indications for a variety of corneal and anterior segment procedures.
25. Demonstrate understanding of common and less common corneal and anterior segment procedures, their expected outcomes and the importance of management of realistic expectations.
26. Know and be able to explain the risks, benefits, options and aftercare of common and less common corneal and anterior segment procedures.
27. Follow up on all laboratory/visual study results and communicate results back to patients in a timely fashion.

Medical Knowledge

Goal: To acquire knowledge in the field of cornea and external disease in ophthalmology, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Learn ophthalmic terminology to describe eye findings.
2. Learn the layers of the cornea.
3. Demonstrate an advanced knowledge of anatomy of the cornea and anterior segment as it relates to disease, treatment, and surgical intervention.
4. Prescribe and manage therapy for common and less common corneal and anterior segment conditions including knowledge of important, common and uncommon side effects.
5. Demonstrate knowledge of current developments in diagnosis and treatment of common and less common corneal and anterior segment ophthalmic conditions.
6. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
7. Integrate knowledge of basic science and pathophysiology with patient care.
8. Explain the underlying basic science mechanism of common ophthalmic disorders, including cataract formation, dry eye syndrome, keratitis, and infections.
9. Participate in supervised and unsupervised simulator exercises and wet lab exercises to learn all of the steps of cataract surgery.
Educational Goals

Practice-Based Learning and Improvement

**Goal:** Develop skills in acquiring, analyzing, applying and teaching corneal and external diseases ophthalmology knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

**Objectives:**
1. Demonstrate knowledge of current developments in diagnosis and treatment of corneal and external ophthalmic conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students, optometry students, and resident rotators anterior segment ophthalmic exam skills.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.
10. Maintain a portfolio that contains patient care encounters that demonstrate mastery of the core competencies.

Interpersonal Communication

**Goal:** To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

**Objectives:**
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
Educational Goals

13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for corneal and external disease ophthalmic patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Learn to effectively utilize support staff.
9. Demonstrate ethical behavior with pharmaceutical representatives.
10. Respect patient confidentiality.

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

Objectives:
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Increased understanding and application of principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.
15. Delegate tasks appropriately to members of the health care team.
Educational Goals

16. Articulate understanding of how cost-benefit analysis is applied to patient care (i.e. via principles of screening tests and the development of clinical guidelines).

17. Identify the role of various health care stakeholders including providers, commercial and government payers, pharmaceutical industry and medical device companies, and their varied impact on the cost of and access to health care.

Cornea and External Disease Rotation PGY-4

Patient Care

Goal: To provide care for ophthalmic patients with cornea and external disease concerns that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

Objectives:
1. Determine the patient’s specific and general eye concerns
2. Obtain complete and accurate history from both the patient and the chart
3. Exhibit an in-depth knowledge of the structure and function of the external eye and cornea.
4. Perform appropriate physical examination for patient with ocular surface disorders.
5. Perform appropriate physical examination for patient with infections of the eyelids, conjunctiva, cornea and sclera.
6. Perform appropriate physical examination for patient with immune mediated disorders of the eyelids, conjunctiva, cornea and sclera.
7. Perform appropriate physical examination for patient with neoplasms of the eyelids, conjunctiva, and cornea.
8. Perform appropriate physical examination for patient with congenital anomalies of the cornea and sclera.
9. Perform appropriate physical examination for patient with corneal dystrophies.
10. Perform appropriate physical examination for patient with degenerative disorders of the conjunctiva, cornea and sclera.
11. Perform appropriate physical examination for patient with toxic and traumatic injuries of the anterior segment.
12. Perform appropriate physical examination for patient with corneal transplant.
13. Perform appropriate physical examination for patient with interest in refractive surgery.
14. For simple, difficult and complex problems, formulate a focused differential diagnosis and an expanded differential diagnosis with uncommon or rare diagnoses.
15. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
Educational Goals

16. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
17. For common and uncommon diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
18. Develop appropriate treatment plans or follow-up plans for common and uncommon conditions.
20. Perform and interpret special stains of the cornea and conjunctiva.
22. Perform esthesiometry when appropriate.
23. Perform corneal topography when appropriate.
24. Explain appropriate application of eye drops to patients.
25. Perform conjunctival biopsy when appropriate.
26. Perform tarsorrhaphy with appropriate.
27. Perform the role of primary assistant and primary surgeon in the operating room during pterygium excision.
28. Perform the role of primary assistant and primary surgeon in the operating room during corneal transplantation.
29. Perform the role of primary assistant and primary surgeon in the operating room during cornea and anterior segment surgery.
30. Know the appropriate indications for a variety of corneal and anterior segment procedures.
31. Demonstrate understanding of common and less common corneal and anterior segment procedures, their expected outcomes and the importance of management of realistic expectations.
32. Know and be able to explain the risks, benefits, options and aftercare of common and uncommon corneal and anterior segment procedures.
33. Follow up on all laboratory/visual study results and communicate results back to patients in a timely fashion.

Medical Knowledge

Goal: To acquire knowledge in the field of cornea and external disease in ophthalmology, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Learn ophthalmic terminology to describe eye findings.
2. Learn the layers of the cornea and describe various methods of corneal transplant procedures.
3. Demonstrate an advanced knowledge of anatomy of the cornea and anterior segment as it relates to disease, treatment, and surgical intervention.
Educational Goals

4. Prescribe and manage therapy for common and less common corneal and anterior segment conditions including knowledge of important, common and uncommon side effects.
5. Demonstrate knowledge of current developments in diagnosis and treatment of common and uncommon corneal and anterior segment ophthalmic conditions.
6. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
7. Integrate knowledge of basic science and pathophysiology with patient care.
8. Explain the underlying basic science mechanism of common ophthalmic disorders, including cataract formation, dry eye syndrome, keratitis, and infections.
9. Participate in simulator exercises and wet lab exercises to enhance proficiency in all of the steps of cataract surgery.
10. Demonstrate knowledge of promptly addressing and managing complications due to corneal and anterior segment procedures.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching corneal and external diseases ophthalmology knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of corneal and external ophthalmic conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students, optometry students, and resident rotators anterior segment ophthalmic exam skills.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.
10. Demonstrate an ability to educate patients on corneal and external disease treatments using appropriate language for the level of learner.
11. Maintain a portfolio that contains patient care encounters that demonstrate mastery of the core competencies.
Educational Goals

Interpersonal Communication

**Goal:** To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

**Objectives:**
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Communicate effectively with pharmacy and insurance representatives as needed.
14. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

**Goal:** Develop a commitment to excellence, integrity, and sensitivity in the care for corneal and external disease ophthalmic patients and in the interactions with other health professionals and staff.

**Objectives:**
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Learn to effectively utilize support staff.
9. Demonstrate ethical behavior with pharmaceutical representatives.
10. Respect patient confidentiality.

Systems Based Practice

**Goal:** Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.
Educational Goals

Objectives:
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Regularly apply principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.
15. Delegate tasks appropriately to members of the health care team.
16. Articulate understanding of how cost-benefit analysis is applied to patient care (i.e. via principles of screening tests and the development of clinical guidelines).
17. Identify the role of various health care stakeholders including providers, commercial and government payers, pharmaceutical industry and medical device companies, and their varied impact on the cost of and access to health care.
18. Identify gaps and shortfalls in health care systems broadly.
19. Articulate an awareness of current debates/issues of health care financing and how it will affect patients, providers, third party payers and other stakeholders.

GLAUCOMA

Overall Goal: To gain sufficient knowledge and experience to manage common forms of glaucoma in a comprehensive ophthalmology practice and to recognize what patients should be referred for subspecialty care.

Preceptor: Steven Shields, MD

Glaucoma Rotation PGY-2

Patient Care
Educational Goals

**Goal:** To provide care for ophthalmic patients with glaucoma that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

**Objectives:**
1. Determine the patient’s specific and general eye concerns
2. Obtain complete and accurate history from both the patient and the chart
3. Perform appropriate physical examination for patient with common forms of glaucoma, including primary open angle, normal tension, exfoliative, pigmentary, primary angle closure, and neovascular.
4. Learn how to perform gonioscopy and identify the normal structures of the angle.
5. Perform gonioscopy and begin to appreciate major abnormalities of the angle.
6. For simple problems, formulate a focused differential diagnosis rank ordered from most likely to least likely.
7. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
8. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
9. For common diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
10. Develop appropriate treatment plans or follow-up plans for common conditions.
11. Demonstrate efficiency in clinic.
12. Perform and interpret stereo examination of the optic nerve head.
13. Explain appropriate application of eye drops to patients.
14. Observe and perform the role of primary assistant in the operating room during filtering and glaucoma drainage device surgery operations.
15. Observe and perform the role of primary assistant and primary surgeon for laser iridotomy procedures.
16. Observe and perform the role of primary assistant and primary surgeon for trabeculoplasty procedures.
17. Know the appropriate indications for a variety of glaucoma procedures.
18. Demonstrate understanding of common glaucoma procedures, their expected outcomes and the importance of management of realistic expectations.
19. Know and be able to explain the risks, benefits, options and aftercare of common glaucoma procedures.
20. Follow up on all laboratory/visual study results and communicate results back to patients in a timely fashion.
21. Coordinate care of indigent patients to insure adequate health care access to prevent blindness from glaucoma.
Educational Goals

Medical Knowledge

Goal: To acquire knowledge in the field of glaucoma, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Learn ophthalmic terminology to describe eye findings.
2. Learn the anatomy of the angle.
3. Demonstrate a good knowledge of anatomy of the cornea and anterior segment as it relates to disease, treatment, and surgical intervention.
4. Prescribe and manage therapy for common glaucoma conditions including knowledge of important and common side effects.
5. Demonstrate knowledge of current developments in diagnosis and treatment of common glaucoma conditions.
6. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
7. Integrate knowledge of basic science and pathophysiology with patient care.
8. Explain the underlying basic science mechanism of common glaucoma therapies.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching glaucoma knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of glaucoma.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students, optometry students, and resident rotators anterior segment ophthalmic exam skills pertinent to glaucoma evaluation.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.
Educational Goals

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for glaucoma patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Learn to effectively utilize support staff.
9. Demonstrate ethical behavior with pharmaceutical representatives.
10. Respect patient confidentiality.

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.
Educational Goals

Objectives:
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Begin to understand principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.

Glaucoma Rotation PGY-3

Patient Care

Goal: To provide care for ophthalmic patients with glaucoma that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

Objectives:
1. Determine the patient’s specific and general eye concerns
2. Obtain complete and accurate history from both the patient and the chart
3. Perform appropriate physical examination for patient with common forms of glaucoma, including primary open angle, normal tension, exfoliative, pigmentary, primary angle closure, and neovascular.
4. Perform appropriate physical examination for patient with secondary glaucoma.
5. Learn how to perform gonioscopy and identify the normal structures of the angle.
6. Perform gonioscopy and appreciate all major and most minor abnormalities of the angle.
7. For simple and difficult problems, formulate a focused differential diagnosis and an expanded differential diagnosis with uncommon diagnoses.
8. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
9. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
Educational Goals

10. For common and uncommon diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
11. Develop appropriate treatment plans or follow-up plans for common and uncommon conditions.
12. Demonstrate efficiency in clinic.
13. Perform and interpret stereo examination of the optic nerve head.
14. Explain appropriate application of eye drops to patients.
15. Observe and perform the role of primary assistant and primary surgeon for laser iridotomy procedures.
16. Observe and perform the role of primary assistant and primary surgeon for trabeculoplasty procedures.
17. Know the appropriate indications for a variety of glaucoma procedures.
18. Demonstrate understanding of common glaucoma procedures, their expected outcomes and the importance of management of realistic expectations.
19. Know and be able to explain the risks, benefits, options and aftercare of common and uncommon glaucoma procedures.
20. Follow up on all laboratory/visual study results and communicate results back to patients in a timely fashion.
21. Coordinate care of indigent patients to insure adequate health care access to prevent blindness from glaucoma.

Medical Knowledge

Goal: To acquire knowledge in the field of glaucoma, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Learn ophthalmic terminology to describe eye findings.
2. Learn the anatomy of the angle.
3. Demonstrate a good knowledge of anatomy of the cornea and anterior segment as it relates to disease, treatment, and surgical intervention.
4. Prescribe and manage therapy for common and uncommon glaucoma conditions including knowledge of important and common side effects.
5. Demonstrate knowledge of current developments in diagnosis and treatment of common glaucoma conditions.
6. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
7. Integrate knowledge of basic science and pathophysiology with patient care.
8. Explain the underlying basic science mechanism of common and uncommon glaucoma therapies.
Educational Goals

Practice-Based Learning and Improvement

**Goal:** Develop skills in acquiring, analyzing, applying and teaching glaucoma knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

**Objectives:**
1. Demonstrate knowledge of current developments in diagnosis and treatment of glaucoma.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students, optometry students, and resident rotators anterior segment ophthalmic exam skills pertinent to glaucoma evaluation.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.

Interpersonal Communication

**Goal:** To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

**Objectives:**
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.
Educational Goals

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for glaucoma patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Learn to effectively utilize support staff.
9. Demonstrate ethical behavior with pharmaceutical representatives.
10. Respect patient confidentiality.

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

Objectives:
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Apply the principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.
Educational Goals

Glaucoma Rotation PGY-4

Patient Care

Goal: To provide care for ophthalmic patients with glaucoma that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

Objectives:
1. Determine the patient’s specific and general eye concerns.
2. Evaluate children with glaucoma and determine parent’s specific and general eye concerns.
3. Obtain complete and accurate history from both the patient, caretakers and the chart
4. Perform appropriate physical examination for patient with common forms of glaucoma, including primary open angle, normal tension, exfoliative, pigmentary, primary angle closure, and neovascular.
5. Perform appropriate physical examination for patient with congenital glaucoma.
6. Perform appropriate physical examination for patient with secondary glaucoma.
7. Learn how to perform gonioscopy and identify the normal structures of the angle.
8. Perform gonioscopy and appreciate all major and minor abnormalities of the angle.
9. For simple, difficult and complex problems, formulate a focused differential diagnosis and an expanded differential diagnosis with uncommon or rare diagnoses
10. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
11. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
12. For common and uncommon diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
13. Develop appropriate treatment plans or follow-up plans for common and uncommon conditions.
15. Perform and interpret stereo examination of the optic nerve head.
16. Explain appropriate application of eye drops to patients.
17. Observe and perform the role of primary assistant and primary surgeon for laser iridotomy procedures.
18. Observe and perform the role of primary assistant and primary surgeon for trabeculoplasty procedures.
19. Observe and perform the role of primary assistant and primary surgeon in glaucoma drainage implant procedures.
Educational Goals

20. Observe and perform the role of primary assistant and primary surgeon in angle surgery in children including goniotomy or trabeculotomy.
21. Know the appropriate indications for a variety of glaucoma procedures.
22. Demonstrate understanding of common and uncommon glaucoma procedures, their expected outcomes and the importance of management of realistic expectations.
23. Know and be able to explain the risks, benefits, options and aftercare of common and uncommon glaucoma procedures.
24. Follow up on all laboratory/visual study results and communicate results back to patients in a timely fashion.
25. Coordinate care of indigent patients to insure adequate health care access to prevent blindness from glaucoma.

Medical Knowledge

Goal: To acquire knowledge in the field of glaucoma, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Know ophthalmic terminology to describe eye findings.
2. Know the anatomy of the angle.
3. Learn the causes of congenital glaucoma.
4. Demonstrate a good knowledge of anatomy of the cornea and anterior segment as it relates to disease, treatment, and surgical intervention.
5. Prescribe and manage therapy for common and uncommon glaucoma conditions including knowledge of important and common side effects.
6. Demonstrate knowledge of current developments in diagnosis and treatment of common and uncommon glaucoma conditions.
7. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
8. Integrate knowledge of basic science and pathophysiology with patient care.
9. Explain the underlying basic science mechanism of common and uncommon glaucoma therapies.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching glaucoma knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of glaucoma.
Educational Goals

2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students, optometry students, and resident rotators anterior segment ophthalmic exam skills pertinent to glaucoma evaluation.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.
10. Maintain a portfolio that contains patient care encounters that demonstrate mastery of the core competencies.

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for glaucoma patients and in the interactions with other health professionals and staff.
Educational Goals

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Learn to effectively utilize support staff.
9. Demonstrate ethical behavior with pharmaceutical representatives.
10. Respect patient confidentiality.

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

Objectives:
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Regularly apply principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.
15. Delegate tasks appropriately to members of the health care team.
16. Articulate understanding of how cost-benefit analysis is applied to patient care (i.e. via principles of screening tests and the development of clinical guidelines).
17. Identify the role of various health care stakeholders including providers, commercial and government payers, pharmaceutical industry and medical device companies, and their varied impact on the cost of and access to health care.
18. Identify gaps and shortfalls in health care systems broadly.
19. Articulate understanding of the intersection of the legal system and health care system in the context of medical error.
Educational Goals

20. Articulates an awareness of current debates/issues of health care financing and how it will affect patients, providers, third party payers and other stakeholders.

LOW VISION

Overall Goal: To introduce residents to the management of low vision patients to provide optimal visual function with currently available technologies

Preceptor: Thomas Porter, OD

Low Vision Rotation PGY-2

Patient Care

Goal: To provide care for ophthalmic patients with low vision that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

Objectives:
1. Determine the patient’s specific and general eye concerns.
2. Determine the patient’s specific limitations and restrictions related to low vision.
3. Obtain complete and accurate history from both the patient and the chart.
4. Obtain functional vision case history.
5. Identify reversible causes of low vision.
6. Perform appropriate physical examination for patient with moderate to severe visual disturbance.
7. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
8. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
9. Perform low vision testing with single letter and reading test.
10. Perform trial frame refraction.
11. Understand options in low vision aides available for patient use.
12. Develop appropriate treatment plans or follow-up plans for common conditions.
13. Learn appropriate indications for prescribing or recommending low vision aides.
14. Learn to educate patients regarding options and train in use of low vision devices.
15. Refer patients to appropriate low vision societies.
Educational Goals

Medical Knowledge

**Goal:** To acquire knowledge in the field of low vision in ophthalmology, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

**Objectives:**
1. Learn the definition of low vision and legal implications.
2. Learn what low vision devices are available and their indications for use.
3. Use current literature to manage patients with evidence based medicine on reversible causes of low vision (i.e. use of PubMed, Ovid, on-line resources and textbooks).
4. Integrate knowledge of basic science and pathophysiology with patient care.

Practice-Based Learning and Improvement

**Goal:** Develop skills in acquiring, analyzing, applying and teaching low vision ophthalmology knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

**Objectives:**
1. Demonstrate knowledge of current developments in diagnosis and treatment of conditions that can lead to low vision.
2. Use current literature to manage patients with evidence based medicine on reversible causes of low vision (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Identify areas in own practice that need improvement and implement needed changes.
5. Identify specific areas of interest.
6. Investigate areas of interest where certain clinical questions are left unanswered.

Interpersonal Communication

**Goal:** To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

**Objectives:**
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to attending physicians.
3. Be attentive to staff needs.
Educational Goals

4. Communicate effectively with consulting physicians and primary care physicians.
5. Write understandable letters to other physicians.
6. Explain things at an appropriate level for patients to understand.
7. Provide written materials to patients when necessary.
8. Use translators appropriately.
10. Create an environment in which patients are comfortable to ask questions.
11. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for low vision disease ophthalmic patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Learn to effectively utilize support staff.
9. Demonstrate ethical behavior with pharmaceutical representatives.
10. Respect patient confidentiality.

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

Objectives:
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
Educational Goals

11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Understand principles of coding (ICD-9/10) and reimbursement (E&M levels/ procedures) appropriate to medical record documentation.

NEURO-OPHTHALMOLOGY

Overall Goal: To gain sufficient knowledge and experience to manage common forms of neuro-ophthalmic diseases in a comprehensive ophthalmology practice and to recognize what patients should be referred for subspecialty care.

Preceptors: Sophia Chung, MD
John Selhorst, MD

Neuro-Ophthalmology Rotation PGY-2

Patient Care

Goal: To provide care for neuro-ophthalmic patients that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

Objectives:
1. Determine the patient’s specific and general eye concerns
2. Obtain complete and accurate history from both the patient and the chart
3. Perform a thorough review of prior records, including imaging studies and labs.
4. Become familiar with common diseases affecting the optic nerve, visual pathways, and motility system.
5. Perform appropriate physical examination for patient with arteritic and non-arteritic ischemic optic neuropathy.
6. Perform appropriate physical examination for patient with elevated intracranial pressure.
7. Perform appropriate physical examination for patient with ischemic 6th nerve palsies.
8. Perform appropriate physical examination for patient with traumatic 4th nerve palsies.
9. Perform appropriate physical examination for patient with optic nerve drusen.
10. For simple problems, formulate a focused differential diagnosis rank ordered from most likely to least likely.
12. Perform color vision testing.
Educational Goals

13. Perform in-depth description of the pupil exam.
15. Become familiar with techniques to evaluate nystagmus.
16. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
17. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
18. Perform basic interpretation of MRI and CT scans as they apply to the orbit, eye and visual pathway.
19. For common diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
20. Develop appropriate treatment plans or follow-up plans for common conditions.
22. Perform the role of primary assistant in temporal artery biopsies.
23. Follow up on all laboratory/visual study results and communicate results back to patients in a timely fashion.

Medical Knowledge

Goal: To acquire knowledge in neuro-ophthalmology, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Learn the normal appearance of the optic nerve and common variations of normal.
2. Recognize major abnormalities in the appearance of the optic nerve.
3. Learn ophthalmic terminology to describe eye findings.
4. Learn the neuro-ophthalmic visual pathways on MRI and CT scans.
5. Learn common visual field deficits related to injury to the visual pathways and correlate with localized lesions or insult to the visual pathway.
6. Prescribe and manage therapy for common neuro-ophthalmic conditions including knowledge of important and common side effects.
7. Demonstrate knowledge of current developments in diagnosis and treatment of common neuro-ophthalmic conditions.
8. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
9. Integrate knowledge of basic science and pathophysiology with patient care.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching neuro-ophthalmology knowledge. Develop the ability to self-analyze and the
Educational Goals

ability to design quality improvement projects to optimize patient outcomes.

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of neuro-ophthalmic conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students and resident rotators neuro-ophthalmic exam skills.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.
Educational Goals

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for neuro-ophthalmic patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Demonstrate ethical behavior with pharmaceutical representatives.

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

Objectives:
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the neuro-ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Begin to understand principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.
Educational Goals

Neuro-Ophthalmology Rotation PGY-3

Patient Care

Goal: To provide care for neuro-ophthalmic patients that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

Objectives:
1. Determine the patient’s specific and general eye concerns
2. Obtain complete and accurate history from both the patient and the chart
3. Perform a thorough review of prior records, including imaging studies and labs.
4. Become familiar with common and uncommon diseases affecting the optic nerve, visual pathways, and motility system.
5. Perform appropriate physical examination for patient with arteritic and non-arteritic ischemic optic neuropathy.
6. Perform appropriate physical examination for patient with elevated intracranial pressure.
7. Perform appropriate physical examination for patient with ischemic 6th nerve palsies.
8. Perform appropriate physical examination for patient with traumatic 4th nerve palsies.
9. Perform appropriate physical examination for patient with optic nerve drusen.
10. Perform appropriate physical examination for patient with facial nerve disorders.
11. Perform appropriate physical examination for patient with systemic conditions with neuro-ophthalmic signs.
12. Perform appropriate physical examination to differentiate non-organic (e.g. malingering) from organic neurologic signs and symptoms.
13. For simple and difficult problems, formulate a focused differential diagnosis rank and an expanded differential diagnosis rank ordered from most likely to least likely that includes uncommon/rare neuro-ophthalmic conditions.
14. Perform manual perimetry
15. Perform color vision testing.
17. Perform in-depth description of ocular motility exam.
18. Improved techniques to evaluate nystagmus.
19. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
20. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
21. Perform basic and advanced interpretation of MRI and CT scans as they apply to the orbit, eye and visual pathway.
Educational Goals

22. For common and uncommon diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
23. Develop appropriate treatment plans or follow-up plans for common conditions.
24. Demonstrate efficiency in clinic.
25. Perform the role of primary assistant and primary surgeon in temporal artery biopsies.
26. Follow up on all laboratory/visual study results and communicate results back to patients in a timely fashion.

Medical Knowledge

Goal: To acquire knowledge in neuro-ophthalmology, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Learn the normal appearance of the optic nerve and common variations of normal.
2. Recognize major and minor abnormalities in the appearance of the optic nerve.
3. Learn ophthalmic terminology to describe eye findings.
4. Learn the neuro-ophthalmic visual pathways on MRI and CT scans.
5. Learn common and uncommon visual field deficits related to injury to the visual pathways and correlate with localized lesions or insult to the visual pathway.
6. Prescribe and manage therapy for common and uncommon neuro-ophthalmic conditions including knowledge of important and common side effects.
7. Demonstrate knowledge of current developments in diagnosis and treatment of common and uncommon neuro-ophthalmic conditions.
8. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
9. Integrate knowledge of basic science and pathophysiology with patient care.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching neuro-ophthalmology knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.
Educational Goals

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of neuro-ophthalmic conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students and resident rotators neuro-ophthalmic exam skills.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.
10. Maintain a portfolio that contains patient care encounters that demonstrate mastery of the core competencies.

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for neuro-ophthalmic patients and in the interactions with other health professionals and staff.
Educational Goals

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Demonstrate ethical behavior with pharmaceutical representatives.

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

Objectives:
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the neuro-ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Apply principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.
15. Delegate tasks appropriately to members of the health care team.
16. Articulate understanding of how cost-benefit analysis is applied to patient care (i.e. via principles of screening tests and the development of clinical guidelines).
17. Identify the role of various health care stakeholders including providers, commercial and government payers, pharmaceutical industry and medical device companies, and their varied impact on the cost of and access to health care.
Educational Goals

OCULOPLASTIC SURGERY

Overall Goal: To gain sufficient knowledge and experience to manage common forms of disorders affecting the orbit, eyelids, lacrimal system in a comprehensive ophthalmology practice and to recognize what patients should be referred for subspecialty care.

Preceptors: Gabriela Espinoza MD
John Holds, MD

Oculoplastic Rotation PGY-2

Patient Care

Goal: To provide care for pediatric and adult oculoplastic patients that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

Objectives:
1. Determine the patient’s specific and general oculoplastic eye concerns
2. Obtain complete and accurate history from both the patient and the chart
3. Gain an in-depth knowledge of the structure and function of the orbits, sinuses, eyelids and lacrimal system.
4. Perform appropriate physical examination for patient with tearing.
5. Perform appropriate physical examination for patient with infections of the eyelids and orbit.
6. Perform appropriate physical examination for patient with immune mediated disorders of the eyelids and orbit.
7. Perform appropriate physical examination for patient with neoplasms of the eyelids, lacrimal gland and orbit.
8. Perform appropriate physical examination for patient with congenital orbital anomalies.
9. Perform appropriate physical examination for patient with congenital nasolacrimal duct obstruction and acquired causes of tearing.
10. Perform appropriate physical examination for patient with thyroid eye disease.
11. Perform appropriate physical examination for patient with orbital trauma.
12. Perform appropriate physical examination for patient with congenital and acquired ptosis.
13. Evaluation of the six P’s: pain, proptosis, progression, palpation, pulsation and periorbital changes.
14. For simple problems, formulate a focused differential diagnosis rank ordered from most likely to least likely.
15. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
16. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
Educational Goals

17. For common diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
18. Develop appropriate treatment plans or follow-up plans for common conditions.
20. Perform and interpret dilation and irrigation of the canalicular system.
21. Observe and perform the role of primary assistant and primary surgeon in the operating room during common pediatric oculoplastic procedures such as nasolacrimal duct surgery, orbitotomy for excision of lesions, ptosis repair, and incision and drainage of chalazia.
22. Observe and perform the role of primary assistant and primary surgeon in the operating room during common adult oculoplastic procedures such as simple blepharoplasty, enucleation, evisceration, and repair of eyelid lacerations.
23. Observe and perform the role of primary assistant in the operating room during common pediatric oculoplastic procedures such as dacryocystoplasty and dacryocystorhinostomy.
24. Observe and perform the role of primary assistant in the operating room during common adult oculoplastic procedures such as exenteration, orbital fracture repair, and optic nerve sheath fenestration.
25. Know the appropriate indications for a variety of oculoplastic procedures.
26. Demonstrate understanding of common oculoplastic procedures, their expected outcomes and the importance of management of realistic expectations.
27. Perform basic interpretation of orbital CT scan and MRI.
28. Know and be able to explain the risks, benefits, options and aftercare of common oculoplastic procedures.

Medical Knowledge

Goal: To acquire knowledge in the field of oculoplastics, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Learn ophthalmic terminology to describe eye findings.
2. Learn the layers of the eyelid.
3. Demonstrate a good knowledge of anatomy of the orbit and sinuses as it relates to disease, treatment, and surgical intervention.
4. Prescribe and manage therapy for common oculoplastic conditions including knowledge of important and common side effects.
5. Demonstrate knowledge of current developments in diagnosis and treatment of common oculoplastic conditions.
6. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
Educational Goals

7. Integrate knowledge of basic science and pathophysiology with patient care.
8. Explain the underlying basic science mechanism of common ophthalmic disorders, including orbital inflammation and thyroid disease.
9. Participate in wet lab exercises to improve surgical skills.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching oculoplastic knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of oculoplastic conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students, optometry students, and resident rotators external ophthalmic exam skills.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
Educational Goals

11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for oculoplastic patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Learn to effectively utilize support staff.
9. Demonstrate ethical behavior with pharmaceutical representatives.
10. Respect patient confidentiality.

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

Objectives:
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Begin to understand principles of coding (ICD-9/10) and reimbursement (E&M levels/ procedures) appropriate to medical record documentation.
Educational Goals

**Oculoplastic Rotation PGY-3**

**Patient Care**

**Goal:** To provide care for pediatric and adult oculoplastic patients that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

**Objectives:**
1. Determine the patient’s specific and general oculoplastic eye concerns
2. Obtain complete and accurate history from both the patient and the chart
3. Gain an in-depth knowledge of the structure and function of the orbits, sinuses, eyelids and lacrimal system.
4. Perform appropriate physical examination for patient with tearing.
5. Perform appropriate physical examination for patient with infections of the eyelids and orbit.
6. Perform appropriate physical examination for patient with immune mediated disorders of the eyelids and orbit.
7. Perform appropriate physical examination for patient with neoplasms of the eyelids, lacrimal gland and orbit.
8. Perform appropriate physical examination for patient with congenital orbital anomalies.
9. Perform appropriate physical examination for patient with congenital nasolacrimal duct obstruction and acquired causes of tearing.
10. Perform appropriate physical examination for patient with thyroid eye disease.
11. Perform appropriate physical examination for patient with orbital trauma.
12. Perform appropriate physical examination for patient with congenital and acquired ptosis.
13. Evaluation of the six P’s: pain, proptosis, progression, palpation, pulsation and periorbital changes.
14. For simple and difficult problems, formulate a focused differential diagnosis rank ordered from most likely to least likely.
15. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
16. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
17. For common and uncommon diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
18. Develop appropriate treatment plans or follow-up plans for common and uncommon conditions.
20. Perform and interpret dilation and irrigation of the canalicular system.
21. Observe and perform the role of primary assistant and primary surgeon in the operating room during common adult oculoplastic procedures such as
Educational Goals

- simple blepharoplasty, ptosis repair, entropion and entropion repair, enucleation, evisceration, and repair of eyelid lacerations.
- Observe and perform the role of primary assistant and primary surgeon in the operating room during common adult oculoplastic procedures such as exenteration, orbital fracture repair, and optic nerve sheath fenestration.
- Know the appropriate indications for a variety of oculoplastic procedures.
- Demonstrate understanding of common oculoplastic procedures, their expected outcomes and the importance of management of realistic expectations.
- Perform basic interpretation of orbital CT scan and MRI.
- Know and be able to explain the risks, benefits, options and aftercare of common oculoplastic procedures.

Medical Knowledge

Goal: To acquire knowledge in the field of oculoplastics, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:

1. Learn ophthalmic terminology to describe eye findings.
2. Learn the layers of the eyelid.
3. Demonstrate a good knowledge of anatomy of the orbit and sinuses as it relates to disease, treatment, and surgical intervention.
4. Prescribe and manage therapy for common oculoplastic conditions including knowledge of important and common side effects.
5. Demonstrate knowledge of current developments in diagnosis and treatment of common and uncommon oculoplastic conditions.
6. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
7. Integrate knowledge of basic science and pathophysiology with patient care.
8. Explain the underlying basic science mechanism of common ophthalmic disorders, including orbital inflammation and thyroid disease.
9. Participate in wet lab exercises to improve surgical skills.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching oculoplastic knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

Objectives:

1. Demonstrate knowledge of current developments in diagnosis and treatment of oculoplastic conditions.
Educational Goals

2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students, optometry students, and resident rotators external ophthalmic exam skills.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.
10. Maintain a portfolio that contains patient care encounters that demonstrate mastery of the core competencies.

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for oculoplastic patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
Educational Goals

2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Learn to effectively utilize support staff.
9. Demonstrate ethical behavior with pharmaceutical representatives.
10. Respect patient confidentiality.
11. Effectively lead the team of residents and technicians that are working with you in the care of a patient.

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

Objectives:
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Regularly apply principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.
15. Delegate tasks appropriately to members of the health care team.
16. Articulate understanding of how cost-benefit analysis is applied to patient care (i.e. via principles of screening tests and the development of clinical guidelines).
17. Identify the role of various health care stakeholders including providers, commercial and government payers, pharmaceutical industry and medical device companies, and their varied impact on the cost of and access to health care.
Educational Goals

OFFICER OF THE DAY

Overall Goal: To provide experience in the management of urgent and emergency outpatient ocular problems.

Preceptor: Sangeeta Khanna, MD

Office of the Day Rotation PGY-2

Patient Care

Goal: To provide care for urgent and emergent ophthalmology patients that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

Objectives:
1. Determine the patient’s specific eye concerns.
2. Obtain complete and accurate history from both the patient and the chart.
3. Perform an eight point eye examination on ophthalmic patients presenting with recent onset eye complaints.
   - External exam
   - Vision
   - Pupils
   - Motility
   - Confrontation Visual Fields
   - Slit Lamp Examination
   - Tonometry by Goldman applanation and Tonopen®
   - Indirect fundus examination
4. Perform appropriate physical examination for patient with red eye.
5. Perform appropriate physical examination for patient with eye infections.
6. Perform appropriate physical examination for patient with gradual versus sudden vision loss.
7. Perform appropriate physical examination for patient with high velocity versus low velocity ocular trauma.
8. Perform appropriate physical examination for patient with corneal abrasions.
9. Evaluation of the six P’s: pain, proptosis, progression, palpation, pulsation and periorbital changes.
10. For simple problems, formulate a focused differential diagnosis ranked ordered from most likely to least likely.
11. For difficult problems, formulate a broad differential diagnosis and contact an upper level resident to help develop a focused differential diagnosis.
12. Appropriately differentiate between sight threatening and non-sight threatening emergencies and know when to seek assistance from upper level residents or attendings.
Educational Goals

13. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.

14. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to an upper level resident or attending physician of the appropriate subspecialty.

15. For common diseases, formulate and execute a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated. Common minor ocular emergencies to be managed independently when appropriate include dry eye, allergic and viral conjunctivitis, blepharitis, chalazion, contact lens over wear, and corneal abrasions.

16. Develop and execute appropriate treatment plans or follow-up plans for common conditions.

17. Perform basic interpretation of orbital CT scan and MRI.

Medical Knowledge

Goal: To acquire knowledge in the field of ophthalmology, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Learn ophthalmic terminology to describe eye findings.
2. Prescribe and manage therapy for common ophthalmic urgent and emergent conditions including knowledge of important and common side effects.
3. Demonstrate knowledge of current developments in diagnosis and treatment of common ophthalmic urgent and emergent conditions.
4. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
5. Integrate knowledge of basic science and pathophysiology with patient care.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching urgent and emergent ophthalmic care. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of urgent and emergent ophthalmic conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
Educational Goals

3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students and optometry students basic ophthalmic exam skills.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for urgent and emergent ophthalmic patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 4 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
Educational Goals

6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Learn to effectively utilize support staff.
9. Demonstrate ethical behavior with pharmaceutical representatives.
10. Respect patient confidentiality.

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

Objectives:
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Begin to understand principles of coding (ICD-9/10) and reimbursement (E&M levels/ procedures) appropriate to medical record documentation.

OPHTHALMIC PATHOLOGY

Overall Goal: To provide a structured series of lectures and clinicopathological conferences devoted to ocular pathology plus a laboratory experience in gross and microscopic examination of pathological specimens.

Preceptor: Morton Smith, MD

Ophthalmic Pathology Rotation PGY-2

Patient Care
Educational Goals

**Goal:** To provide diagnostic services for ophthalmology patients requiring pathologic review of specimens that is effective assisting clinicians with diagnosis and optimizing patient outcomes.

**Objectives:**
1. Obtain accurate history from the requisition patient chart.
2. Obtain further clinical data from the requesting physician when indicated.
3. Identify shave vs. punch vs. excisional biopsy of tissue.
4. Identify artifact on slides.
5. Diagnose between inflammatory and neoplastic disease.
6. Identify margin of tissue and comment upon presence or absence of lesion at margin.
7. Identify organisms on histochemical stains.
8. Based on the history, formulate a focused differential diagnosis rank ordered from most likely to least likely.
9. Present with clarity the physical findings of gross specimens that appear normal and abnormal.
10. Present with clarity the physical findings on microscopic review that appear normal and abnormal.
11. Based on clinical history and pathologic review, formulate a more specific diagnosis and correlate the clinical impression with histopathological findings.
12. Identify discordance between clinical findings and pathological findings and formulate possible rational for such discrepancies.
13. Develop a clinical plan based upon histopathological findings.

Medical Knowledge

**Goal:** To acquire knowledge in ophthalmic pathology, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in clinicopathologic correlation.

**Objectives:**
1. Use histopathological terminology to describe microscopic findings.
2. Provide differential diagnosis based upon histopathological findings for common neoplastic and inflammatory conditions.
3. Demonstrate knowledge of current developments in diagnosis and treatment of common ophthalmic conditions.
4. Understand and communicate the relevance of histopathological findings to medical conditions.
5. Explain the underlying basic science mechanism of common ophthalmic disorders including malignancies, complications of disease, and infections.
6. Formulate clinicopathological correlation.
7. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
Educational Goals

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching ophthalmic pathology knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of ophthalmic conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Identify areas in own practice that need improvement and implement needed changes.
5. Identify specific areas of interest.
6. Investigate areas of interest where certain clinical and histopathological questions are left unanswered.
7. Identify process for incident and error reporting in the institution.
8. Maintain a portfolio that contains ophthalmic pathology cases that demonstrate mastery of the core competencies.

Interpersonal Communication

Goal: To communicate with health professionals and ancillary staff in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Communicate with physicians sending pathological material to obtain further medical information and/or communicate findings on pathology.

Professionalism

Goal: Develop a commitment to excellence and integrity in ophthalmic pathology and in the interactions with other health professionals and staff.
Educational Goals

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Learn to effectively utilize support staff.

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious ophthalmic pathology care.

Objectives:
1. Practice cost-effective medicine in particular as it pertains to ordering ancillary immunohistochemical and histochemical stains.
2. Demonstrate knowledge and manageability of insurance issues.
3. Communicate with consulting physicians and primary care physicians.
4. Understand the relevance of the ophthalmic pathology findings to underlying medical conditions.
5. Obtain appropriate consultations and laboratory testing for patients.
6. Understand and address how social situations impact patient compliance and accessibility to health care systems.
7. Understand the importance of continuity of care and help to facilitate this.
8. Utilize EMR efficiently and independently.
9. Access support services appropriately.
10. Utilize non-medical staff and non-physician medical staff in coordination of patient care.

PEDIATRIC OPHTHALMOLOGY AND ADULT STRABISMUS

Overall Goal: To gain sufficient knowledge and experience to manage common forms of pediatric eye diseases and adult strabismus in a comprehensive ophthalmology practice and to recognize what patients should be referred for subspecialty care.

Preceptors: Oscar Cruz, MD  Bradley Davitt, MD
Educational Goals

**Pediatric Ophthalmology and Adult Strabismus Rotation PGY-2**

**Patient Care**

**Goal:** To provide care for pediatric ophthalmic and adult strabismus patients that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

**Objectives:**
1. Determine the patient’s specific and general eye concerns.
2. Determine the parent’s specific and general eye concerns.
3. Obtain complete and accurate history from both the patient, family and the chart.
4. Perform an eight point eye examination on healthy normal pediatric patient presenting for routine eye examination.
   - External exam
   - Vision
   - Pupils
   - Motility
   - Confrontation Visual Fields
   - Slit Lamp Examination
   - Tonometry by Tonopen®
   - Indirect fundus examination
5. Perform appropriate physical examination for pediatric patients, understanding developmental milestones for visual development, ocular motility, and refraction.
6. Perform appropriate physical examination for patient with amblyopia.
7. Perform appropriate physical examination for patient with cataract.
8. Perform appropriate physical examination for patient with conjunctivitis.
9. Perform appropriate physical examination for patient with viral keratitis.
10. Perform appropriate physical examination for patient with stye or chalazion.
11. For simple problems, formulate a focused differential diagnosis rank ordered from most likely to least likely.
12. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
13. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
14. For common diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
15. Develop appropriate treatment plans or follow-up plans for common conditions.
17. Perform initial refraction on patients before verification by senior residents or attendings.
Educational Goals

18. Explain appropriate application of eye drops to patients and parents.
19. Follow up on all laboratory/visual study results and communicate results back to patients in a timely fashion.

Medical Knowledge

Goal: To acquire knowledge in pediatric ophthalmology and adult strabismus, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Learn the normal ocular anatomy in children.
2. Learn the developmental milestones for ocular motility.
3. Learn the common cranial nerve palsies that affect adult motility.
4. Learn patterns of congenital ptosis.
5. Learn the signs and symptoms of neurofibromatosis in children.
6. Learn ophthalmic terminology to describe eye findings.
7. Prescribe and manage therapy for common ophthalmic conditions including knowledge of important and common side effects.
8. Demonstrate knowledge of current developments in diagnosis and treatment of common ophthalmic conditions.
9. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
10. Integrate knowledge of basic science and pathophysiology with patient care.
11. Explain the underlying basic science mechanism of common congenital syndromes, such as neurofibromatosis.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching pediatric ophthalmology and adult strabismus knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of pediatric ophthalmic and adult strabismus conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students, optometry students, and resident rotators basic pediatric and motility exam skills.
5. Identify areas in own practice that need improvement and implement needed changes.
Educational Goals

6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for pediatric ophthalmic and adult strabismus patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Demonstrate ethical behavior with pharmaceutical representatives.
Educational Goals

Systems Based Practice

**Goal:** Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

**Objectives:**
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Begin to understand principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.

**Pediatric Ophthalmology and Adult Strabismus Rotation PGY-3**

**Patient Care**

**Goal:** To provide care for pediatric ophthalmic and adult strabismus patients that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

**Objectives:**
1. Determine the patient’s and parent’s specific and general eye concerns and elicit an appropriate review of systems based on these concerns.
2. Obtain complete and accurate history from both the patient, family, and the chart.
3. Perform an eight point eye examination on healthy cooperative and less cooperative pediatric patient presenting for eye examination.
   - External exam
   - Vision
   - Pupils
   - Motility
   - Confrontation Visual Fields
   - Slit Lamp Examination
Educational Goals

- Tonometry by Goldman applanation or Tonopen®
- Indirect fundus examination

4. Recognize presence of all major abnormal exam findings on routine eye examination.
5. Perform appropriate physical examination for pediatric patients, understanding developmental milestones for visual development, ocular motility, and refraction.
6. Perform appropriate physical examination for patient with amblyopia.
7. Perform appropriate physical examination for patient with cataract.
8. Perform appropriate physical examination for patient with conjunctivitis.
9. Perform appropriate physical examination for patient with viral keratitis.
10. Perform appropriate physical examination for patient with stye or chalazion.
11. Perform appropriate physical examination for patient with motility disturbances. Recognize common motility problems such as esodeviations, exodeviations, vertical deviations, A and V patterns, paralytic strabismus, restrictive strabismus, and nystagmus.
12. For simple and difficult problems, formulate a focused differential diagnosis and an expanded differential diagnosis rank ordered from most likely to least likely that includes uncommon/rare ophthalmic conditions.
13. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
14. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
15. For common and uncommon diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
16. Develop appropriate treatment plans or follow-up plans for common and uncommon conditions, including non-surgical management of amblyopia and strabismus.
17. Selection of diagnostic tests is appropriate, evidence-based and cost-effective.
18. Demonstrate efficiency in clinic.
19. Use results of diagnostic tests to narrow down the differential diagnosis.
20. Perform refraction on patients with more advanced knowledge of glasses prescriptions including single vision and bifocal prescriptions.
21. Perform role of first assist and primary surgeon in the operating room in cases of simple, horizontal muscle imbalances in children.
22. Perform role of first assist and primary surgeon in the operating room in cases of nasolacrimal duct probing and chalazion incision and drainage.
23. Explain appropriate application of eye drops to patients.
24. Appropriately recognize and refer patients to subspecialty clinics.
25. Understand and explain common pediatric surgical procedures to patients along with risks, benefits and alternatives of surgery.
26. Explain post-operative care to patients and parents.
27. Manage operative and post-operative complications of pediatric ophthalmic surgery.
Educational Goals

28. Follow up on all laboratory/visual study results and communicate results back to patients in a timely fashion.

Medical Knowledge

Goal: To acquire knowledge in pediatric ophthalmology and adult strabismus, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Learn the normal ocular anatomy in children.
2. Learn the developmental milestones for ocular motility.
3. Learn the common cranial nerve palsies that affect adult motility.
4. Learn patterns of congenital ptosis.
5. Learn the signs and symptoms of neurofibromatosis in children.
6. Learn ophthalmic terminology to describe eye findings.
7. Prescribe and manage therapy for common ophthalmic conditions including knowledge of important and common side effects.
8. Demonstrate knowledge of current developments in diagnosis and treatment of common ophthalmic conditions.
9. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
10. Integrate knowledge of basic science and pathophysiology with patient care.
11. Explain the underlying basic science mechanism of common congenital syndromes, such as neurofibromatosis.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching pediatric ophthalmology and adult strabismus knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of pediatric ophthalmic and adult strabismus conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students, optometry students, and resident rotators basic pediatric and motility exam skills.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
Educational Goals

7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.
10. Maintain a portfolio that contains patient care encounters that demonstrate mastery of the core competencies.

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for pediatric ophthalmic and adult strabismus patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Demonstrate ethical behavior with pharmaceutical representatives.
Educational Goals

Systems Based Practice

**Goal:** Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

**Objectives:**
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Routinely apply the principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.

**Pediatric Ophthalmology and Adult Strabismus Rotation PGY-4**

**Patient Care**

**Goal:** To provide care for adult strabismus patients that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

**Objectives:**
1. Obtain complete and accurate history from both the patient and the chart.
2. Recognize common motility problems such as esodeviations, exodeviations, vertical deviations, A and V patterns, paralytic strabismus, restrictive strabismus, and nystagmus.
3. Recognize uncommon motility problems such as Brown’s syndrome, skew deviation, and Duane syndrome.
4. Document proper surgical history and physical, and treatment plans with appropriate depth in the medical record.
5. Perform role of first assist and primary surgeon in the operating room in cases of simple, horizontal muscle imbalances in adults.
6. Perform role of first assist in the operating room in adult strabismus cases.
7. Understand and explain common adult strabismus surgical procedures to patients along with risks, benefits and alternatives of surgery.
Educational Goals

8. Explain post-operative care to patients.

Medical Knowledge

**Goal:** To acquire knowledge in adult strabismus, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

**Objectives:**
1. Learn the normal extra-ocular muscle anatomy in adults.
2. Learn the common cranial nerve palsies that affect adult motility.
3. Learn ophthalmic terminology to describe eye findings.
4. Prescribe and manage therapy for common ophthalmic conditions including knowledge of important and common side effects.
5. Demonstrate knowledge of current developments in diagnosis and treatment of common ophthalmic conditions.
6. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
7. Integrate knowledge of basic science and pathophysiology with patient care.
8. Explain the underlying basic science mechanism of strabismus and suppression of vision.

Practice-Based Learning and Improvement

**Goal:** Develop skills in acquiring, analyzing, applying and teaching adult strabismus knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

**Objectives:**
1. Demonstrate knowledge of current developments in diagnosis and treatment of adult strabismus conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students, optometry students, and resident rotators basic surgical skills.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.
Educational Goals

10. Maintain a portfolio that contains patient care encounters that demonstrate mastery of the core competencies.

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Document surgical history and physical, and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for adult strabismus patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Demonstrate ethical behavior with pharmaceutical representatives.
Educational Goals

Systems Based Practice

**Goal:** Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

**Objectives:**
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Routinely apply the principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.

RETINA AND VITREOUS

**Overall Goal:** To gain sufficient knowledge and experience to manage common forms of diseases affecting the posterior segment of the eye in a comprehensive ophthalmology practice and to recognize what patients should be referred for subspecialty care.

**Preceptors:**
- Levent Akduman, MD
- Stephen Feman, MD
- Sweta Tarigopula, MD

**Retina and Vitreous Rotation PGY-2**

**Patient Care**

**Goal:** To provide care for patients with posterior segment disease that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.
Educational Goals

Objectives:
1. Determine the patient’s specific and general posterior segment concerns.
2. Obtain complete and accurate history from both the patient and the chart.
3. Gain an in-depth knowledge of the structure and function of the retina and vitreous.
4. Perform appropriate physical examination for patient with flashes and floaters.
5. Perform appropriate physical examination for patient with diabetes.
6. Perform appropriate physical examination for patient with hypertension.
7. For simple problems, formulate a focused differential diagnosis ranked from most likely to least likely.
8. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
9. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
10. For common diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
11. Develop appropriate treatment plans or follow-up plans for common conditions.
12. Demonstrate efficiency in clinic.
13. Perform a thorough dilated fundus exam with recognition of all normal anatomy and major abnormal findings.
14. Observe and perform the role of primary assistant and primary surgeon in the operating room during common retinal procedures such as vitrectomy.
15. Observe and perform the role of primary assistant and primary surgeon in office procedures such as intravitreal injections.
16. Know the appropriate indications for a variety of retinal procedures.
17. Demonstrate understanding of common retinal procedures, their expected outcomes and the importance of management of realistic expectations.
18. Perform basic interpretation of fluorescein angiography.
19. Know and be able to explain the risks, benefits, options and aftercare of common retinal procedures.

Medical Knowledge

Goal: To acquire knowledge in the field of posterior segment disease, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Learn ophthalmic terminology to describe eye findings.
2. Learn the layers of the retina.
3. Demonstrate a good knowledge of anatomy of the retina and vitreous.
4. Prescribe and manage therapy for common retinal and vitreous conditions including knowledge of important and common side effects.
Educational Goals

5. Demonstrate knowledge of current developments in diagnosis and treatment of common retinal and vitreous conditions.
6. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
7. Integrate knowledge of basic science and pathophysiology with patient care.
8. Explain the underlying basic science mechanism of common ophthalmic disorders, including posterior scleritis and malignancy.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching posterior segment disease knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of retinal and vitreous conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students, optometry students, and resident rotators skills for fundoscopy.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
Educational Goals

8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for posterior segment disease patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Learn to effectively utilize support staff.
9. Demonstrate ethical behavior with pharmaceutical representatives.
10. Respect patient confidentiality.

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

Objectives:
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
Educational Goals

13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Begin to understand principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.

Retina and Vitreous Rotation PGY-3

Patient Care

Goal: To provide care for patients with posterior segment disease that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

Objectives:
1. Determine the patient’s specific and general posterior segment concerns
2. Obtain complete and accurate history from both the patient and the chart
3. Gain an in-depth knowledge of the structure and function of the retina and vitreous.
4. Perform appropriate physical examination for patient with flashes and floaters.
5. Perform appropriate physical examination for patient with diabetes.
6. Perform appropriate physical examination for patient with hypertension.
7. For simple and complex problems, formulate a focused differential diagnosis rank ordered from most likely to least likely.
8. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
9. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
10. For common and uncommon diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
11. Develop appropriate treatment plans or follow-up plans for common conditions.
12. Demonstrate efficiency in clinic.
13. Perform a thorough dilated fundus exam with recognition of all normal anatomy and all major and most minor abnormal findings.
14. Observe and perform the role of primary assistant and primary surgeon in office procedures such as intravitreal injections.
15. Know the appropriate indications for a variety of retinal procedures.
16. Demonstrate understanding of common retinal procedures, their expected outcomes and the importance of management of realistic expectations.
17. Perform basic interpretation of fluorescein angiography.
18. Know and be able to explain the risks, benefits, options and aftercare of common retinal procedures.
Educational Goals

Medical Knowledge

Goal: To acquire knowledge in the field of posterior segment disease, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Learn ophthalmic terminology to describe eye findings.
2. Learn the layers of the retina and their appearance on imaging studies such as OCT and fluorescein angiography.
3. Demonstrate a good knowledge of anatomy of the retina and vitreous.
4. Prescribe and manage therapy for common retinal and vitreous conditions including knowledge of important and common side effects.
5. Demonstrate knowledge of current developments in diagnosis and treatment of common retinal and vitreous conditions.
6. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
7. Integrate knowledge of basic science and pathophysiology with patient care.
8. Explain the underlying basic science mechanism of common ophthalmic disorders, including posterior scleritis and malignancy.

Practice-Based Learning and Improvement

Goal: Develop skills in acquiring, analyzing, applying and teaching posterior segment disease knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

Objectives:
1. Demonstrate knowledge of current developments in diagnosis and treatment of retinal and vitreous conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students, optometry students, and resident rotators skills for fundoscopy.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.
Educational Goals

10. Maintain a portfolio that contains patient care encounters that demonstrate mastery of the core competencies.

Interpersonal Communication

Goal: To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

Objectives:
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

Goal: Develop a commitment to excellence, integrity, and sensitivity in the care for posterior segment disease patients and in the interactions with other health professionals and staff.

Objectives:
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Learn to effectively utilize support staff.
9. Demonstrate ethical behavior with pharmaceutical representatives.
10. Respect patient confidentiality.
Educational Goals

Systems Based Practice

Goal: Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

Objectives:
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Routinely apply principles of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation.

Retina and Vitreous Rotation PGY-4

Patient Care

Goal: To provide care for patients with posterior segment disease that is caring, sensitive, and effective in optimizing evaluation, management, patient education and outcomes.

Objectives:
1. Determine the patient’s specific and general posterior segment concerns
2. Obtain complete and accurate history from both the patient and the chart
3. Gain an in-depth knowledge of the structure and function of the retina and vitreous.
4. Perform appropriate physical examination for patient with flashes and floaters.
5. Perform appropriate physical examination for patient with diabetes.
6. Perform appropriate physical examination for patient with hypertension.
7. For simple and complex problems, formulate a focused differential diagnosis rank ordered from most likely to least likely.
8. Document history, physical, differential diagnosis, evaluation and treatment plans with appropriate depth in the medical record.
Educational Goals

9. Present with clarity history, physical findings, differential diagnosis, evaluation and treatment plans to the attending physician.
10. For common and uncommon diseases, formulate a diagnostic work-up for patients including laboratory testing and further vision testing or imaging when indicated.
11. Develop and initiate appropriate treatment plans or follow-up plans for common conditions.
12. Coordinate care among other specialists (e.g. diabetic patients to improve glucose control and reduce diabetic eye disease).
14. Perform a thorough dilated fundus exam with recognition of all normal anatomy and all major and all minor abnormal findings.
15. Observe and perform the role of primary assistant and primary surgeon in office procedures such as intravitreal injections and laser surgery.
16. Observe and perform the role of primary assistant and primary surgeon in the operating room for retinal surgery and vitrectomy surgery.
17. Know the appropriate indications for a variety of retinal procedures.
18. Demonstrate understanding of common retinal procedures, their expected outcomes and the importance of management of realistic expectations.
19. Perform basic interpretation of fluorescein angiography.
20. Know and be able to explain the risks, benefits, options and aftercare of common retinal procedures.

Medical Knowledge

Goal: To acquire knowledge in the field of posterior segment disease, demonstrate competence in knowledge of topics outlined in the Basic and Clinical Science Course books put out by the American Academy of Ophthalmology, and develop expertise in patient management.

Objectives:
1. Learn ophthalmic terminology to describe eye findings.
2. Learn the layers of the retina and their appearance on imaging studies such as OCT and fluorescein angiography.
3. Demonstrate a good knowledge of anatomy of the retina and vitreous.
4. Prescribe and manage therapy for common retinal and vitreous conditions including knowledge of important and common side effects.
5. Demonstrate knowledge of current developments in diagnosis and treatment of common retinal and vitreous conditions.
6. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
7. Integrate knowledge of basic science and pathophysiology with patient care.
8. Explain the underlying basic science mechanism of common ophthalmic disorders, including posterior scleritis and malignancy.
Educational Goals

Practice-Based Learning and Improvement

**Goal:** Develop skills in acquiring, analyzing, applying and teaching posterior segment disease knowledge. Develop the ability to self-analyze and the ability to design quality improvement projects to optimize patient outcomes.

**Objectives:**
1. Demonstrate knowledge of current developments in diagnosis and treatment of retinal and vitreous conditions.
2. Use current literature to manage patients with evidence based medicine (i.e. use of PubMed, Ovid, on-line resources and textbooks).
3. Ask for feedback during the rotation and use suggestions to improve clinical practice.
4. Teach medical students, optometry students, and resident rotators skills for fundoscopy.
5. Identify areas in own practice that need improvement and implement needed changes.
6. Identify specific areas of interest.
7. Investigate areas of interest where certain clinical questions are left unanswered.
8. Identify process for incident and error reporting in the institution.
10. Maintain a portfolio that contains patient care encounters that demonstrate mastery of the core competencies.

Interpersonal Communication

**Goal:** To communicate with patients, their families, and other health professionals in a clear, concise, caring, and respectful manner.

**Objectives:**
1. Demonstrate respect and courteousness to ancillary staff.
2. Demonstrate respect and courteousness to fellow residents.
3. Demonstrate respect and courteousness to attending physicians.
4. Be attentive to staff needs.
5. Communicate effectively with consulting physicians and primary care physicians.
6. Write understandable letters to other physicians.
7. Explain things at an appropriate level for patients to understand.
8. Provide written materials to patients when necessary.
9. Use translators appropriately.
10. Develop skills with phone triage and accurately document these interactions in the medical record.
11. Instill confidence in patients.
12. Create an environment in which patients are comfortable to ask questions.
Educational Goals

13. Document history, physical, differential diagnoses, evaluation and treatment plans with appropriate depth in the medical record.

Professionalism

**Goal:** Develop a commitment to excellence, integrity, and sensitivity in the care for posterior segment disease patients and in the interactions with other health professionals and staff.

**Objectives:**
1. Demonstrate good ethical judgment.
2. Be sensitive to a diverse patient population.
3. Demonstrate punctuality to clinic.
4. Be willing to stay past 5 pm when necessary.
5. Demonstrate willingness to do fair share of the work.
6. Work as a team member.
7. Do not push off responsibilities on other staff members.
8. Learn to effectively utilize support staff.
9. Demonstrate ethical behavior with pharmaceutical representatives.
10. Respect patient confidentiality.

Systems Based Practice

**Goal:** Competently navigate the health care system using the resources available to provide effective yet cost-conscious patient care.

**Objectives:**
1. Practice cost-effective medicine.
2. Handle prior authorizations (medication and surgical) in a timely fashion.
3. Demonstrate knowledge and manageability of insurance issues.
4. Act as a patient advocate for coverage of treatment/diagnostic procedures.
5. Communicate with consulting physicians and primary care physicians.
6. Understand the relevance of the ophthalmic findings to underlying medical conditions.
7. Obtain appropriate consultations and laboratory testing for patients.
8. Explain the nuances of insurance to patients.
9. Understand and address how social situations impact patient compliance and accessibility to health care systems.
10. Understand the importance of continuity of care and help to facilitate this.
11. Utilize EMR efficiently and independently.
12. Access support services appropriately.
13. Utilize non-medical staff and non-physician medical staff in coordination of patient care.
14. Routinely apply principles of coding (ICD-9/10) and reimbursement (E&M levels/ procedures) appropriate to medical record documentation.
Supervision and Clinical Assignments

SUPERVISION AND LINES OF RESPONSIBILITY

The supervision for 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. Residents will be supervised at all times by one or more attending physicians. Supervision may be direct (the attending examines the patient with the resident), indirect (the attending is immediately available on-site or by phone), or by oversight (the supervising attending reviews patient care after care has been delivered). Patients examined in outpatient clinics, emergency rooms and inpatient wards may be directly, indirectly, or oversight supervised according to the policies and procedures of the clinical assignment (below).

For overall concerns and communications related to the residency program, the residents will communicate with their Chief Resident. The Chief Resident will then manage the issue or communicate further with the residency program coordinator and/or program director. The Chief Resident also has access to the chairman and all other faculty to review and discuss clinical or surgical issues; however it is the responsibility of the residency program coordinator and program director to communicate with other areas and members of the department regarding the residents.

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.

Monthly resident meetings with the program director and quarterly town hall meetings with the program coordinator present the opportunity for discussion of any suggestions or concerns from the residents and follow-up on any issues impacting the residents. The residents are also encouraged to establish and maintain open communications with the Chairman, Program Director, and all faculties.

When in clinical or surgical activities, the resident is supervised by the attending faculty physician, who is responsible to the Chairman, Oscar Cruz, M.D.
Supervision and Clinical Assignments

The following is the list of procedures that residents can perform independently without direct faculty supervision. All surgeries performed in the operating room are directly supervised with an attending physician present during the critical parts of the operation.

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)
- Insertion and removal of punctual plugs
- 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
- Incision and drainage of lid abscess
- Anterior segment OCT
- 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 on site).
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 incision and drainage
- Retrobulbar or peribulbar anesthesia
- Laser suture lysis
- Subconjunctival or subtenons injections
- Anterior chamber and vitreous tap

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

- Intraocular injections
- YAG laser capsulotomy
- Laser peripheral iridotomy
Supervision and Clinical Assignments

- Laser peripheral iridoplasty
- Laser trabeculoplasty

The following is a list of common circumstances that require faculty involvement.

- Any patient requiring surgical intervention in the operating room.
  - Ruptured globe/suspected rupture globe
  - Orbital fracture with entrapment
  - Orbital cellulitis with abscess
  - Macula-on retinal detachment
- Admission to the hospital under the care of the ophthalmology service.
  - Pediatric hyphema with sickle cell trait or high risk
  - Compressive optic neuropathy
- Major change in vision or acute vision threatening condition.
  - Sudden loss of vision, unknown cause
  - Acute blind painful eye
  - Uncontrollable glaucoma
  - Uncontrollable uveitis
  - Endophthalmitis
  - Pupil involving 3rd
  - Pseudotumor cerebri (idiopathic intracranial hypertension)

CLINICAL ASSIGNMENTS: DESCRIPTIONS, POLICIES, PROCEDURES AND EXPECTATIONS

The following descriptions of clinical rotations (including policies, procedures and expectations unique to each service) are listed in the table below and outlined in the subsequent pages. At the beginning of each rotation, the resident and attending(s) should review these descriptions and revise them if there have been changes to the rotation since the last revision of this manual.*

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Supervision and Clinical Assignments

COMPREHENSIVE OPHTHALMOLOGY SERVICE

- Structure - a Comprehensive Clinic is an opportunity to provide the resident more independent responsibility for patient care. There is more Comprehensive Clinic time for residents during the first and third years. There is always a third year resident available in the Comprehensive Clinic. The third year is responsible for educating the junior residents. This responsibility involves answering questions, assisting with patients, and making sure that the clinic runs smoothly. Questions regarding individual patients should be addressed to the appropriate third year resident or the attending staff in Comprehensive Clinic prior to asking the sub-specialty attending staff who is not in clinic. Individual responsibilities are outlined in this guide.

The rotation schedule is also designed to promote resident cooperation and comraderie. The approach to seeing patients in Comprehensive Clinic should be a team approach. All residents assigned to Comprehensive Clinic are to report at 8:00 a.m. It is expected and appreciated that residents help each other evaluate patients expeditiously and efficiently. All a.m.-scheduled patients are to be evaluated prior to lunch. The afternoon Comprehensive Clinic should run similarly. Residents should leave as a team from the Comprehensive Clinic after the last patient has been examined.

- If surgery or another emergency comes up that you know about in advance that will remove you from your normal time slot in the Clinic, you are expected to find a replacement among the other residents. If this does happen you should inform the chief resident and the attending that you are not available and who your replacement is.

- On your assigned O.R. days, surgery is scheduled to begin at 8:00 a.m. You should arrive at 7:00 a.m. to complete the history and physical, select IOL’s etc. If you have no surgeries you are to make yourself available to see patients in the clinic if the need arises. In general, all surgical patients from the comprehensive clinic are the responsibility of the third year resident. He/She should ensure that all appropriate testing has been performed prior to surgery (i.e. IOL calculations), that the surgical dictations are completed, and that the post-operative follow-up is arranged.

- Concerning the Ancillary Staff, such as the ophthalmic technicians, it is to your benefit to learn how to do the tests and use the equipment yourself. First year residents are encouraged to do these tests themselves for the first few months until they become comfortable with them. As your expected caseload in the Clinic increases, the ancillary support will become more available to you.
Supervision and Clinical Assignments

- The Third Year Rotation - the third year resident assigned to the rotation is the Comprehensive Clinic "chief." He/she spends more time in clinic than any other resident, and should have the greatest ongoing understanding of the Comprehensive Clinic patients. The "chief" is responsible for assisting the first year residents with diagnostic and clinical dilemmas, and arbitrating patient assignment (especially in regards to laser and minor procedures) in the Comprehensive Clinic. He/She is the primary cataract surgeon with the attending, but should also teach the junior residents and get them involved in surgery when appropriate.

CONSULT SERVICE

- The consult/neuro-ophthalmology resident handles the consultations at Saint Louis University Hospital during clinic hours (normal business hours). The resident assigned to Cardinal Glennon Children's Hospital is responsible for the consultations at Cardinal Glennon Children's Hospital during normal business hours.

- When the consult/neuro-ophthalmology resident is busy in neuro-ophthalmology clinic, the officer of the day becomes primarily responsible for seeing consultations for that half-day. However, if the officer of the day is also busy seeing emergency patients in the clinic, then the chief resident should be contacted in order to determine which resident is the most appropriate to go and perform the consult.

- On Tuesdays, the oculoplastics resident handles the consultations at Saint Louis University Hospital during clinic hours. Dr. Espinoza will round on patients as indicated on this day.

- Consultations are to be seen on the day that they are requested.

- Hospital consultations that require continued ophthalmologic evaluation and management become the responsibility of the consult resident the following morning. These patients should be followed while patient is in-house in a timely fashion appropriate to the specific problem. The consult list should be maintained and updated on a daily routine.

- Drs. Khanna, Chung & Council will make rounds on all in-house consultations at various times during the week. In addition, other attending physicians are available to round on in-house patients if there is a problem specific to their subspecialty. These situations are to be handled on an "as-needed" basis.
Supervision and Clinical Assignments

- When asked for "Referring Physician," residents will not sign their name, but will fill in the name of the physician requesting the consultation.

- Any resident doing a consultation must route the consult note to the attending with whom they are rounding. If no attending rounds on the patient, then the consult note is routed to the attending on call.

- Consultations which are of subspecialty interest should be discussed with the appropriate faculty member.

- The consult/neuro-ophthalmology resident and the pediatric resident should communicate on Friday afternoon with the resident(s) who is/are on-call over the weekend to make him/her aware of all inpatients that are being followed by the ophthalmology service, and what specifically (if anything) needs to be done. Monday morning the consult/neuro-ophthalmology resident and the pediatric resident should communicate with the resident(s) on-call over the weekend for "check out" of events that occurred over the weekend. Please refer to the hand-off policy for further details.

- When the consult/neuro-ophthalmology resident and/or the pediatric resident(s) is/are on vacation the Chief Resident will determine which other resident will complete consults for the service.

CONTACT LENS SERVICE

- Patients entering the contact lens service will enter by one of two ways. 1) By referral from the General Clinic or another service or, 2) self-referral having never been seen at Saint Louis University Eye Institute. Each of these patients requires a somewhat different initial visit procedure.

- Those patients referred by another service should have the following performed at the initial visit:
  
  o Brief history including reason for desiring contact lenses, any history of contact lens, wear, types of lenses previously worn, reason for success or failure, and type of lens care system used. This should be followed by a current and accurate refraction and keratometry. Those who are post penetrating keratoplasty, keratoconus or irregular corneal findings, should have corneoscopy or corneal topography. (Current corneascope photos or topography maps may be included in the chart from the cornea service. In this case, new photos will not be required.) A complete slit-lamp examination should be performed as well as evaluation of tear quality; including
Supervision and Clinical Assignments

tear breakup time or Schirmer tear strip.

- Following a complete discussion of lens options with the patient, a trial fitting of the most appropriate lens design will be performed. The contact lens technician in charge should complete the billing sheet following completion of the exam. This applies to all visits in the contact lens service.

- Those patients who have not been previously seen at the Saint Louis University Eye Institute require a complete examination along with a contact lens fitting. A practical suggested order of proceeding with such an exam is as follows:

  - Complete history, including past medical history, past ocular history, any medications, and specific contact lens questions as above. Keratometry can then be performed followed by a complete refraction. A slit-lamp examination can then be performed.

  - At this point it may be appropriate to begin trial lens fitting, especially if soft hydrogel lenses will be used. The reasons for this are as follows: Fluorescein destroys soft lenses; therefore they need to be inserted prior to the instillation of fluorescein including Fluress. Also, a contact lens fit needs to be performed prior to any dilation.

  - Once the fitting is complete, one can proceed with the remaining exam which should include tear breakup time, Schirmer tear test, followed by applanation tonometry and dilation.

- All new wearers should have lenses first inserted either by the resident or technician. Following evaluation of fitting and visual acuity, insertion and removal will be practiced as well as lens care demonstrated by the technician. Patients should then begin contact lens wear and will be asked to return in one to two weeks (depending on the patient) following at least four hours of contact lens wear.

FOLLOW UP VISIT

- At follow-ups, the following should be evaluated:
  - brief histories including patient acceptance, chief complaint as well as specific lens care questions as follows:
    - Is your vision good both far away and up close?
    - Are the lenses comfortable?
    - How long have you worn your lenses today?
    - What is the longest that you have worn the lenses?
    - How are you cleaning your lenses?
    - With what are you cleaning your lenses?
Supervision and Clinical Assignments

- With what are you disinfecting your lenses?
- Do you use weekly cleaner?
  
  - Check visual acuity with over-refraction and slit-lamp examination to evaluate contact lens fit and corneal integrity. Following lens removal if indicated, an evaluation of corneal integrity, keratometry, and refraction will be performed.

CORNEA AND EXTERNAL DISEASE SERVICE

- The second or third year resident on the cornea service will be present for every clinic. Clinics generally start at 8:00 am, and the resident should arrive at that time. He/She should make an effort to see every patient in clinic before the attending. If this is not possible, then he/she should at least try to see every new patient and all patients with interesting corneal pathology. Routine or straight-forward follow-ups can be seen by the attending only, if necessary. The third year resident is generally welcome to use his/her judgment in ordering tests before the patient is seen by the attending. In general, all procedures should not be performed until the patient is seen by the attending. At that point, the attending will notify the third year resident that there is a procedure to be performed and generally allow him/her to do it. Any necessary dictations will be done by the attending.

- On certain days, a first year resident will be in the clinic is well. His/her responsibilities are similar to those of the third year resident. The third year resident will also be available to assist the first year resident whenever necessary. At the end of the clinic, "chart rounds" are undertaken during which time the interesting events of the day will be discussed with the team.

- As with any clinic, the residents are encouraged to participate in all aspects of the patient visit. This includes working up patients and performing relevant tests. In addition, the resident(s) may be asked to help fill out paperwork as necessary (I.e. surgery scheduling forms, lab requisitions, etc.). The technical staff is available to assist with this as well.

- In addition, the residents may be asked to help with clinical research projects while they are on the cornea rotation. In general, this will consist of identifying patients that are eligible to participate in a study, obtaining informed consent, ensuring that all appropriate information is obtained, and at times assisting with the collection of data.

- In the operating room, all of the pre-operative paperwork is to be completed by the resident(s) prior to surgery. The attending and resident(s) will determine the operative plan before the case and what
Supervision and Clinical Assignments

special arrangements (if any) will need to be made. In addition, the resident should be aware of clinical research studies that involve operative patients, and make sure that these patients are handled in the appropriate manner. Patient follow-up will be based on the nature of the procedure performed. The attending will generally dictate all operative reports.

GLAUCOMA SERVICE

- Rotating through the Glaucoma Service can be an extremely interesting and educational experience. In order to make the transition into the flow of the service easier, a few basic comments and guidelines are provided.

- On the daily schedule posted in clinic is information about the patient visit. The clinic generally starts at 8:00 am, and the earliest scheduled patients are either new, com, or post-ops. "New" and "com" visits are long visits that generally require the patient to undergo the usual eight point ophthalmic exam along with visual fields, OCT, and pachymetry. In addition, gonioscopy should be done for all new patients. "Est" visits are usually short visits for established patients who usually need pressure checks or are post-ops. To the right of the patient name are other comments and clues regarding what the patient needs done that day. Additional information can also be found in Dr. Shields' last chart note or typed note. Always read the assessment and plan of the previous visit to help direct patients’ treatment plan.

- Residents are not expected to see every patient. Residents (especially first-year resident) are encouraged to “shadow” Dr. Shields as much as they like. The percentage of patients seen by residents will vary according to the speed and experience of the individual. At this point in your career, the primary focus is quality. Efficiency will come with experience and without compromising quality of care.

- Short Visits: The patient is worked up and IOP is checked by applanation and tonopen. Read the last chart or dictated note to see if the patient needs other tests that day, such as refraction or PAM.

- Long Visits:

  New Patients: The patient is worked up in the usual manner. IOP is measured by applanation and tonopen. Gonioscopy is performed prior to dilation if the patient is seen at this point; otherwise gonioscopy is done after dilation. Patient is dilated and asked to wait in waiting area. Visual fields, OCT, and pachymetry and are obtained with the appropriate forms filled out. The patient
Supervision and Clinical Assignments

returns to clinic and the rest of the exam is exam done by resident.

Return Patients: These patients are scheduled as long visits because they need visual fields and OCT or photos. The patient is worked up, IOP is checked by applanation and tonopen, and the patient is dilated. The patient is then sent for visual fields and OCT or photos. Afterwards, the patient is seen by the resident and fundoscopic is performed.

- At each visit the problem list, medications, allergies, surgical treatments, diagnoses, and other medical problems should be updated. Please update if surgery or other procedure has been performed or medications have changed.

- If you are unsure what the plan is on the patient, please ask Dr. Shields or the technician in the clinic.

- EPIC orders for surgical cases should be completed prior to surgery. The operative plan and any special arrangements for the case will be discussed with Dr. Shields prior to the operation. The resident will discuss the appropriate post-operative plan with Dr. Shields and make sure that this is communicated to the patient. The resident will dictate all operative reports. In addition, a brief operative report should be included in the chart to provide a high level summary of what was performed. The surgical procedure should also be added to the patient history in EPIC. In general, the resident will see all one day post-ops in the clinic and will discuss their care with Dr. Shields.

LOW VISION SERVICE

- The Low Vision Service provides functional evaluation of patients with vision impairments not correctable by standard medical, surgical or refractive means. Individual case histories are taken to determine desired goals of visual rehabilitation. Careful measurements are then taken of residual vision using special test charts and lighting. Thorough demonstration and trial use of various optical magnifying aids are also performed to determine appropriate items to provide optimum visual performance.

- After appropriate orientation to the specific procedures involved in Low Vision evaluation, the residents will be able to perform these procedures (minimally):
Supervision and Clinical Assignments

- Functional case history.
- Visual acuity (single letter and reading test.)
- Assessment of the eye condition.
- Trial frame refraction.
- Low vision aid evaluation.
- Patient education/training in use of devices.

NEURO-OPHTHALMOLOGY SERVICE

- The Neuro-Ophthalmology Service is a strong clinical rotation. The second year resident on the service is also responsible for all in-patient consults at St. Louis University Hospital (except for days when he/she is unavailable due to other responsibilities, mainly on Tuesday afternoons when Dr. Selhorst has clinic). He/she is free of clinical duties in the afternoon in order to perform the consults (please see discussion of the consult service for more detail).

- There are often residents from other services and medical students that rotate on the neuro-ophthalmology service. They are part of the team and generally have the same responsibilities in clinic as the ophthalmology resident(s).

- Neuro-ophthalmology Clinic with Dr. Selhorst is attended by two residents, one second year resident and one first year resident (and any rotating residents/students). This clinic held on Tuesday afternoons, and Tuesday morning clinic with Dr. Chung may run over into this time. This is generally not a problem, as there is adequate support to make the transition from one clinic to the next smooth. Dr. Selhorst is to see all new patients and return visits.

- Neuro-ophthalmology clinic with Dr. Chung is attended by the second year resident. Morning clinics begin promptly at 8:00 a.m.

- A thorough history should be taken with special attention to the onset of symptoms, duration, and progressive nature. How it affects their daily activities is important. Although you may feel it is not relevant to the patient's chief complaint, a complete review of systems should be taken. A thorough medical and surgical history is documented. Pertinent family history should also be detailed.

- The resident should do a thorough eye examination. A distance and near vision is measured. If the patient is not 20/20, please refract the patient to the best corrected acuity. External examination entails measuring the palpebral fissures and levator function. Exophthalmometry is performed on appropriate patients. Pupils should be examined carefully for size,
reactivity, and for a relative afferent defect. Motility examination not only includes ductions and versions, but pursuits, saccades, and OKN's should be assessed on all patients, including optic nerve disease patients. It is helpful to understand the normal variations before recognizing pathology. A thorough slit-lamp examination should be done. A Goldmann visual field or a Humphrey visual field is done by the resident in Dr. Chung's clinic and by the technician in Dr. Selhorst's clinic on all new patients as deemed appropriate, unless they had a recent field examination. III4e, I4e, and I2e (with correction) isopters are used. No drops should be instilled in the patient's eyes until Dr. Chung has reviewed the history and examined the patient. Having done so, the intraocular pressure is measured and the patient's eyes are dilated. The resident should be able to formulate a differential diagnosis and discuss appropriate diagnostic procedures and management.

- Follow-up examinations are evaluated differently. Visual acuity and intraocular pressure should be checked on all patients. Other parts of the examination are dependent on the patient's problem and individualized. In other words, a patient with a cranial nerve palsy should have motility evaluated. A dilated examination is not required. However, a patient with pseudotumor cerebri requires a dilated examination each visit. Please ask when not sure.

- During the Neuro-ophthalmology rotation the assigned residents are expected to read from various sources that pertain to their patients and from selected references in the neuro-ophthalmic literature. Dr. Chung will provide the appropriate textbooks at the start of the rotation.

- Neuro-ophthalmology is a unique service with many challenging diagnostic and therapeutic challenges. Let's take the opportunity to learn and have fun.

**OCULOPLASTIC SERVICE**

- The goal of the Ophthalmic Plastic, Orbital, and Lacrimal Surgery Service is to provide subspecialty clinical care and resident education in the field of ophthalmic plastic, orbital and lacrimal surgery. This is to be achieved through a yearly lecture schedule, self-study done by the residents throughout the course of their training, and by clinical interaction with Drs. Espinoza and Holds in clinics, emergency situations, and the operating room.

- The three-month rotation on the Ophthalmic Plastic, Orbital and Lacrimal Surgery Service is the principal opportunity for the resident to gain expertise in diagnosis and treatment within these areas. It is expected that
Supervision and Clinical Assignments

the resident will make continuous progress during the three-month rotation, supplementing knowledge gained in the first year of residency. The resident is encouraged to discuss puzzling cases with the attending faculty or to use the attending faculty to direct self-study. Residents will be encouraged to write up interesting cases to be presented, either at meetings or as general publications. Residents will also be expected to learn the basics of interpreting various radiographic studies as they apply to oculoplastics and ophthalmology in general.

- The second-year resident assigned to the Oculoplastics is responsible for the day-to-day running of the service. These activities include admitting, daily rounds on, and the discharge of all private patients admitted to the service, as well as rounding-on all consult patients being followed by the service. All admitted patients should be seen before 8:00 a.m. and, if necessary, at the conclusion of the day. All patients should have a brief operative note on the chart at the conclusion of surgery. Dr. Holds will ask the resident to dictate the majority of operative reports, while Dr. Espinoza will dictate her own operative reports. Postoperative patients should always be seen before leaving the hospital for the evening and a brief progress note written.

- The resident should try to see all clinic patients before the attending physician, and leave a concise but complete chart note. An attempt will be made to discuss cases either during the course of clinic or at the end of clinic. It is extremely helpful to the resident to think ahead and facilitate the flow of clinic by completing or starting paperwork such as operative orders, medical releases, and history and physicals. CT scans and laboratory studies should be tracked down before the attending sees the patient. As the rotation progresses, the resident will be given more leeway to perform basic diagnostic and therapeutic tests before the attending sees the patient. When in doubt, however, always check with the attending before doing anything.

- In new patients presenting to the clinic, a brief history is obtained focusing on the presenting complaint and prior therapy or other relevant medical history. The full name and address or other identifying information should be obtained for the referring physician and for other health providers involved in the patient's care. The private subspecialty clinic does not exist to provide primary eye care; however, the abbreviated problem-oriented eye examination employed in the patient with obvious external pathology is not applicable to all patients. Patients with potential optic nerve compromise or with post-traumatic complaints often require a complete neuro-ophthalmological examination. The majority of patients with apparent external pathology will have clinical photographs taken. In these cases, it is important that the Dr. Espinoza evaluate the patient prior to any drops or fluorescein being instilled into the patient's eyes.
Supervision and Clinical Assignments

- Monday is the adult operative day for the oculoplastics service at St. Louis University Eye Institute. Tuesday is the pediatric operative day for the oculoplastics service at Cardinal Glennon Hospital. Days are set aside as needed at Saint Louis University Hospital for interdisciplinary cases or cases that require post-operative hospitalization. These cases will be performed with Dr. Espinoza. Residents will be responsible for all pre-op and post-op paperwork necessary for the patient. The residents will assist in the surgery, and will do parts of or the entire procedure, based upon their level of skill and the complexity of the case. Residents will receive intensive instruction in oculoplastic surgical techniques.

- Additional surgical experience will take place on Tuesdays at Dr. Hold's private ambulatory surgery center in West County. The second year on service will attend these cases. The first case on these days begins at 6:30 am. It is important to arrive early as the resident is responsible for all of the pre-operative paperwork as well as ensuring that ample local anesthetic is prepared for the day's case load. On every other Tuesday, Dr. Hold's fellow will be there as well. Each resident should make sure that he or she has the proper credentials before starting the rotation. See the program coordinator for paperwork. There will be occasional cases on other days, and every effort will be made to get the resident involved in these cases. In addition, it is not uncommon for after-hour emergency add-on cases to arise at St. Louis University Hospital or Cardinal Glennon Children's Hospital. It is the responsibility of the second year resident on the service to assist Dr. Espinoza with these cases.

- Dr. Espinoza is always available for consultation--either in person or by telephone. Dr. Holds and his fellow will typically provide coverage when she is out of town.

OFFICER OF THE DAY SERVICE

- The Officer of the Day will be expected to handle emergent walk-in patients (who are not patients of other clinics in session), transferred emergency room patients, and--if the consult resident is unavailable--hospital consultations as well.

- He/she is responsible for examining all emergencies and walk-ins. These patients are to be seen as promptly as possible. It is the resident's responsibility to obtain the pertinent history and perform a complete examination. For example, new patients should have an eight-point examination unless they have EKC, or if they are a regular patient of the clinic with a new and specific problem. If a subspecialty patient presents with an emergency the Officer of the Day should efficiently refer that patient to the appropriate clinic. If neither the specialty attending nor the
Supervision and Clinical Assignments

resident is available, the patient care falls on the Officer of the Day as a default.

- If the patient needs to be admitted or followed closely, the physician should contact the appropriate resident or attending staff. For example, if a patient with microbial keratitis is referred during non-clinic time, the Officer of the Day performs a complete examination and contacts the appropriate resident on the Cornea Service. The resident should contact the cornea specialists, culture the patient as per his/their instructions, and take the necessary steps to admit the patient to the hospital. Only if the resident and/or fellow are unavailable, should the triage resident do the above as the triage resident is busy managing other emergencies. Once the patient has been admitted or transferred to the attending’s service with his/her consent, the patient is no longer the responsibility of the Officer of the Day.

- The Officer of the Day is somewhat of a triage physician. If a patient walks in for refraction, the triage physician can make the decision to provide the patient a routine appointment for Comprehensive Clinic. Routine refractions alone do not constitute an emergency. However, please be courteous!

- For EKC patients, a visual acuity, external examination, and a slit lamp examination should be documented and the patient given a follow-up appointment in two-to-three weeks in order to perform a complete exam. It is not necessary to contaminate additional equipment in these cases. The examination lane should be cleaned with Clorox, or the room immediately marked to indicate it is contaminated prior to examining the next patient. Remember: wash your hands!

- There may be occasional overlap with the consult resident. The consult resident’s primary responsibility is to see inpatient hospital consultations. Usually, consultations may be done by the consult resident during the day; however, occasional STAT consultations should be handled as follows: the consult resident should go to evaluate these cases unless he/she is committed to Neuro-Ophthalmology Clinic. In these instances, it becomes the Officer of the Day's responsibility to perform the bedside examination. However, if the Officer of the Day is also busy seeing emergency patients in the clinic, then the chief resident should be contacted in order to determine which resident is the most appropriate to go and perform the consult. Continued care of the patient should be transferred to the consult resident when possible.

- At times when the emergency volume is reduced, the Officer of the Day should assist his/her fellow residents by evaluating Comprehensive Clinic scheduled patients. The Officer of the Day serves as a point of continuity for the resident clinic, and should not leave the clinic for any reason, i.e.,
Supervision and Clinical Assignments

read in the library, do research, etc., except for meals and when performing bedside examinations when the consult resident is unavailable. Emergencies and walk-ins often arrive without notice. So please, be available.

- The Officer of the Day is not permitted to take vacation during his/her block. Exceptions must be cleared through the chief resident and program director.

ON CALL TEAM

First Year Residents:

- First year residents will provide emergency coverage for the Saint Louis University Eye Institute, Saint Louis University Hospital and Cardinal Glennon Children’s Hospital every night of the year.

- Call duties begin at 4:00 pm on a weekday and 8:00 am on a weekend day. The on-call resident is expected to remain on the premises until 5:00 pm during the week, and then to be available at home for the remainder of the evening until 8:00 am the following morning. Weekend call may be taken from home.

- At any time in transit they must be available on their beeper.

- All emergencies which occur after regular clinic hours are to be seen by the first year resident on call within 20-minutes of being notified by the emergency room. The only exception to this rule would occur if the resident were in the process of evaluating a patient. If this occurs, the emergency room requesting service should be notified that you are in the process of evaluating a patient and estimated time of arrival should be given. If there is more than one emergency requiring immediate attention, and the first year resident is unable to manage this situation by him/herself, the senior resident should be notified.

- On-call residents should remain sufficiently close to the hospital to arrive in the emergency room within thirty minutes of being called if needed.

- EPIC charts/documentation of on-call emergency room visits and after hours consultations at Saint Louis University Hospital are routed the attending on call. Daytime consultations go to assigned faculty. Cardinal Glennon Children's Hospital consultations go to Dr. Davitt or Dr. Cruz.

- All patients seen by the on call residents that require continued care or
Supervision and Clinical Assignments

Follow-up should be transferred to the consult resident at 8:00 a.m. the following morning. A copy of the consultation will be available in EPIC. A consult list should be maintained and updated daily.

Second Year Residents:

- During the first two months on your second year, you will be on “buddy” call with the new first years. You will assist in all calls and see patients with the first year residents until such time as they can act safely and efficiently without direct supervision.

- After the first two months, you will not be in the on call schedule again until you are a third year unless you take time off during the consult service. Due to the burden on first year residents to cover daytime consults in addition to after-hours consults, you will be responsible for repaying the call time on your return.

- The second year rotations may have regularly scheduled surgical patients that proceed beyond regular business hours. It is your responsibility to stay until all cases are done unless directed otherwise by your attending.

Third Year Residents:

- There will be a third year resident on call for the Saint Louis University Eye Institute, Saint Louis University Hospital and Cardinal Glennon Children’s Hospital for every night of the year.

- The third year resident on call may be called by the first year on call for any case that provides diagnostic or therapeutic difficulties.

- The third year resident on call is expected to come in and review the case.

- The third year resident on call may then call the attending if necessary—the attending should be called only after the third year resident has evaluated the patient.

- All potentially surgical cases must be reviewed by the third year resident. He will then call the attending, which will review the case, and assist or do the surgery.

- The attending surgeon can only schedule emergency and urgent surgical cases for the Department of Ophthalmology at Cardinal Glennon Children’s Hospital. No resident is authorized to schedule emergency/urgent surgery.
Supervision and Clinical Assignments

Consultations and emergencies that come in during regular clinic hours will be handled as follows:

- **ABI** 8:00 am – 4:30 pm Officer of the Day
- **SLU** 8:00 am – 4:00 pm Adult consult resident
- **CGCH** 8:00 am – 4:00 pm Pediatric consult resident

OPHTHALMIC PATHOLOGY

- Ophthalmic pathology is directed by Morton Smith, M.D., a consultant to the eye institute. Dr. Smith is board certified in ophthalmology and in anatomic pathology.

- The microscope for examining slides is a Zeiss five-headed microscope with an illuminated pointer. There is also a Zeiss photomicroscope for black and white and color photography. We are able to obtain all aspects of light microscopy, including special stains. More specialized studies can be performed at Saint Louis University Hospital; these include immunohistochemistry and flow cytometry, as well as electron microscopy.

- The slides used are mostly surgical specimens from the clinic and from the operating rooms here at the Anheuser-Busch Institute and at Cardinal Glennon Hospital. A few specimens are referred in, including whole globes as well as biopsies. Residents have exposure to both the handling and processing of pathologic specimens as well as the gross and microscopic review of these specimens. They also have exposure to specimens that arise from Washington University department of ophthalmology.

- During the oculoplastics rotation, the first year residents spend one half-day per week with Dr. Smith and/or Dr. Harocopos at Washington University. This allows for them to participate in the processing of specimens directly derived from their surgical experience on the rotation. Additionally, Dr. Smith holds a monthly morning conference for one hour at Saint Louis University Eye Institute, and a monthly evening conference for two hours at Washington University. Yearly, the residents attend a separate OKAPS review by Dr. Smith.

PEDIATRIC OPHTHALMOLOGY AND ADULT STRABISMUS SERVICE

- The Pediatric Ophthalmology Service will provide a broad exposure to all
aspects of pediatric ophthalmology as well as adult motility problems. The second year resident is responsible for all clinics at Cardinal Glennon Children’s Hospital and the Saint Louis University Eye Institute. The resident will learn (and perform) procedures, including naso-lacrimal duct probings, EUA's, and strabismus surgery (including fornix-incision, limbal-incision, and adjustable suture techniques).

- The Pediatric Ophthalmology resident is to be available for all consults at Cardinal Glennon Children’s Hospital. These consults are to be performed on the day that the request is made by the referring physician and discussed with the attending pediatric ophthalmologist within 24 hours. Retinopathy of prematurity exams are the responsibility of the attending staff. Residents are welcome and encouraged to participate in these difficult examinations.

- Prior to beginning the Pediatric Ophthalmology Service, it is essential for the first and second year residents to familiarize themselves with the basic format of a strabismus exam. This may be achieved by reading, in its entirety, von Noorden’s "Atlas of Strabismus", which is available in the Library. In addition, it is recommended that the residents read chapters 3-19 of Volume 1 in the Duane's series, which discusses the basic abnormalities of ocular motility.

- The second year resident is to perform the pre-operative history and physical examination of all patients undergoing surgery either at the Saint Louis University Eye Institute or Cardinal Glennon Children's Hospital. The resident should be at Cardinal Glennon no later than 6:45 a.m. the day of surgery. The resident may or may not be responsible for the surgical dictations, as this is to the discretion of the attending.

- The optimal time for a resident to rotate through the Pediatric Ophthalmology service (if they are interested in a Pediatric Ophthalmology fellowship) is the first rotation in the second-year.

**RETINA AND VITREOUS SERVICE**

- Retina service starts promptly at 8:00 a.m. Help see new and return patients and present them to the staff attending the clinic for the day. Occasionally patients are brought over for us to examine from other services, such as general clinic or neuro-ophthalmology. These patients should be promptly and courteously seen. Similarly, hospital consult patients are often sent directly to the Retina Service, especially if the patients have been seen by us before. These patients should also be promptly seen.
Supervision and Clinical Assignments

- **NEW PATIENTS**
  - All new patients should be initially evaluated by a resident or the faculty member in attendance. Appropriate and detailed history should be taken including medications, allergies, other medical problems, and where pertinent, past medical details. The resident or faculty member will dilate the patient after the initial components of the exam (visual acuity, intraocular pressure, visual field, external examination, and slit-lamp exam). Assessment of an afferent pupillary defect must be made by a resident or faculty member. Refraction should be performed when indicated by a significant improvement in pinhole visual acuity, patient request, or a vision-examination discrepancy (ex: "functional" problem). Post-op patients will rarely be refracted before three months. Technical help will occasionally be requested to perform visual acuities, intraocular pressure measurements, or lensometer readings. Technical help will be required when Goldmann visual fields, Humphrey visual fields, electrophysiology (ex: ERG, EOG, dark adaptation), color vision testing (Farnsworth-Munsell 15 hue or 100 hue test), or echography is needed. Technicians may also be requested to assist patients to photography for color photos or fluorescein angiography, or to Saint Louis University Hospital for laboratory tests. When possible, the resident who initiated a new patient workup should complete the fundus exam since this will result in more teaching value. Patients who have not been seen at Saint Louis University Eye Institute for three years or more or who have not previously been seen on the retina service should be considered new patients.

- **RETURN PATIENTS**
  - These patients have been on the Retina Service within the previous three years and are returning for routine follow up. The most recent note should be reviewed to alert the clinic personnel of any special testing or examination procedures anticipated. This will also help us avoid the potential problems of dilating narrow angle glaucoma patients prior to peripheral iridectomy, diabetics who should have rubeosis iridis checks, or patients requiring near refraction. The visual acuity and intraocular pressure should be performed by the technician when feasible. Interval history and pertinent anterior segment, visual field, periphery, motility, or other exams should then be obtained by the resident or attending faculty member. Again, technical help will be required for supplementary testing. Fundus exams should be completed by the initiating physician to maintain patient continuity and maximize the correlative assessment.

- **POST-OP PATIENTS**
  - These patients should be handled similarly to return patients except that the assisting resident or operating attending should be consulted if significant symptoms or complaints are volunteered.
Supervision and Clinical Assignments

- **EMERGENCY PATIENTS**
  - Patients arriving on a scheduled faculty service day between 8:00 a.m. and 5:00 p.m. should be handled as any new patient. On nonscheduled days, faculty may request or agree to patient visits. Such exceptions should be clearly stated by the attending faculty member to the scheduling desk, scheduled on IDX, or communicated directly to clinic personnel. Otherwise, patients should be directed through the usual channels or contact made with the appropriate service attending faculty.

- At the beginning of the surgical Retina rotation, the resident will be directly involved in the care of retinal detachment patients. An absolute prerequisite for this involvement is skill in the examination with the indirect ophthalmoscope. This is learned by meticulous examination and retinal drawing of attached and detached retinas, examination in the operation room of patients with retinal detachment, and assisting in surgery.

- It will be the resident’s responsibility to evaluate assigned patients preoperatively, perform a history and physical (until other arrangements are made) and assist in obtaining appropriate consultations for anesthesia clearance. A member of the vitreoretinal service will discuss and obtain the consent with the patient so that the resident may obtain signature of the form prior to surgery.

- Retinal drawings should be done on every operative case including pneumatic retinopexy. The involved eye should be examined fully. As for a conventional scleral buckle procedure, the contralateral eye should be examined for lesions necessitating prophylactic therapy. A drawing should also be made.

- When a patient with a detachment is sent home to await surgery at a later date, the resident is responsible for placing that patient on a dilating drop to avoid posterior synechiae. Use Scopolamine 1/4% b.i.d. in the operative eye. This must be done even if such patients are sent home for only one or two days. If this is not done, approximately 10% of the patients will return with uveitis and posterior synechiae. In addition, the resident must record the findings in the non-detached eye at the initial examination and record these on the standard examination sheet.

- All letters to referring physicians will be written by attending physicians. Post-operative visits should be arranged, whenever possible, on days when the faculty member involved in surgery is scheduled in clinic.

- It is the resident’s responsibility to round on every inpatient on which he has assisted or performed retinal detachment surgery. This must be done every day of the week and these rounds must be completed before going to
the OR reporting to the Vitreoretinal Service. It is discourteous to the patients to operate on them on one day and not examine the eye and write activity orders until noon of the next day. Post-operative eye drops should not be ordered until the patient has been evaluated on the first post-operative day. In general, the patient should remain at bed rest until the first post-operative examination. Ambulation may be begun after staff examination. Gross visual acuity, counts finger or hand motion, should be recorded—along with intraocular pressure by Tonopen—every post-operative day. The patient should be examined at a slit-lamp. No patient should be discharged from the hospital until this has been checked. Again, when patients are discharged, it is expected that they will be examined and discharged prior to the resident reporting to the operating room for surgery or reporting to the clinic.

- One frequent problem in a referral service is complaints from referring physicians indicating that patients were led to believe that their care by their referring physicians was not adequate. This is almost always a misinterpretation by the patient of something we say. Therefore, when discussing patients, asking questions, or discussing results of previous detachment surgery or vision, be exceedingly careful about the choice of words. An unguarded statement, such as, "He was detached for a long time before we saw him", could easily result in accusation or litigation against the referring physician. As a rule, discussion of the nature of previous ophthalmic care should not be performed in front of the patient.

- Our objective during this rotation is to give you a sound basis in the following techniques or subjects: Indirect ophthalmoscopy, macular disease, diabetic retinopathy and fluorescein angiography. To this end we present the following list of topics and tasks which you are expected to accomplish during your rotation:

  o Indirect Ophthalmoscopy
    - To become facile with the indirect ophthalmoscope using either hand. Begin to practice and learn scleral depression.
    - Examine and draw the fundus of your retinal detachment patients.
    - Perform panfundoscopic lens examination of the vitreous and retina in appropriate patients.
    - Examine as many postoperative retinal detachment patients as possible on retina service days.

  o Macular Disease
    - Study chapter 9 ("Hereditary Macular Dystrophies") and chapter 23 ("Acquired Macular Disease") in Duane’s Clinical Ophthalmology.
    - Become familiar with the fundus measurements and definitions of macula, fovea, disc, and avascular zone.
Supervision and Clinical Assignments

- Recognize in patient’s serous detachments and hemorrhagic detachments of the retina, serous pigment epithelial detachments and hemorrhagic pigment epithelial detachments and clinical characteristics of subretinal neovascular membranes.
- Perform contact lens and slit-lamp examinations together with direct and indirect ophthalmoscopic examinations of the posterior pole.
- Be sure that you understand the present theory and pathologic physiology of age-related macular degeneration.
- Know clinical manifestations and treatment of presumed ocular histoplasmosis and ocular toxoplasmosis.
- Know clinical and angiographic features of malignant melanoma and metastatic fundus tumors.
  - Diabetic Retinopathy
    - Familiarize yourself with the nomenclature and characteristics of proliferative retinopathy, NVD, NVE, IRMA’S, background retinopathy and macular edema.
    - Know the indications for photocoagulation of diabetic retinopathy as indicated by the Diabetic Retinopathy Study.
    - Know the present status of photocoagulation of diabetic macula edema (ETDRS).
  - Fluorescein Angiography
    - Review the daily fluorescein angiograms with staff on a regular basis and listen to discussions with patients concerning treatment. Observe macular photocoagulation treatment being applied.
    - Present cases at the rounds concerning medical-retinal conditions along with fluorescein angiographic features.
  - Procedures
    - Read about, discuss and observe techniques of retrobulbar anesthesia. Generally first or second year residents give retrobulbar anesthetics under direct supervision.
    - Observe all laser procedures performed by the staff and perform the laser procedures when deemed appropriate.
    - Observe, and when appropriate, perform outpatient cryopexy, air-fluid exchanges and vitreous taps performed by the staff.
    - Observe, and when appropriate, perform intravitreal injections.
TRANSITION OF CARE (HAND-OFFS)

ACGME Common Program requirements effective July 2011 focus on improving patient safety, continuum of care, and work hour limitations. As a consequence, there will be an increase in the number of handoffs during patient care. In an effort to promote physician communication and care delivery the Program has developed a handoff protocol and evaluation tool.

JCAHO has established “a standardized approach to handoff communications” as a national patient safety goal. The primary objective of a “handoff” is to provide accurate information about a patient’s care, treatment, and services, current condition and any recent or anticipated changes.

Daily sign-out is done at 8am and at end of work day (approximately 5pm) via phone or face-to-face between residents as appropriate given current clinical location assignments. An electronic patient care list which resides in EPIC, where it is accessible to all residents at all times, is used. Tasks are delegated and responsibilities are assigned and documented on the patient list. The patient list is updated in real time by the daily consult residents. The list includes the responsible resident(s) and attending for each patient. Inpatients will be signed over to the respective SLUH and CGH day Consult residents. Clinic follow up patients as appropriate will be signed-over to the “officer of the day” or the appropriate specialty service.

Daily consult residents round on patients, complete necessary tasks. The PGY3 on weekday Consult service will round/staff with appropriate attending Monday, Tuesday, Wednesday, and Friday. (and as otherwise appropriate)

List updated in real time by consult residents and tasks needing further follow-up signed out (via phone or face-to-face as possible based on current clinical locations) to night/weekend call person at end of clinical day (approximately 5pm).

The night/weekend on call resident completes tasks as necessary and updates patient list in real time.
Evaluations

RESIDENT EVALUATION OF FACULTY, PROGRAM, AND ASSIGNMENTS

- Faculty
  - Residents perform a comprehensive evaluation of each full-time faculty once a year using an online evaluation system. To preserve anonymity, resident evaluations of the faculty are tabulated anonymously. All faculty evaluations are held by the program coordinator, and are not viewable by the faculty, except in final printed form, with all names hidden to protect anonymity.
  - Residents have the opportunity to evaluate faculty lectures each time they give a presentation on paper forms. These reports are returned to the faculty yearly to preserve anonymity.
  - Faculty evaluations are reviewed by each attending and reviewed annually with the Chairman at their annual review.

- Program
  - Residents evaluate the overall residency program once a year. All comments remain anonymous and are summarized into a single report that is provided to the Program Director and clinical faculty for review. These will be brought up at the Annual Program Evaluation meeting to be discussed by residents and faculty.

- Rotation
  - At the beginning of each rotation, the resident and faculty are required to review the goals and objectives for that rotation. At mid-cycle, these goals and objectives will be reviewed again to assess progress in learning plan.
  - At the end of each rotation, the resident will complete an online evaluation of the rotation. To preserve anonymity, resident evaluations of the rotation will be collated and tabulated once a year anonymously.
Evaluations

FACULTY AND STAFF EVALUATION OF RESIDENTS AND PROGRAM

- Resident
  - 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. It is expected that this evaluation will be performed once each quarter with each resident.
  - Faculty will complete a comprehensive quarterly resident evaluation that covers assessment in the six core competencies (patient care, medical knowledge, interpersonal communication skills, systems-based practice, professionalism, and problem-based practice). This evaluation will be available to the resident for review within 1 week of the end of each rotation.
  - Each resident will meet at least twice a year with the Program Director for a formal evaluation and review of the resident’s performance. A summative evaluation will be filled and signed by both the resident and the Program Director at the conclusion of the evaluation.
  - Surgical skill evaluations will be performed by attendings during surgical encounters in the operating room and in the wet lab or simulator.

- Program
  - Faculty evaluates the overall program once a year. All comments remain anonymous and are summarized into a single report that is provided to the Program Director and Chairman. These will be brought up at the Annual Program Evaluation meeting to be discussed by residents and faculty.

OTHER EVALUATIONS OF RESIDENTS

- In addition to the faculty evaluations, the residents are evaluated by technicians, secretaries, office staff, fellow residents and operating room staff on a semi-annual basis via an online survey. These 360 degree evaluations are anonymous and randomly assigned. The summary is reviewed at the resident’s semiannual evaluation with the Program Director and is available for review in the resident portfolio.
- Residents will be evaluated by faculty and fellow residents on their presentations skills at Grand Rounds and Journal Club.
### Lectures, Conferences, Courses and Seminars

#### Lectures, Conferences, Courses and Seminars

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<td>Friday</td>
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<td>Retina Conference</td>
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#### Chairman’s Rounds

Once per quarter, the residents will meet with Dr. Cruz. One resident may be assigned to provide a current journal article for review. It is his or her responsibility to provide copies to residents and Dr. Cruz well in advance of the meeting. At this time Dr. Cruz will distribute news from the department and residents are free to vocalize concerns.

#### Grand Rounds

- Grand Rounds is to start at 8:00 a.m. sharp each week on Wednesdays, unless there is a Visiting Professor.
- Dr. Feman will facilitate Grand Rounds and direct questions and discussion to both residents and faculty.
- A schedule will be given to the residents indicating which resident is responsible for presenting a patient at each Grand Rounds session.
- Each resident will be expected to present several times per year.
- At least two patients should be presented each week, including July. Ideally, one resident should present one patient. (It may be necessary, occasionally, for one resident to present more than one.) Please refer to your quarterly schedule.
Lectures, Conferences, Courses and Seminars

- These patients may have any number of issues to discuss, i.e., difficult management issues, surgical issues, unusual pathology, and "show-and-tell" cases.
- The resident will present the case in a concise fashion and present any slides relevant to the case.
- Photos, scans, and pertinent studies should be available for Grand Rounds presentations.
- Any unscheduled cases of interest or cases from community attendings are welcome.

JOURNAL CLUB

- Journal club meets several times a year, on a weekday evening of the month when there is no SLOS meeting.
- Journal club rotates through the homes of the faculty members.
- The hosting faculty member is responsible for three or four articles of his/her choice on the topic(s) of his/her choice. A variety of topics for each journal club are encouraged to reflect interests of the faculty.
- Each article is assigned to one resident.
- The resident is responsible for presenting the article succinctly and reviewing the pertinent points, the merits and problems with the article.
- Resident assignment will be handled through the sponsoring faculty member or Gabriela Espinoza, M.D.
- The hosting faculty member is responsible for copying and distributing the articles for all residents, fellows and faculty in a timely fashion.
- Discussion is limited to one hour, 15-20 minutes per article.
- Format:
  - Social half-hour: food and drink (the faculty member is responsible for food and drink of his/her choice)
  - Discussion for one hour (maximum of one hour and 30 minutes)

MORBIDITY AND MORTALITY (M&M) CONFERENCE

Morbidity & Mortality Conferences are held in place of Grand Rounds quarterly, in a closed session limited to members of the Department of Ophthalmology. These will address complex issues involving patient safety and quality improvement issues related to patient care. It is an opportunity to discuss complications which have arisen during the care of patients in a free and open manner so that all may benefit from the experience without having to directly experience it themselves. This provides a mechanism for monitoring the occurrence of complications, the rate of complications, and the need for remediation or modification of surgical privileges.
Lectures, Conferences, Courses and Seminars

OKAP PRACTICE QUIZ

- It is mandatory that each resident take the OKAP Examination each year of his/her residency.
- We have practice quizzes each week on Wednesday morning organized by the chief resident, each covering approximately 90 pages of reading. That quiz schedule will take us completely through the BCSC 13 book series each year. The goal is to provide a systematic review of the BCSC course published by the American Academy of Ophthalmology, to prepare residents for the Ophthalmic Knowledge Assessment Test (OKAP) and Written Qualifying Examination (WQE) for board certification, and to develop skills in writing examination question and teaching peers.
- The quizzes will be made up on Fridays on those Wednesday mornings that are used for Chairman’s rounds and Program Director Review.
- The residents participate in the oral review of the tests with the resident group immediately after the tests are turned into the preceptor—be prepared to discuss the examination and provide rationales to explain correct versus incorrect answers on the weekly examination.

PROGRAM DIRECTOR REVIEW

Once a month, the residents will meet with Dr. Espinoza. Residents will bring cases that they have added to their learning portfolio to discuss care and management. These will then be further selected for further development of evidence based medicine and used to practice systems based learning and practice based learning. At this time Dr. Espinoza will discuss departmental issues and GME issues with the residents and residents are free to vocalize concerns.

RETINA CONFERENCE/PATHOLOGY CONFERENCE

- Retina conference is held once a month on a Friday morning from 7:00 – 8:00 a.m.
- On some Fridays, there may be Pathology conference with Dr. Mort Smith either in lecture form, or slide review.
- Dr. Krummenacher or Dr. Akduman will chair the Retina Conferences.
Lectures, Conferences, Courses and Seminars

TOWN HALL MEETINGS

Quarterly, the residents will meet with the program coordinator, Judee Renner-Sliment. Residents will have the opportunity to discuss departmental issues, review service issues and review residency requirements such as duty hour and surgical logs.

VISITING PROFESSORS

Clinical Visiting Professors are scheduled approximately one every other month, typically on the third Thursday afternoon of the month. Case Presentations with live patients are followed by discussion and lecture by the guest speaker. Three times each year we host the St. Louis Ophthalmological Society meeting, which would then follow the Thursday afternoon session. Washington University will also host the alternate meetings. The meeting includes dinner at the University Club tower and a lecture by the guest speaker. Residents are expected to sign up for these meetings.
POLICY ON MOONLIGHTING

In accordance with the Saint Louis University Graduate Medical Education policy (see below), the department of ophthalmology forbids moonlighting during residency.

Those who violate this policy will be subject to dismissal from the residency program.

Saint Louis University Graduate Medical Education policy on Moonlighting:

Appointment to postgraduate training programs of the Saint Louis University School of Medicine is a full-time professional education commitment on the part of the trainee. This commitment extends to the full fifty-two week term of each trainee’s appointment period. Accordingly, the trainee is not to engage in any remunerative professional work, (“moonlighting”) or to accept fees for services rendered to patients in the course of the training program. Any exceptions to this policy must be approved, in advance, in writing by the Dean. Only exceptions recommended by the residency program director, the concerned clinical department chairman, and the Associate Dean of Graduate Medical Education will be considered. Any violation of this policy shall be cause for dismissal from the program.

Appointment to a Residency or Subspecialty Residency Training Program of the School of Medicine will not under any circumstances include restrictive covenants.
Policies

POLICY ON RESIDENT DUTY HOURS

Resident duty hours have become the subject of intense interest both inside graduate medical education and within public forums. As a result, residency programs are required to strictly comply with ACGME requirements regarding their policy on resident duty hours. http://www.acgme.org/acgmeweb/tabid/271/GraduateMedicalEducation/DutyHours.aspx

POLICY

Resident Duty Hours for SLUEI Residents in Ophthalmology

1. Residents and faculty members should be familiar with the ACGME Duty Hours language. http://www.acgme.org/acgmeweb/tabid/271/GraduateMedicalEducation/DutyHours.aspx
2. Residents will take call from home and limit their time spent in the hospital after hours to only critical patient needs.
3. The first year residents should ask for assistance from the senior residents on call if their time in the hospital becomes excessive and risks excessive fatigue or a Duty Hours violation.
4. Duty Hours must be limited to 80 hours/week, averaged over a 4-week period.
5. On call residents must immediately report to the program director or the attending on-call any instance where a resident on-call has been involved in continuous patient care for 24 hours PLUS 4 additional hours after call (the additional 4 hours can be used to promote didactic learning and continuity of care, including assisting in clinics and surgeries). If this occurs (i.e., continuous duty for 28 hours), the program director or on-call attending will arrange for at least a 14 hour period of rest for the affected resident before any further clinical or academic activities occur.
6. In addition to the above, the program will monitor resident duty hours as follows:
   a. The results of surveys completed by our residents (both national ACGME surveys and our own, internal GME surveys) will be reviewed for any residents self-reporting duty hours violations.
   b. If any resident reports a Duty Hour violation in Section 4 above - or reports a violation on a survey - the program director will institute a comprehensive monitoring of the duty hours of all residents for one quarter using the New Innovations Duty Hours Log provided by our GME office to determine if the residency program overall is exceeding the maximum allowable Duty Hours.
   c. In addition, the program will use the New Innovations Duty Hours Log System to monitor individual resident compliance.
   d. If duty hours are found to be at risk of being exceeded, the program will alter the on-call responsibilities of the various levels of training to ensure 100% compliance.
Policies

POLICY ON 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 incoming residents complete the program on “Sleep, Fatigue, and Patient Safety.” The faculty participates in the educational module regarding sleep, fatigue, and patient safety.

If a resident has signs of fatigue or sleep deprivation after extended duty, the resident is to take a strategic nap of 30 minutes, or delay participation in the next morning’s activities up to two hours. If the resident’s duty on the subsequent morning will be delayed, then the resident must contact the attending or chief resident as soon as possible prior to missing their assignment. 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 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.

RESEARCH

All second and third year residents are required to conduct research mentored by one or more faculty members and to present the results of their research at the annual Resident and Alumni Weekend. First year residents are encouraged to identify an area of interest and begin to formulate a mentor for their research. Our goal is to encourage inquiry and scholarship among the residents, develop new knowledge, learn to evaluate research findings, and development habits of inquiry as a continuing professional responsibility.

All residents must successfully complete a tutorial provided by the Institutional Review Board regarding protection of subjects participating in research studies before beginning clinical research projects. In consultation with a faculty research mentor, residents are to design a valid research study that will provide statistically valid answers to one or more questions posed by the hypothesis. Residents should gain basic knowledge of valid design of research studies including rudimentary use of common statistical methods including: p-values; t-test; mean; mode; median; incidence; prevalence; and standard deviation. Each project must have an appropriate Institutional Review Board application and have the proposed project approved.

Oral presentation of preliminary or final research during the department’s annual residency meeting is required for all second and third year residents and optional.
Policies

for first year residents. Residents are encouraged to submit all research for publication in a peer review journal and for presentation of the results at a professional meeting.

RESOURCES AND EQUIPMENT

St. Louis University Department of Ophthalmology Advancement Program

- A set of Basic Clinical Science Course books valued at approximately $840.00 will be given as an entry gift to each resident. These books are presented by the Academy of Ophthalmology. They represent the equivalent of a graduation gift from the department.
- Each resident will also receive, free of charge, a membership to:
  - The American Academy of Ophthalmology
  - The St. Louis Ophthalmological Society
- As a member of the American Academy of Ophthalmology, each resident will receive a free subscription to the journal, *Ophthalmology*, during the three-year residency.
- First year residents will also receive a complimentary subscription to *Survey of Ophthalmology*.
- Each resident will also receive a basic set of lenses (20D and 90D) from the Department.
- Each resident will receive a gonioscope as a donation from Dr. Brady.

Library

- The library is open Monday through Friday, 8:00 a.m. to 5:00 p.m.
- Faculty and Residents have keyed access to use the library after hours when necessary.
- Currently, there are approximately 1,500 books and approximately 80 journals in the library, along with a beginning collection of rare books and archival materials. All current library materials are listed in the Saint Louis University libraries' MERLIN system, available on workstations in the library.
- Additionally, the library Web Homepage offers several relevant databases including MEDLINE, Core Biomedical Collection, and Current Content. We have access to 750 full-text journals online as well as databases that provide full-text books.
- There are currently three computers in the library that offer access to the Internet as well as software such as *Microsoft Office* including Word, Excel, and Power Point.
- Training is available using the databases and various Internet functions.
- Interlibrary loan service is available when you need materials not immediately available in the library.
Policies

- Journals do not leave the library.
- Books may be borrowed for up to three weeks.
- Residents are expected to do their own copying, available at no cost to the resident at the Departmental copying machine available in the library.
- For additional information, or if you have questions, contact the SLU reference desk at 577-8606

PAGERS

- All residents will wear pagers at all times during work hours, and at times when they are on call and not at home (in transit, etc.).
- Any change in address, phone number, or beepers, must be notified immediately to Saint Louis University Hospital operator, the Saint Louis University Eye Institute operator, Program Coordinator Judee Renner-Sliment, Luann Weiss and the Chief Resident for immediate change in the resident's listing. (This is the obligation of the individual resident.)

DRESSCODE

- All residents should be neatly dressed in relatively conservative clothing, which includes slacks, dresses or skirts and white coat for women residents and slacks, shirt tie and white coat for men residents. This dress code applies to on-call duties after hours, although scrubs with a white coat are acceptable. Jeans are inappropriate at any time. Open-toed & athletic shoes are inappropriate for clinic.

CHIEF RESIDENT

- Those pursuing chief resident must submit their interest in writing to the chairman. The chief resident is selected by the faculty.
- The chief will take six days of call each month. They may be taken as weekends or weekdays as mutually agreed upon by the senior residents, but most likely as one weekend and three weekdays each month. The other senior residents will equally distribute the remaining call days.
- The chief will not take call on a major holiday. The three major holidays - Thanksgiving, Christmas, and New Years - will each be taken by one of the other senior residents.
- The chief will not take call on the weekend that the junior residents are at the Memphis review course.
Policies

MISCELLANEOUS POLICY

- Residents are expected to remain physically in the Saint Louis University Eye Institute until 5:00 p.m. each weekday, even when they have been excused from their scheduled responsibilities. If a resident should have some free time during the day, said resident should check to see if he/she could be helpful in the General Clinic. If the resident is not needed in the clinic, said resident should remain at the S.L.U.E.I. and study in the resident lounge or library.

- Residents are not to leave the clinic area until all patients have been seen.

- Residents must check with the scheduling desk before telling any patient (other than an emergency patient) that it is all right to come to the clinic immediately and be seen without waiting.

- Patients with appointments should be given priority over non-emergent walk-ins.

- Residents should use the phones in the back area, and avoid using phones at the front desk of the clinic.

- Prior to performing any temporal biopsy, please make sure the following are obtained:
  1. A copy of the patient's history, ocular examination, and patient's blood pressure.
  2. ESR (STAT).

- Residents must inform the chief resident and Judee Renner-Sliment of any and every change in their schedule. This includes last minute surgery, illness, everything.

- Any chemical, material or object which is brought in by patients, relatives or ambulance staff, etc., which is said to have caused an injury to the patient being examined, should be taken by the staff to Pathology for logging into the Saint Louis University Eye Institute Pathology Laboratory as a permanent specimen which may later be required for medicolegal purposes.

- When ordering X-rays, it is preferable to specify the part to be examined, and a brief reason for the exam, without restricting the examination to limited views (e.g., AP view only.) For medicolegal reasons, it is preferable to allow the technologists to take the full standard legal views, especially in cases that involve trauma, foreign body or possible tumor. If additional special views are needed, they should be requested (in addition to the standard views.)
Policies

- Meals credits are available for residents on-call through Saint Louis University Hospital. Judee will request your meal credit on a monthly basis depending on the number of call days. Meal credits for residents on-call at Cardinal Glennon Children's Hospital will be issued by Nancy Rath in Dr. Davitt's office. She can be contacted at 577-5660.

LEAVE POLICIES

POLICY ON LEAVE REQUESTS FOR RESIDENTS

- In order to prevent disruption of service in the comprehensive clinics, the following scenarios are envisioned:
  
  - Full Complement of Residents Assigned to Service (resident/fellow on service, not on vacation): This becomes an intraservice problem, so no residents should be requested from the resident clinic. There should be no exceptions to this.

  - Service Resident/Fellow on Vacation: Again, this is an intraservice problem. It is up to the individual attendings to cover without requesting additional residents. The faculty member should be aware that by granting the vacation, it is done with his/her consent and discussion, as evidenced by the signing of the vacation release form. The consult services at Saint Louis University and Cardinal Glennon require resident coverage at all times, this will be arranged by the Chief Resident.

  - Off-hours Clinic/Emergency: This refers to patients referred during the part of the day when the attending is not assigned a clinic space. Since the attending has a primary technician, who may be acting as a back-up on another service, arrangements should be made by the primary technician for space and initial evaluation (i.e., hx, VA, IOP). As a courtesy to the colleague who has the space for that day, the primary technician should request space for the evaluation of that particular patient. If the patient is assigned to the Officer of the Day (O.D.) who will perform the initial evaluation, the attending will be contacted by the O.D. for review and evaluation and again after requesting space from the attending using the rooms.

  - Non-emergent Surgery: If surgery occurs during the faculty’s assigned operating room day and time, coverage will be by the service resident.

  - If surgery is scheduled or performed during an unassigned time,
Policies

and a service resident is not available, it is the responsibility of the faculty physician to perform all pre-surgical, surgical and post-surgical care. Exception to this rule may occur on complicated retina cases which require capable assistants to perform scleral indentation during vitrectomy, etc.

STUDY LEAVE

- Study leave must be taken as part of vacation leave with the same constraints.

MEETING LEAVE

- Approved meeting leave may be taken in addition to regular vacation leave. This leave must be organized at least six weeks in advance.

- Residents are allowed one paid trip to the American Academy of Ophthalmology one time during either the second year or third year of residency. They are not required to present any material, although this is encouraged. To insure adequate service coverage, two residents from the second year class and two from the senior class will be allowed to attend the AAO meeting each year. This will be decided by consensus among each class as to which two of the four residents will attend AAO during their second year and which two of the four will attend during their senior year.

- Any resident presenting original scientific material at a recognized and approved ophthalmology meeting on the mainland United States (Example: Academy, ARVO, etc.) may request meeting leave. This will usually be granted if the scientific abstract has been reviewed and selected in competition with material submitted by other peer groups, for a recognized meeting. The resident will be permitted the day before and day of the presentation as meeting leave. Additional time must be taken as vacation.

  o All other travel approval is based on scholarly merit at the sole discretion of the chairman. Travel will be paid for accepted abstracts that have reasonable likelihood of being accepted for peer-review publication (as determined by faculty review). Abstracts must be submitted to the chairman before being submitted to national meetings for acceptance. Unless pre-approved by the chairman, meeting expenses will not be paid by the department even if the abstract is accepted for presentation.

- Each presentation should reflect new data, different from that presented at previous meetings.
Policies

- A copy of the abstract is to be submitted to Drs. Gabriela Espinoza and Oscar Cruz PRIOR to submission to the designated meeting.

- Limitations to above meeting leave are as follows:
  First-year residents may attend one meeting.
  Second-year residents may attend no more than a total of two meetings (including Academy).
  Third-year residents may attend no more than a total of three meetings (including Academy).

  Travel beyond these limitations must be pre-approved by Dr. Cruz prior to Submission of an abstract.

- There are several meetings on the days preceding the AAO Annual Meeting each year. Some of these are sponsored by the AAO. A resident may attend a pre-AAO meeting, but the resident can only be absent from the department a total of the normal AAO meeting days. In other words, if a resident leaves a day early for a pre-AAO meeting, the resident must return from the AAO a day early. The pre-AAO meeting will not be considered a separate meeting for reimbursement. Second-year residents would still be eligible for one additional meeting, and third-year residents would still be eligible for two additional meetings if novel research is presented.

- All above study and meeting leave will be approved only if it does not cause significant disruption of the clinical service/training. Example: Conflict with other vacation leave, etc.

- Requests for a conference leave will be assessed in the order that they are received. It is not expected that more than two third year residents will be permitted to go to the Academy of Ophthalmology at the one time. If a conflict occurs, preference will be given to residents presenting original material at meetings over other residents wishing to attend the same meeting.

- **ALL REQUESTS FOR STUDY/MEETING LEAVE, FOLLOW THE SAME SUBMISSION GUIDELINES OF **AT LEAST SIX WEEKS IN ADVANCE.

FELLOWSHIP/INTERVIEW LEAVE

- Residents may have five working days during the three-year residency, over and beyond their vacation, to interview for fellowships or job opportunities. However, the resident:
  - Must show documentation from the interviewer (or his/her office)
Policies

designating the times and duration of the interview. This documentation does not necessarily need to be presented before the interview, but must be presented in a timely fashion.

- Should give at least one week's notice to the faculty attending, clinic personnel, and Judee Renner-Sliment. The request for leave should still be completed as usual. The further advance notice given, the better.
- Must take vacation days if more than five working days per residency are required for interviews. Documentation is still required for all interviews.

- Faculty may not prohibit residents from interviewing for fellowships nor job opportunities.

VACATION LEAVE

- The resident schedule (grid) has been organized so that 2nd and 3rd years are with one attending or service each quarter. Some of the 1st years are on one service, while others are split between services. This has been designed to maximize resident education and provide continuity of care. If an attending is not engaged in patient care, often that attending's resident is reassigned on the grid. If the original attending has unusual clinical or surgical responsibilities, they may request that their resident assist through discussion with the Chief Resident.

- If a resident's attending is out on vacation, said resident will be reassigned to clinical responsibility at the discretion of the chief to maximize resident education. The chair and residency director will have ultimate authority and can supersede the chief’s decision at their discretion.

- Residents are encouraged, but not expected, to take vacation time to coincide with the vacation time of their respective attending. Information regarding Faculty vacations can be obtained from administrative staff or the chief. First year residents may not take vacation on the Officer of the Day service. Second year residents may take 1 week of vacation either on their Neuroophthalmology or Pediatrics rotations in order to minimize disruption of coverage for consults. No resident can take vacation during the month of July or the last 2 weeks of June.

- There is a Resident Vacation Request Form. It will be initiated by a resident's request for a specific date of leave. The resident will then provide it to the chief and date it. The chief will have 2 business days to provide a list of attendings and residents out for the requested dates of leave, and the residents, if any, available for coverage. The requesting resident will then give it to the appropriate attending and date it. The attending will then have 3 business days to review, sign, and return the
vacation request form to the resident, and date it upon return to the resident. The resident will then bring it to the chief for final signature, at which date it will be considered completed. The date of the final chief signature must be 6 weeks in advance of the beginning of the requested date of leave. If less than 6 weeks in advance, then the Resident Vacation Request Form will be nullified. This is designed to allow Faculty to reduce patient volumes in clinics if they deem necessary. Resident coverage of clinics is not guaranteed in order to avoid disruption of resident education.

- If the chief and/or respective attending do not return the Resident Vacation Request Form to the requesting resident within the allotted time frame above, each delinquent day will be subtracted from the 30 business days of the required 6 weeks advance notice. This would allow the requesting resident to submit a valid Resident Vacation Request Form with less than 6 calendar weeks’ notice.

- When a resident requests vacation leave, available coverage will be readily apparent on the Resident Vacation Request Form. If residents are available the attending may request coverage and be assured of receiving it. If there are no available residents, the attending will assume sole clinical responsibility for their respective service. Six weeks is required for the Resident Vacation Request Form so that attendings may reduce their clinics, if necessary, to ensure quality patient care. If residents become available after the Resident Vacation Request Form has been completed, the available residents will be reassigned to clinics to maximize resident education and coverage of clinical responsibilities, at the discretion of the chief. This will likely occur at very short notice, and attendings may not rely on last minute coverage for their clinics.

- The Resident Vacation Request Form cannot be refused or rejected by an attending if submitted, signed, and completed by each respective party with 6 weeks or more advance notice. If requests are completed with less than 6 weeks’ notice, the respective attending need not sign the Resident Vacation Request Form.

- As obtaining signatures for Resident Vacation Requests can take up to 5 or more full business days, residents are strongly encouraged to initiate vacation requests at least 8 weeks in advance of the beginning of their requested date of leave.

- Residents are not to book any flights or accommodations until the final chief signature, which signifies completion of the Resident Vacation Request Form.

- No more than two residents will be allowed to take vacation leave on any given clinical day. Priority will be based on a first-come, first-served basis. Senior residents will be given priority if vacations are requested.
Policies

simultaneously. If a dispute arises, settlement will be at the discretion of the chief, with final authority resting in the residency director and chair. The resident vacation schedule is available in the Program Coordinator’s room.

- Each resident is provided 15 days of vacation each year. Resident vacation must be taken in a block Monday-Friday, not to exceed 5 days off for vacation in a given quarter. Variations from this may be accepted or rejected for extenuating circumstances at the discretion of the chief, with ultimate authority resting in the residency director and chair.

- Each resident is provided up to 5 days of leave for interviews during their residency at Saint Louis University, to be used for fellowship or job interviews in their 2nd or 3rd years. If additional days are needed, the resident must use vacation leave. (See section “fellowship/interview leave” for details).

- Extenuating circumstances will exist and will be addressed on a case by case basis. If a resident requests non-vacation leave (e.g. funerals, interviews, and sickness) without 6 weeks’ notice before the requested date of leave, the chief will provide coverage to each affected attending as is possible and equitable and to maximize resident education. The responsibility of reassigning residents will fall to the discretion of the chief, with ultimate authority resting in the residency director and chair.

- Third year residents requesting time off at the end of their residency to transition to their fellowship or job must save adequate vacation days to take their requested leave.

SICK/DISABILITY LEAVE

- Sudden onset of sickness that does not permit attendance at clinics, operating rooms, or teaching sessions must be reported immediately (at least early in the morning of the day in which absence is expected) to one of the following in prioritized order:

  1. Chief Resident
  2. The assigned attending
  3. Judee Renner-Sliment

- Sickness entailing absence for three or more consecutive days requires a medical certificate.

- Elective medical problems—such as elective surgery—should be scheduled, if at all possible, at least eight weeks in advance with the usual
Policies

notifications required from vacation leave.

- Disability Leave/Pregnancy Leave/Family Act Bill: The University Policy allows 30 work-days (one month) with pay for a prolonged disability or pregnancy. The Family Act Bill allows for a three-month leave without pay, without loss of employment. However, one month's absence significantly compromises resident education and, therefore, if a resident is gone necessarily for over four weeks, he/she must show competence in the subspecialty area(s) missed, by the subspecialty attending staff and the chairman of the department. If the trainee is able to return to the program and does not do so, it shall be the responsibility and prerogative of the chairman of the department and his/her designee to determine whether or not the time missed shall be made up, and such decision shall be final. Continued provision of the stipend during sick leave in excess of one month during the appointment year will be allowed only in exceptional circumstances, such as work-connected disability, and only if agreed to by the department chairman or his/her designee. Please refer to the University's Handbook of Policies for further information.

MATERNITY LEAVE

- Maternity Leave Policy: The Department of Ophthalmology feels that maternity leave is important for the full recovery of the resident and to ensure her ability to work a complete schedule upon her return. Maternity leave, with pay, for post-natal recovery, of four weeks (30 calendar days) for a normal vaginal delivery and five weeks for a cesarean section delivery is available. Thirty days of maternity leave is also available to residents who adopt a child. Any additional post-natal time should be taken from vacation time. In the unlikely event that time is needed beyond maternity leave, sick time and vacation time, such time must be taken as a recognized leave of absence. Maternity leave from required rotations is to be made up from completion of the program.

- Paternity Leave Policy: Paid paternity leave of five-day duration is provided for residents. This leave is also available to residents who adopt a child.

FAMILY LEAVE POLICY

- If family leave time is required (up to 12 weeks of leave per year permitted by the Family Medical Leave Act of 1993), such additional time must be made up at the end of the residency, at no compensation.

- Any leave in excess of six weeks (including vacation, educational leave, maternity/paternity leave, military leave, and family leave) is unpaid.

- The resident may be required to provide advance leave notice and medical certification, as allowed by the Family Medical Leave Act of 1993.
Policies

- The resident ordinarily must provide 30 days advance notice when the leave is "foreseeable."

- The Department will require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the Department’s expense) and a fitness for duty report to return to work.

ARMY RESERVE LEAVE

- Residents may join a military Reserve at their discretion.

- The two week duty time is not deducted from vacation time, but residents are not paid by Saint Louis University for their active duty service. Saint Louis University will, however, pay a resident the regular two-week salary if the resident turns in the military paycheck. Residents choose this option if the military check is lower than the regular two-week pay.

- The two weeks of Army Reserve leave required by Federal Regulations per year MAY be waived by the Army in lieu of evidence of spending the equivalent time in training in ophthalmology. This approach must be tried first prior to insisting on two weeks away from the program.

  If required, the program director will make contact with the Army Reserve to support the contention that the training in ophthalmology should be taken as the two week stipulated period required.

- If this cannot be accomplished, then the military leave should be organized at least eight weeks in advance, with the same constraints with respect to conflicts, etc. as applies to vacation leave.

HOLIDAYS

- Residents are entitled to a total of 15 working days’ vacation per year as well as the following holidays:

  Independence Day
  Labor Day
  Thanksgiving Day (and possibly the day following)
  Christmas Day
  New Year's Day
Policies

Memorial Day

NOTE: these holidays are subject to change if University operations necessitate.

MEDICAL MISSIONS

Residents may travel with a full-time faculty member to medical missions. The Department grants five business days for medical mission. Vacation time must be used for additional time off. Funds must be provided externally, i.e. the Department will not provide the funds, except in unusual circumstances.

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).

PROBATION AND DISMISSAL

Probation

- 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. Normally, a resident would have had prior notification before taking this action. Any action placing a resident on probation shall be reported immediately to the Associate Dean for Graduate Medical Education.
- Specific deficiencies must be pointed out in writing to the resident who should be asked to sign the letter of probation and concur with the remediation plan, which must include assistance by the GME Ombudsman and the appointment of a mutually agreeable faculty advisor. Other remedial help as appropriate must be provided and a probationary period (typically three (3) months) specified. Monthly evaluations of performance should be kept by all supervisors and must be reviewed by the program training committee and/or the program.
- A decision of reinstatement/advancement, or extension of the probationary period, retention at the same level, or of dismissal must be made on the basis of the resident’s performance with adequate documentation of the basis for the decision. Such documentation must be
Policies

reviewed and acknowledged by the resident. Residents retained at the same level of training do not advance in stipend level.

Dismissal

- A resident may be dismissed because of inadequate performance (as outlined above) and/or because of unethical or clearly negligent conduct. Dismissal should be the decision of the Associate Dean for Graduate Medical Education on the recommendation of the program director, the department chairman or division director, as appropriate, with appropriate consultation (faculty, hospital, Human Resources, and University General Counsel.).
APPENDIX I – OCULAR HISTORY AND EXAMINATION

I. History

A. Chief Complaint

B. History of Present Illness
   1. Onset (sudden?, gradual?, when?).
   2. Constant or variable?
   3. Unilateral or bilateral?
   4. Specific problems (distance vision or near, photophobia, night blindness).

C. Past Ocular History
   1. Previous ocular disease or trauma.
   2. List past ocular surgery, including laser procedures, giving dates when possible.

D. Past Medical History
   1. Medical illnesses.
      a. Diabetes.
      b. Hypertension.
      c. Atherosclerotic cardiovascular disease.
      d. Coagulation disorders.
      e. Neoplastic disease.
      f. Miscellaneous.
   2. Current medications.
   3. Allergies.
   4. Previous hospitalizations.

E. Past Surgical History
   1. List previous surgeries.
   2. Trauma.
   3. Specifically inquire about problems with anesthesia.

F. Family History
   1. Ocular disease (strabismus, glaucoma, cataract, retinal detachment, myopia, macular disease).
   2. Systemic illness (diabetes, hypertension, atherosclerotic vascular disease, neoplastic disease, etc.).

G. Social History
   1. Job positions including chemical exposures
   2. Tobacco and alcohol use

II. Basic Ocular Examination
Appendix

A. Visual Acuity
   1. With and Without correction.
      a. Distance with Pinhole Examination
      b. Near.
   2. How did you measure visual acuity?
      a. Eyechart - note distance.
      b. Newspaper, etc. (estimation).
      c. Counting fingers - note the distance.
      d. Hand motion.
      e. Light projection (if so, where?).
      f. Light perception without projection.
      g. No light perception.
   3. Refraction (manifest or objective)

B. External Examination
   1. General-body, head, and face.
   2. Lids, lashes and lacrimal apparatus.
   3. Orbital examination-palpate orbital rims, check for proptosis
      (use Hertel exophthalmometer if necessary), check for retropulsion (do this after checking intraocular pressure).
   4. Palpate for lymphadenopathy.
   5. Corneal sensation (corneal sensation to be done before application of anesthetic drops).

C. Pupils
   1. Color, Shape, Size.
   2. Reaction to Light, Near, Swinging flashlight test.

D. Visual Fields
   1. Peripheral (screening).
      a. Finger counting (hand motion, light projection).
   2. Peripheral (formal).
      a. Goldmann perimeter.
      b. Humphrey visual field (more commonly for central 30 degrees).
   3. Central (screening) fields.
      a. Do you see all of my face?
      b. Count how many fingers I have up.
      c. Amsler grid (macular disease).
   4. Central (formal) fields.
      a. Tangent screens.
      b. Humphrey visual field.
      c. Goldmann perimeter.

E. Motility
Appendix

1. Random eye movements (appropriate?, associated with head thrust?)
2. Position and steadiness of the eyes and head in primary gaze.
3. Lid function (fatigue?, lid lag?, ptosis?).
4. Alignment (phoria or tropia?, latent nystagmus?).
5. Convergence.
6. Ductions (degree of excursion of each eye in cardinal positions of gaze).
7. Saccades (rapid movements with or without refixation targets).
8. Pursuit (slow movements at varying velocities).
9. Oculocephalic (vestibulo ocular) reflexes with head turning and chair rotation, inability to suppress the vestibulo ocular response with visual fixation.
10. Response to forced eyelid closure (Bell’s phenomenon).

E. Slit-Lamp Examination
1. Undilated.
   a. Lids, lashes and lacrimal apparatus.
   b. Conjunctiva and sclera.
   c. Cornea.
   d. Anterior chamber.
      i. Depth-central and peripheral.
      ii. Cells and flare.
   e. Gonioscopy, if indicated.
   f. Iris.
   g. Lens (poor view undilated).
2. Dilated.
   a. Lens,
   b. Anterior vitreous.

F. Intraocular pressure (better undilated).
   a. Goldmann applanation tonometry.
   b. Pneumotonometry-damaged or edematous corneas.
   c. Perkins.
   d. Tonopen.
   e. Shiotz.

G. Fundus Examination (dilated).
   a. Ruby lens (on slit-lamp).
   b. Volk 90 or 78 diopter lens (with slit-lamp).
   c. Indirect ophthalmoscopy.
   d. Goldmann contact lens or three-mirror lens.
   e. 

H. Ancillary tests and special situations.
   a. Cataract.
      i. Laser-interferometry.
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ii. Potential acuity meter.
iii. Brightness acuity testing.
iv. Others.

b. Corneal Studies.
i. Keratometry.
ii. Corneoscopy.
iii. Pachymetry.
iv. Computerized video - keratography (EyeSys).
v. Specular microscopy.

c. Small pupil examination.
i. Direct scope.
ii. Small pupil indirect.
iii. Transillumination.

d. Electrophysiologic testing.
i. E.R.G.
ii. E.O.G.
iii. Evoked response.

e. Echography.
i. Cloudy media.
ii. Axial length.
iii. Foreign bodies in mass locations inside.

f. Radiologic studies.

g. Color vision.
i. Color plates.
ii. Farnsworth 15 Hue Test
iii. Farnsworth 100 Hue Test

APPENDIX II – READING LISTS BY TOPIC

Cataract Surgery & Lens Implantation


Contact Lens

1. CLAO Pocket Guide to Contact Lens Fitting.
2. Contact Lens Problem Solving. Bennett ES.
Appendix

Cornea and External Disease

Appendix


Glaucoma

Ophthalmology Residents PGY-2

2. Basic and Clinical Science Course, Section 8-Glaucoma, Lens and Anterior Segment Trauma. American Academy of Ophthalmology.
Appendix


Ophthalmology Residents PGY-3

9. Ritch and Shields. The Secondary Glaucomas

Ophthalmology Residents PGY-4


Neuro-Ophthalmology

Appendix


Ocular Pathology

3. Apple DJ and M Rabb. Ocular Pathology, 4th Edition. Mosby, 1991. (While not perfect--its section on the orbit is minimal--this is probably the most useful single text for the resident.)
5. Yanoff M and BS Fine. Ocular Pathology, 1 Color Atlas, 2nd Edition. Gower, 1992. (Many color photos, very little text--so this should be read in conjunction with a text.)

Oculoplastics

Appendix


Pediatric Ophthalmology and Adult Strabismus

Appendix


Retina and Vitreous


Hypertensive Retinopathy
Appendix


Diabetic Retinopathy


Peripheral Retinal Neovascularization


Appendix


Retinopathy of Prematurity


Venous Occlusive Disease


Cystoid Macular Edema

Appendix


Central Serous Retinopathy


Age-Related Macular Degeneration


Histoplasmosis

Appendix

Posterior Segment Trauma


Choroidal Melanoma


Retinal Breaks and Lattice Degeneration


Retinal Detachment
Appendix


Endophthalmitis


White Dot Syndrome

Appendix


REMOVAL OF THE WRONG EYE
Removal of the Wrong Eye
Borrowed from:
Bascom Palmer Eye Institute
Anne Bates Leach Eye Hospital
by H. M. Traquair, Edinburgh

The most terrible disaster which can occur to the ophthalmic surgeon and to his patient is "removal of the wrong eye."

It might be thought that this accident was merely a possible but unlikely danger about which teachers should warn students but which has never actually occurred. That was my impression when I wrote in 1916 that by the use of local analgesia "the possibility, however remote, of such a calamity as it's (the wrong eye's) removal is totally avoided." At that time I imagined that removal of the wrong eye was a hypothetical possibility rather than an actual fact, a view which had been to some extent previously expressed by Hermann Knapp when he wrote in 1898, "... we should be on our guard lest we take the good eye out. This awful mistake is sensationally mentioned in textbooks and periodicals; I do not know whether it has actually occurred, but the possibility is undeniable."

Knapp's statement was based on the literature before 1898. Of over 60 textbooks on ophthalmology and ophthalmic surgery published before that year, I have been able to examine 37 in only one of which (Mauthner) is the subject mentioned. Only four of 14 books published since 1898 contain references and also two later editions of older works (Lawson, Czermak). Recent works do not mention the subject, the Graefe-Saemisch Handbuch (Sattler, 1922), appears to be the latest. Medico-legal textbooks are likewise silent. There cannot have been many "textbooks and periodicals" in which Hermann and Knapp found the subject "sensationally mentioned."

It may be noted that of eight direct references, only one is British, the remainder being German and American.

There is, nevertheless, abundant evidence that this catastrophe has actually occurred. Apocryphal stories exist in relation to both eastern and western hemispheres; a well-known one is that of the surgeon who on discovering his mistake rushed into an adjoining room and shot himself. According to another, the patient received a solatium of $10,000 and a pension. It is related that in a case (presumably of glioma) in a child, the surgeon--having removed the wrong eye--promptly removed the other one also and explained to the parents that bilateral removal was necessary as the disease always affected both eyes. In this instance, however, it is within the bounds of possibility that the surgeon's error
saved the patient's life. Such stories have no value as evidence, their only interest lies in the suggestion that where there is smoke there is possibly fire.

The scanty references in the literature mostly contain warnings against the risk of the accident and advice as to how it may be avoided. The method recommended is the indication of the eye to be removed by affixing a piece of adhesive plaster on the brow or in some other way such as by bandaging it. The earliest reference I have found is that of Mauthner, who wrote in 1881 that he has been personally present when the mistake was nearly made in a case of sympathetic ophthalmia. His own words are worth quoting:

"Beider Enucleation, wie sie ouf dem Gebiete der sympathischen Leiden kommt ist aber Eines die Hauptsache, und dies ist, dass man das richtige Auge enucleirt. Das scheint ein mussiger Rath, vielleicht ein Scherz aber wer wie ich schaudernd daneigestanden, wie statt des erblindeten Auges bald cas noch sehende enucleirt worden ware, scherzt nicht bei diessen Worten. Das Versehen ist nicht so unerklaerlich, wenn man bedenkt, dass die Enucleation je so haufig bei schon entwickelter sympathischer Kyklitis ausgefuhrt wird, dass im Aussehen der beiden Augen nicht immer ein markanter Unterschied bemerkbar ist, und dass der Operateur, sein ganzes Augenmerk auf die Operatio richtend, sich willig vom Assistent leiten lassend, die Operation an jenem Auge beginnt, in welches der Assistent irrthumlich die Lidhalter eingelegt. Der Patient ruhrt sich nicht, denn er ist . . . narcotisirt.*

Elschnig, re-editing Czermak's book on ophthalmic operations, quotes Mauthner and adds the following passage:-

"Dasselbe konnte aber, und vielleicht noch leichter, vorkommen wenn es sich um einen intrakularen Tumor handelt, der noch zu keinen Veranderungen am vorderen Augapfelschnitt gefuhrt hat. Da sehen beide Augapfel ganz gleic und normal aus. Man gebe sich also vor Beginn jeder Enukleation Rechenschaf welches das zu enukleierende Auge ist, und in Fallen, wo sein Ausseres nicht sicheres Merkzeichen tragt, verlasse man sich nie auf sein Gedachtnis, sonde sehe unmittelbar vorher in seiner Vormerkung nach. Das mag manchem als uberflussige Vorsicht erscheinen, allein beim besten Gedachtnisse kann einmal ein irrrthum unterlaufen und wenn er in einem deratigen Falle unterliefe--ist es uberflussig das auszumalen. (Ein Irrthum ist hedenfalls dann augeschlossen, wenn das zu enukleierande Auge vor Beginn der eventuellen Narkose gereinigt und mit einem Heftpflaste bande geschlossen wird.) (Sol ubrigens seither schon tatsachlich vorgekommen sein!)**

The interesting point in Elschnig's statement is contained in the footnote which shows that, evidently--in spite of precautions--a case had occurred within his knowledge.
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Haab\(^4\) mentions the danger associated with a general anesthetic and points out that both eyes may be abnormal in appearance though equally so, as in sympathetic ophthalmia. This condition, however, as a factor in connection with removal of the wrong eye is of little importance nowadays, as the offending eye is usually removed at the earliest sign of change in the other or before any sign has appeared.

Beard\(^6\) writes "That this most deplorable accident is not beyond the realm of the possible has been abundantly proven and that by more than a single instance."

* "In enucleation, as practiced in sympathetic affections, it is of chief importance that one enucleates the correct eye. That may appear superfluous advice, even a joke, but one who like myself has stood horrified while the seeing eye was nearly enucleated instead of the blind one, will not find amusement in these words. The accident is not so unexplainable when one remembers that enucleation is so often performed in already developed sympathetic cyclitis, that there is not always a pronounced difference in the external appearance of the two eyes, and that the surgeon—all his attention directed towards his operation and willingly allowing himself to be guided by his assistant, begins the operation on the eye in which the assistant has mistakenly inserted the speculum. The patient does not disturb himself, for he is . . . anesthetized."

** "The error can even more easily occur when dealing with an intra-ocular tumour which has not caused any changes in the anterior segment of the eye. Both eyeballs appear normal and the same. Before beginning any enucleation, one should therefore provide oneself with a statement as to which eye is to be removed, and in cases where no definite external sign is present, one should never rely on one's memory, but should refer to notes immediately beforehand. That may seem to many a superfluous precaution, but even with the best of memories, it is possible for an error to slip in, and if in such a case is should occur—it is unnecessary to say more. (A mistake can, in any case, be excluded if, commencing the anesthesia, the eye to be removed is cleaned and covered with an adhesive plaster.) (Since then a case has already, after all, actually occurred!)

Wood\(^7\) says "Lamentable but, fortunately rare instances have occurred."

"Near misses" (Mauthner\(^4\), Lawson\(^10\)) are relatively more common. In them, the operation is commenced or about to be commenced on the wrong eye, or wrong side, but the mistake is discovered before serious harm has been done. Conversations with colleagues indicate that many have had experiences of this nature.

There is much evidence that paired or multiple organs can easily be confused. Burrows\(^11\), writing of operating on the wrong side for hernia states "Such confusion between the left hand and the right appears to be no rare thing in clinical note taking; . . . " Here the error is in the notes rather than in failure to refer to them.
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The wrong eye has been operated on for cataract, the wrong kidney and the wrong finger have been operated on, and the wrong leg has been amputated (for sarcoma). Innumerable wrong teeth have been extracted: the present writer has made this mistake himself.

For the removal of the wrong eye two postulates are essential: The patient must be under a general anesthetic and the eye to be removed must not be obviously different in appearance from the other. Secondary or adjuvant causes include omission to indicate the eye by a mark on the forehead or even delegation of the marking to a nurse or house surgeon, an error in the notes, or omission to verify the eye to be removed by examination or reference to notes immediately before the operation. The surgeon may hurry in the operating theatre where the patient is waiting on the table completely anesthetized and proceed without delay or further scrutiny to remove "an" eye.

It is evident that advice to mark the eye and the other precautions mentioned, which have been recommended during the last 50 years and are included in the teaching of many ophthalmic surgeons, have not produced the desired results as cases have occurred within recent years. It will, presumably, never be known except to those directly concerned whether the mistake has ever occurred owing to marking of the wrong eye or an error in the case notes, but such possibilities constitute the weak point of reliance on any safeguard other than immediate preoperative examination of the patient in cases in which a general anesthetic is used.

The diseases concerned, in actual instances, have been intraocular tumour, glaucoma, and sympathetic ophthalmia, probably mainly the first. Nothing is known as to even the approximate number of cases. As might be expected, in every known case, a general anesthetic was used.

In infants and young children, the risk must be taken and it is the duty of the surgeon to take proper precautions personally, and not to delegate such an important responsibility. The eye should be examined immediately before the operation while the patient is on the table. If a general anesthetic is to be given either to an adult or to a child, administration should not be commenced until the surgeon is present.

The only infallible preventive, if any measure can be infallible, is the use of local analgesia. The method should be adopted in all adult cases in which the eye to be removed is not obviously and distinctly different in external appearance from the other.

A paragraph on this subject should be included in every textbook in which removal of the eye is mentioned.

REFERENCES
Appendix


GUIDE TO MEDICAL CASE PRESENTATIONS

Guide to Medical Case Presentations

Borrowed with permission from:
Peter M. Yurchak, M.D.
Department of Medicine
UCLA School of Medicine
San Fernando Valley Program
Sepulveda VA Medical Center

Case presentation is an important acquired skill for the House Officer. Only by the effective case presentation can one convey a clear and comprehensible account of the patient's medical problem or problems. At the same time, the beginner usually receives little or no coaching in this matter. The following points will serve as guide lines: they should be reviewed frequently.
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It is most important to realize that a case presentation is not simply a verbatim recital of the case write-up. A written Admission Note may be as detailed as one chooses, covering several pages in the record. Although few will read a prolix account, it may serve as a repository of details of the history, should anyone need them in the future. On the other hand, case presentation is basically "medical reporting", a terse and rapidly-moving account of what has happened to the patient. One must approach it on the assumption that he is presenting the story of a disease, occurring in a person, as formulated from the examination. That is, you will describe the unfolding of symptoms and signs and something about the patient as an individual. Properly delivered, it will stimulate your listener to construct his own differential diagnosis as the story unfolds. By including a judicious amount of positive and negative features of the history and physical examination, one can take up implicitly the main differential points, only to exclude them from further consideration.

Several points can be drawn from principles of journalism. The opening statement must catch the listener's attention, and rivet his thought processes on the patient's major problem. I would like to condemn the old fashioned admonition that a verbatim statement of the patient's chief complaint be used as the reason for his admission. Setting forth the patient's own words may be a good idea for the written case record, but his verbatim statement usually does not adequately set the stage for the presentation of his illness. Instead, state the real reason for his admission, as you see it, on the basis of your initial appraisal of his clinical picture. (In other words, say "This 40-year-old man enters because of fatigue and a 20-pound weight loss", not "I ain't felt so good.") From that moment on, your listener will entertain the differential diagnosis of fatigue and weight loss in a 40-year-old man.

There are two schools of thought about the amount of information to include in the opening statement. Some clinicians prefer to hear the patient's occupation (if a man) and whether the patient is married and has children (if a woman). Those who prefer this feel that it gives them a better feeling for the "disease-in-a-person." The other school of thought favors limiting the opening statement to the patient's age and sex (and reason for seeking medical care.) Items from the social history are reserved for separate consideration at an appropriate point in the presentation, viz. "He is the sales manager of an advertising agency, and under a great deal of pressure in his work. He has one or two martinis at lunch time, and a couple more in the evening. He smokes 1.5-2 packs of cigarettes daily, and takes a barbiturate to sleep at night. He is married, and has two small children: his wife and the children enjoy good health and he denies financial problems." None of this is included in the opening statement, so as not to distract attention from the complaint itself. You must decide which of these you prefer, since you have supporters either way.

The fact that the current admission is the patient's first or fifth really is irrelevant since his previous admissions may have been for completely unrelated problems. Therefore, this should be omitted from the opening statement.
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Include a brief statement as to the sources of your information regarding the patient, and the reliability of both the informants and the medical records. There are four general reasons why a patient may not be a reliable informant: (1) Dementia (used to encompass both senility and true dementing neurological disorders), (2) language barrier, (3) intelligence, and (4) obtundation (either from disease process or because of drugs). These four points can be kept in mind as you offer a comment about the reliability of the history. The history is really the key to diagnosis, and the listener must know how much it is worth.

Then you go on to describe the evolution of the chief complaint (as you see it):

(1) Whether it was acute or insidious in onset;
(2) Whether its intensity has been mild, moderate, or severe;
(3) Whether it is progressive or diminishing, and its current severity;
(4) Whether the course has been steady or intermittent, rapid or slow;
(5) Factors exacerbating or relieving it;
(6) The degree of disability which is resulted at the present time.

Having described the main complaint, next take up pertinent associated symptoms, and their time relationship to the main problem. Finally, describe treatment which has been employed, and the response to it. It is most important to account for all of the symptoms which you mention, indicating whether they have persisted or disappeared, and the factors which has apparently accounted for this. (You may wish to include associated symptoms and treatment and its effect with the story of the chief complaint. In any case, keep track of what happens to symptoms and therapy.) Include the patient’s account of what was said and done, and information from any available records.

At this point in the history, you must consider the differential diagnosis which you have raised. Emphasize the features supporting your diagnosis. These include:

(1) Past history of predisposing or etiological factors;
(2) Presence or absence of disease often associated with the primary complaint or complications of it (for example, if the patient has angina pectoris, you would mention the presence or absence of hypertension, diabetes, gout, and a familial incidence of angina pectoris or the foregoing associated conditions. You would also wish to mention whether the patient had developed symptoms of congestive heart failure, or myocardial infarction, or of cardiac arrhythmia.)
(3) You would then add negatives (in the form of "no symptoms suggestive of _____") to exclude other possibilities raised by the differential diagnosis (for example, if you had been describing a patient with chest pain, you would say "there have been no symptoms suggestive of hiatus hernia, intrinsic lung disease, or cervical osteo-arthritis.")
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The history will normally consume slightly over half of your running time. At this point, I might interject my conviction that your presentation should be completed in seven minutes. This is the maximum time during which the listener can give you his active and undivided attention. Beyond seven minutes, he will find it impossible to retain all the facts you have related to him. Remember that they are new to him at the time of your presentation, although you may yourself feel very familiar with them. The more complex a patient's problem, the more you must compress the account of other peripheral medical problems, to hold the seven-minute limit. For example, you had been obliged to detail the evolution of complications of long-standing diabetes, you must settle for the terse statement: "He also has obstructive lung disease and a quiescent duodenal ulcer." However, you must be ready to describe all these items later, in response to queries. Because of time limitations and the philosophy of presenting a "case of disease, occurring in a person", the systems review and past history usually have no place in the case presentation. (You will, of course, have set it forth in detail in the written case record.) Nonetheless, you must be prepared to respond to specific questions about this, should they be raised by your listener.

Description of the physical examination must also be somewhat abbreviated, emphasizing the features supporting your diagnosis. Begin by giving a brief (one or two sentences) general description of the patient: fit-looking or chronically ill; alert and comfortable, or depressed or obtunded; appearing his age, youthful, or prematurely old, and so forth. In so doing you give a brief sketch of a person, on which the physical findings to follow can be affixed. List briefly the important vital signs: pulse, blood pressure, respirations, and temperature. In a disease which is not marked by consistent deviations of these, it is reasonable to state simply "all vital signs were normal." Examples of this would include degenerative arthritis, a hiatus hernia, or prostatic hypertrophy. You must gloss over non-contributory findings, and cover unrelated areas with the term "negative" or "unremarkable." For example, you are describing a patient with a history of recurrent diverticulitis, with no other medical problems, you should say "the head and neck, heart and lungs were unremarkable to examination." You may then spend time detailing the examination of the abdomen and rectum. Significant negatives or normal findings should be mentioned specifically with respect to the area of interest. If the patient has angina pectoris, you should give the pulse rat and blood pressure, even if they are normal. Respirations can be described as normal, unless there is reason to suspect that the patient might have heart failure. The carotid pulses and jugular venous pulse should be mentioned specifically, even if normal. Findings in the lungs should be mentioned. As to the heart, you should specifically mention rhythm and rate, size and shape, sounds and murmurs. Some mention of peripheral arterial pulses and the presence or absence of edema is also pertinent. Other areas, such as examination of the abdomen and rectum, and the neurological survey can be dismissed simply as "unremarkable."

As for physical findings which are a source of disagreement among several observers, this can be simply handled by stating "one observer noted ___
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(describing the finding in question.)” This saves a detailed and distracting account of who heard what, and who disagreed. Group laboratory studies as follows: Routine hemogram; routine urinalysis; blood chemistries, if any; x-rays and ECG’s; other special procedures and data.

If the patient has been in the hospital for more than 24 hours (and if the time permits), you may wish to offer some comment on the course he has pursued. The format might be: "He was initially thought to have _____; treatment consisted of _____; his response to this was _____." You might simply offer a general comment as to whether he is responding well or poorly to therapy. Specific changes in symptoms, physical findings, and laboratory studies may be mentioned. This section of the presentation may be dispensed with if you are running close to your seven-minute limit.

At the close of the foregoing section of the presentation, summarize the entire picture in a few sentences. For example, "In summary, this is a 58-year-old man, previously well, with a history of progressive angina pectoris during the past three weeks. An impending myocardial infarction as a possibility. There is no evidence of hypertension, cardiac failure, or arrhythmia complicating his coronary disease."

Further general recommendations are as follows:

1. Omit all details not relevant to a "case of _____, occurring in a person." You must view yourself as a debater, trying to persuade an informed, interested, and critical judge of the merits of your argument, without distorting the facts--or as a doctoral candidate defending you thesis. If your listener is "worth his salt", he will ask you the appropriate questions to clarify points still unclear in his mind.

2. Every listener will have questions about a given patient's illness. You must not think that these mean an inadequate or incomplete job on your part. Indeed, when telling a complex story, you may purposely have to generalize a bit in your account of peripheral items, and yet be prepared to offer a description of these after giving an over-view during the seven-minute limit. This "Questions and Answer Period" is a perfectly natural sequel to any case presentation.

3. When multiple disease is present in the patient, take each condition separately, recounting its longitudinal story. Your listener cannot jump back and forth from one disease to another, even if you can master the prodigious feat of remembering what has happened with each organ system at any given point. In other words, take the patient's coronary disease, and tell its story from the beginning to the present. Then take up his peptic ulcer, and finally his chronic lung disease. Pick out the most important illness to describe first. The same principle applies to the complications of a systemic disease,
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such as diabetes. Describe the most important complication first, be it ocular, circulatory, or neuropathic. Then take up the other complications in turn.

(4) To say that a patient "showed no clinical evidence of ______" covers symptoms, physical findings, and laboratory studies. It is a useful and economical way of dismissing a point in the differential diagnosis.

(5) You must account for the fate of each symptom and physical finding, and each anomaly of laboratory study or x-ray. If no follow-up tests were done, mention this as part of the study.

(6) Lastly, be kind to the "LMD." The patient's problem may be all too apparent to you now, and you may think that the local physician had "missed the boat." However, factors which obscure the diagnosis at an earlier time may no longer be present, and the passage of time itself clarifies many knotty diagnostic problems. Sometimes the LMD turns out to be a physician of considerable competence, and the patient has simply presented a misleading account of what has been going on.

In your attempts to master this skill, you should do a rehearsal against a seven-minute limit. The breakdown of the various parts of the presentation is usually about four minutes for history, two minutes for the physical findings, and one minute for laboratory tests and a formulation. The ideal way to sharpen this skill is to present to a tape recorder, and then listen to your own presentation afterwards. Pause after each sentence, and ask yourself, "How cold I have condensed that and made every word count?" Listen with a critical ear to the presentation of those who do the job well. Unfortunately, their number is small, as any long-suffering member of the audience at Medical Grand Rounds and other clinical conferences can attest. Best wishes to you in becoming one of the handful of elite.

APPENDIX III – PROTOCOLS FOR PATIENT CARE

III.A HOSPITAL CONSULTS

EMERGENCY PATIENTS -- OUTPATIENT

Emergency patients will be treated in all cases as emergencies. They will be evaluated by the officer of the day primarily within 15 minutes of presentation and, whenever physically possible, disposition will be made within 30 minutes. If, after initial evaluation, the problem is shown to be non-emergent, the resident may engage in other activities while waiting for dilation, tests, etc.

TRAUMA EVALUATION
Appendix

I. General Considerations

A. Consultation requests from Saint Louis University and Cardinal Glennon physicians should not be refused under any circumstances. Take care of the patient first and ask questions later about the propriety of the referral.

B. If you receive a patient transfer request for an ophthalmic emergency from an outside physician, it is incumbent upon you to make absolutely certain that the patient is medically stable. You should specifically inquire as to whether or not the patient has undergone any type of surgery and what kind of medical treatment they are receiving. If the patient has multiple injuries he/she should be admitted to a general surgical service as the primary caretakers. If the patient has an unstable medical condition, he/she should be admitted to general medicine as the primary team.

C. Although many ocular emergencies require prompt attention, therapy can be instituted within hours rather than minutes (with the exception of chemical burns of the eye, central retinal artery occlusion, endophthalmitis, and angle closure glaucoma). Therefore there is time to obtain an unhurried and complete exam and history.

D. When arranging a transfer, have the E.R. physician cover the eye with a shield, advise against use of any ointments, and have the patient placed N.P.O. Obtain an estimated time of arrival and a phone number where the transferring physician may be reached. *Residents may not authorize transfers; therefore, the outside ER physician must contact a SLU ER physician for proper transfer.*

II. Measures to Avoid

A. Ointments of any kind.
B. Any anesthetic for outpatient use.
C. Atropine for routine use.
D. Corticosteroids in any form if:
   1. The diagnosis is uncertain;
   2. Fungal overgrowth or herpes infection is likely.

III. Overview of Management

A. History.
B. Physical examination.
C. Drawing of location of foreign body, if visible.
D. CT-scan if foreign body is suspected but not visualized.
E. X-rays.
F. Shield.
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G. IV antibiotics.
H. Preparation for surgery.

IV. History--this should be as specific as possible. In the event of compensation and/or litigation this becomes extremely important.

A. Circumstances of injury.
   1. How did the injury occur?
   2. Was it self-inflicted?
   3. Was it accidental or intentional?
   4. Did it occur in connection with the patient's work?
   5. Was the patient inebriated?

B. Chronology of events.
   1. What was the exact time of injury?
   2. What activities occurred after injury, e.g., bending, stooping, or lifting heavy objects?
   3. When did the patient last take anything by mouth; i.e., when can he safely undergo anesthesia if necessary?

C. Previous therapy.
   1. Was the patient seen or treated by other professional personnel? What are their names, and how can they be contacted?
   2. If ocular or other therapy was instituted, what was its nature?
   3. Has the patient had tetanus immunization? If so, when? Is the patient allergic to tetanus antitoxin?

D. Pretraumatic condition.
   1. Prior to the injury, did the involved eye have normal vision or pre-existent disease? Is the uninjured eye normal?

E. Foreign-body involvement.
   1. Was a foreign body or missile involved? If so:
      a. Is its composition known?
      b. If it is metal, what type? Is it magnetic?
      c. If a missile originated from the use of tools, what objects were involved: e.g., iron hammer on steel chisel on concrete; steel axe on wood containing nails; wood hammer on steel screwdriver on brass rod?
   2. Were spectacles worn? Were they safety glasses? Were they struck by the foreign body? Are the lenses and frames intact?
   3. Could there be intracranial extension of the injury?

V. Always examine both eyes. Patients with post-traumatic lid swelling, deep lid lacerations, or otherwise damaged periocular tissues require examination of the globe itself with a thoroughness inversely proportional
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to the ease of the examination. However, when the eye has been lacerated, pressure on the globe must be avoided assiduously. An upper lid can be retracted by gentle pulling from the superior orbital rim with the thumb. All pressure should be applied to the brow and no pressure to the eyeball itself. If the view is still inadequate, lid retractors are used with notable gentleness.

A. Visual acuity--must always obtain--"vital sign of the eye".

B. Pupillary examination.

C. Visual fields.

D. Motility examination.

E. Differentiate partially and completely penetrating injuries of the cornea and sclera.

F. External examination.
   1. Note hemorrhages and infections of orbit, lids, or conjunctiva. Account for chemosis.
   2. Investigate depth of all lid lacerations, noting fat in wound. Seek foreign bodies under lid: double eversion may be necessary.
   3. Palpate orbital rim: feel for crepitus through lids; test facial and corneal sensation; auscultate for orbitocranial bruit.
   4. Appraise real or apparent displacement of globe: anterior, posterior or vertical. Use exophthalmometer.

G. Anterior segment.
   1. Inspect for hyphema, iridonesis, and iridodialysis.
   2. Examine cornea for opacities, ulcers, foreign bodies, rust rings, and abrasions. (Use fluorescein strips.)
   3. Use loupe or slit lamp to detect foreign body paths in cornea, iris or lens.
   4. Estimate comparative AC depths.
   5. If traumatized globe is intact and cornea is undamaged, measure intraocular pressure with tonometer.

H. Slit Lamp evaluation. Note: Slit lamps are available at SLUH ER CGH ER.

I. Ophthalmoscopic exam - initial exam may be best opportunity to locate retinal breaks and foreign bodies.

J. CT scans in all cases of possible retained foreign body in globe or orbit or whenever orbital fracture is conceivable.
Appendix

K. Culture all foreign bodies in contact with eye tissue.

TRAUMA TO THE EYELIDS

I. Basic Considerations

A. Determine the extent of the injury - small lacerations should be gently probed and at times explored; large ones should be laid open.

B. If a lid laceration contains fat, the examiner knows that the orbital septum has been perforated. If a perforating instrument or foreign body has penetrated deeply enough to pass through the orbital septum, it may well have perforated the eyeball.

C. Traumatic Ptosis - traumatic damage to the levator muscle may be signaled by an absence of lid fold as well as by blepharoptosis. Lacerations involving the superior portion of the orbit, particularly its medial third, sometimes involve the aponeurosis of the levator tendon. They must be recognized and repaired.

D. Lacrimal Gland Trauma - rare, probably because of its secluded position. Perforating injuries can lead to dacryoadenitis, or can transect the ductules of the gland and superior conjunctival culdesac.

E. Canalicular Injury - lacerations within the medial fourth of the lid may impair tear drainage to the nose by direct injury to the puncta, the canaliculi, the lacrimal sac, or the nasal lacrimal duct. If there is any doubt that the lacrimal system has been invaded, saline can be gently irrigated through the puncta and the patient asked if the liquid can be felt in the back of the throat. In repair of lid lacerations, attention should be directed to the functional role of the lids--not only to the fact that complete lid closure must be obtained to protect the eye, but also to the part that the lids play in the distribution and drainage of tears. The orbicularis fibers of the lower lid, in particular, should be accorded great respect at the time of injury repair; surgical skin flaps or superficial tissue deformity from primary trauma itself can cause irreversible lose of function of the lacrimal drainage passageways, even though the drainage structures themselves are spared from the original trauma.

F. Inflammation of the Eyelids - medial two-thirds of the eyelids drain to the submaxillary nodes, and the lateral one-third to the
Appendix

preauricular nodes. Inflammation of the eyelids is often associated with probable enlargement of these nodes.

G. Eccymosis of the Lids

1. Direct blows to the eyelids.
2. Subcutaneous spread from one eye to the other.
3. Secondary to orbital fractures.
4. Nasal or skull fracture.

H. Animal and Human Bites of the Lid - should be allowed to heal by secondary intention after adequate debridement and extensive wound irrigation. Consider an antibiotic therapy covering aerobes and to a lesser extent anaerobic gram positive cocci as well as penicillinase-producing staph.

I. Check status of tetanus immunization.

INTRAOCULAR AND INTRAORBITAL FOREIGN BODIES

I. Basic Considerations

A. Whenever periorbital or ocular tissues are lacerated or punctured the physician must rule out the presence of a retained intraorbital or intraocular foreign body. Optimal management depends largely on the following: a) accurate localization of the foreign body; b) knowledge of its composition, shape and size; c) delineation of the extent of the ocular or orbital trauma; d) the appropriate decision regarding whether to remove the foreign body or leave it in place; and e) technical competence in the actual removal of the foreign body and the management of complications that may develop.

II. Diagnosis

A. Common Sites
   The anterior chamber 15%, lens 8%, posterior segment 70%, and orbit 7%.

B. Direct Visualization
   1. Slit-lamp examination.
   2. Gonioscopy.
   3. Indirect ophthalmoscopy.
Appendix

4. Indirect evidence: focal corneal bedewing; a biomicroscopically visible corneal, lenticular, or vitreous tract; angle trauma with peripheral anterior synechiae or angle recession; iridotomy or iridodialysis; heterochromia; anisochoria or pupillary irregularity; sector zonulolysis; and persistent uveitis or hypopyon.

C. Indirect Demonstration
   1. X-ray.
   2. CT-scan.
   3. Ultrasound (B-scan)
   4. Electronic foreign body detection.

III. Prognosis

A. Vision

B. Foreign Body Content
   1. Toxic metallic foreign bodies include lead, zinc, nickel, aluminum, copper and iron.
   2. Nonmetallic toxic foreign bodies include vegetable matter, cloth particle cilia and eyelid particles.
   3. Nontoxic metals include gold, silver, platinum and tantalum.
   4. Nonmetallic nontoxic foreign bodies include stone, glass, porcelain, carbon and some plastics.

C. Retinal Detachment - ultrasound is useful in ascertaining whether or not the retina is detached.

IV. Complications

A. Siderosis - rusty coloration (aka rust ring) of the cornea, iris or lens, chronic degenerative changes related to cataract, pigmentary degeneration of the retina, retinal detachment or open-angle glaucoma; usually occurs between two months to two years after the injury, but may occur within several days.

B. Chalcosis
   1. High copper content may cause serious reaction including hypopyon and localized sterile abscesses within the eye. May occur within several days.
   2. Chronic changes with deposition of metal on the basement membranes of the eye. May see Kayser-Fleischer ring Descemet's (deposits in membrane) membrane and a sunflower cataract (deposits in the anterior lens capsule). Better prognosis than siderosis.
Appendix

3. Electroretinogram – allows one to follow ocular metallosis electroretinographically. The results of E.R.G. testing can affect the decision of whether or not to remove an intraocular metallic foreign body.

V. Removal of Intraocular Foreign Bodies - in all cases of a retained intraocular foreign body, the danger of leaving the foreign body in the eye must be compared with the danger of removing it. Principles of therapy with intraocular foreign bodies include: a) close all wounds in the eye; b) prevent infection; c) clear the ocular media; d) remove all vitreous surrounding the foreign body; e) remove the foreign body in the least traumatic way; and f) treat any retinal breaks.

III.B LASER PROCEDURE PROTOCOL

- Laser treatments, both YAG and photocoagulation, are surgical procedures. Informed consent must be obtained by the surgeon or his designate prior to these procedures. A standard surgical consent form or the laser consent form may be used. Be sure to fill out the procedure name completely and specify the treated eye. The attending’s name must appear on the consent.

- You must fill out a pre-authorization order in EPIC and have the staff call insurance for proper billing.

- Patients whom you feel require laser therapy must be evaluated by an attending faculty member prior to treatment.

- Laser procedures are to be supervised by the attending faculty member. Whenever possible, please be familiar with the spot size, approximate power settings, and where applicable, the pulse duration settings for any procedure you perform. Residents demonstrating increased understanding and proficiency will receive greater responsibility and opportunity within the limits allowed by each service.

- Elective glaucoma laser and capsulotomies should be scheduled in the a.m. or early p.m. to allow for postop pressure checks.

- For patients referred from great distances, we should attempt to complete any recommended procedures at the initial visit. Local patients are more reasonably rescheduled if a busy clinic precludes immediate therapy. Some procedures, however, such as acute angle closure or a symptomatic horseshoe break, will require immediate attention even if a faculty member not on call is required in attendance.

- Charge capture section in EPIC must reflect the procedure performed.
Appendix

- A written procedure note is mandatory.
- Laser follow-up should be arranged with the supervising attending ophthalmologist.
- You must log all of your laser procedures.

III.C PROTOCOL FOR SCHEDULED SURGERY
(Hospital Admission or Outpatient Surgery)

- In clinic, fill out pre-operative surgery order in EPIC indicating patient information, attending physician, diagnosis, procedure, anesthesia desired, length of operation, location of surgery, need for medical clearance and any other special requests.

- Complete an appropriate pre-op evaluation including necessary testing and history and physical documentation in the chart (including A-scan). Surgery scheduling will obtain insurance pre-certification.

- Ambulatory Care Unit (ACU) will call the patient the day before to confirm time of arrival to hospital and go over instructions. Remind patients to bring all medications from home, and remain NPO after midnight.

- Encourage patients to get preoperative lab testing done before day of surgery. Lab work is good for 30 days.

- If patient has a legal guardian, please be sure to contact the guardian for informed consent at least 30 days prior to surgery. Include contact information in the surgery order so that the ACU can contact the patient.

- Check charts the day before to make sure everything is available for surgery, i.e. A-scan for IOL calculations is in chart. Inform O.R. if any special instruments or implants are needed. Do as much paperwork and computerwork as you can the day before surgery.

  - Write pre-op orders appropriate for the attending’s preference. Fill in as much of the H&P as possible.

  - Fill out the consent form including risk of surgery, benefits and alternatives. At ABI there are several standard consents available for common procedures. Surgery patients must give informed consent directly to the operating team.

- The day of surgery you may complete the H&P, sign consent, review the clinic chart, pull appropriate IOLs, and mark the surgical eye with skin marking pen.
Appendix

- After surgery, write post-op orders (usually done while in O.R.) and accompany patient to ACU or recovery room. ACU nurses will write post-op instructions for patient in detail and dispense post-op medications only. Complete discharge orders.

- Operative summaries are to be dictated within 24-hours of the procedure. If they are not, operating room privileges for primary surgeries and/or assistants will be suspended until the operative summary is dictated. Please discuss with each attending your duties regarding the operative summaries – you may be required to dictate or write the operative summary with the attending as a co-signer.

III.D SURGICAL LOGBOOKS

- All residents must keep surgical logbooks, as well as log their cases online on the ACGME website (on a weekly basis).

- They are to be filled in with the following information:
  
  o Date
  o Patient’s name
  o Patient’s history number
  o Surgical Procedure
  o Assistant or surgeon
  o Noteworthy features

- Each case is to clearly indicate whether the resident was the principal surgeon, the assistant surgeon, or a particularly interesting case that could be listed if the resident was observing only.

- These logs must be kept up to date, week-by-week, and available at any time for review by the program director.
APPENDIX IV – EVALUATION FORMS

IV.A 360 DEGREE EVALUATIONS
IV.B EVALUATION OF THE PROGRAM
IV.C EVALUATION OF THE ROTATION
IV.D RESIDENCY EVALUATION OF FACULTY
Appendix

IV.E GRAND ROUND EVALUATION

Saint Louis University Eye Institute: Grand Rounds Survey

Date: 

Topic or Chief Complaint: 

Resident Presenter: 

Thank you for taking a moment before leaving today to complete this brief survey for the benefit of today's resident presenter. In keeping with the Accreditation Council for Graduate Medical Education directives, your participation provides written documentation of our resident's progress toward achieving satisfactory competence in their profession.

<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>Not at all Characteristic</th>
<th>Highly Characteristic</th>
<th>Don’t Know</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Knowledge</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Exhibits mastery of the topic</td>
<td>1 2 3 4 5 DK NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Cites current and appropriate literature</td>
<td>1 2 3 4 5 DK NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice-Based Learning and improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Applied their knowledge to this case(s)</td>
<td>1 2 3 4 5 DK NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Taught others what they learned</td>
<td>1 2 3 4 5 DK NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systems-Based Practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Collaborates with other health providers</td>
<td>1 2 3 4 5 DK NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Acts as a patient advocate</td>
<td>1 2 3 4 5 DK NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Obtains consults appropriately</td>
<td>1 2 3 4 5 DK NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal and Communication Skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Presents effectively and succinctly</td>
<td>1 2 3 4 5 DK NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionalism</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Respectful to audience</td>
<td>1 2 3 4 5 DK NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Dresses appropriately</td>
<td>1 2 3 4 5 DK NA</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments (optional)

Name of Reviewer (optional):

Please leave your completed form(s) at the front the auditorium in the survey collection box.

Last Revision: 2011-08-07
Author: Steven Shields, MD
SAINT LOUIS UNIVERSITY EYE INSTITUTE

Ophthimal Clinical Evaluation Exercise (OCEX)

Resident: __________________ Rotation: __________________

The OCEX is an observed encounter between a resident and a new patient. The evaluator should be present in the exam room for the entire interaction. The intent is to rate the resident in all the categories listed below and then provide immediate performance feedback. The rating system is:

<table>
<thead>
<tr>
<th>1 - Does Not Meet Expectations</th>
<th>3 - Meets All Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 - Meets Some Expectations</td>
<td>4 - Exceeds Expectations</td>
</tr>
<tr>
<td>na - Not Applicable</td>
<td>Y-YES N-NO</td>
</tr>
</tbody>
</table>

### Interview Skills

<table>
<thead>
<tr>
<th>1. Introduced self</th>
<th>Y N</th>
<th>7. Review of systems</th>
<th>1 2 3 4 na</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Obtained chief complaint</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. History of present illness</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Pertinent negatives</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Pain inquiry</td>
<td>Y N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Allergies</td>
<td>Y N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Examination

<table>
<thead>
<tr>
<th>1. Best corrected Va</th>
<th>Y N</th>
<th>5. External</th>
<th>1 2 3 4 na</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Pupils / RAPD</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Visual Fields</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Motility</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. External</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. SLE</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. IOP (+/- gonioscopy)</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Funduscoppy</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Documentation</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Interpersonal Skills / Professionalism

<table>
<thead>
<tr>
<th>1. Empathetic</th>
<th>1 2 3 4 na</th>
<th>5. Explained diagnosis</th>
<th>1 2 3 4 na</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Respectful &amp; courteous</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Used language the pt Understands</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Explained findings</td>
<td>Y N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Explained diagnosis</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Explained plan/options</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Asked if patient had questions</td>
<td>Y N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Case Presentation

<table>
<thead>
<tr>
<th>1. Concise &amp; clear</th>
<th>1 2 3 4 na</th>
<th>4. Appropriate differential Dx</th>
<th>1 2 3 4 na</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Pertinent facts</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Pertinent pos &amp; negs</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Appropriate differential Dx</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Appropriate plan</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Response to attending's questions/suggestions</td>
<td>1 2 3 4 na</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: __________________

We have reviewed this OCEX together: Resident Initials: _______ Evaluator initials: _______

Date: ____________
Appendix

IV.G QUARTERLY EVALUATION OF THE RESIDENT
Appendix
Appendix
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV.H</td>
<td>SEMI-ANNUAL EVALUATION OF THE RESIDENT</td>
</tr>
</tbody>
</table>

This section outlines the semi-annual evaluation of the resident, detailing various aspects of their performance and progress within the program. It includes criteria for evaluation, documentation of achievements, and areas for improvement. The evaluation process is designed to ensure the resident's continuous development and alignment with program objectives.
APPENDIX V - ACGME DOCUMENTS

V.A INSTITUTIONAL REQUIREMENTS
http://www.acgme.org/acgmeweb/Portals/0/irc_IRCpr07012007.pdf

V.B PROGRAM REQUIREMENT FOR OPHTHALMOLOGY
http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/240_opthalmology_07012013.pdf

V.C MINIMUM SURGICAL NUMBERS

Case logs for all 2014 program graduates will be reviewed for compliance with minimum numbers. Residents graduating in 2014 are expected to achieve the required minimum numbers for all procedures. Achievement of the required minimum numbers is an indicator of experience, but is not considered an indicator of competence. Programs should continue to evaluate procedural competence in order to ensure that graduates are competent to enter practice without direct supervision. Residents must continue logging procedures after the minimum numbers for procedures are met.

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Minimums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cataract – Total (S)</td>
<td>86</td>
</tr>
<tr>
<td>Laser Surgery – YAG Capsulotomy (S)</td>
<td>5</td>
</tr>
<tr>
<td>Laser Surgery – Laser Trabeculoplasty (S)</td>
<td>5</td>
</tr>
<tr>
<td>Laser Surgery – Laser Iridotomy (S)</td>
<td>4</td>
</tr>
<tr>
<td>Laser Surgery – Panretinal Laser Photocoagulation (S)</td>
<td>10</td>
</tr>
<tr>
<td>Corneal Surgery</td>
<td></td>
</tr>
<tr>
<td>Keratoplasty (S+A)</td>
<td>5</td>
</tr>
<tr>
<td>Pterygium/Conjunctival and other cornea (S)</td>
<td>3</td>
</tr>
<tr>
<td>Keratorefractive Surgery – Total (S+A)</td>
<td>6</td>
</tr>
<tr>
<td>Strabismus – Total (S)</td>
<td>10</td>
</tr>
<tr>
<td>Glaucoma – Filtering/Shunting Procedures (S)</td>
<td>5</td>
</tr>
<tr>
<td>Retinal Vitreous – Total (S+A)</td>
<td>10</td>
</tr>
<tr>
<td>Intravitreal Injection (S)</td>
<td>10</td>
</tr>
</tbody>
</table>
Appendix

<table>
<thead>
<tr>
<th>Oculoplastic and orbit – Total (S)</th>
<th>28</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oculoplastic and orbit – Eyelid Laceration (S)</td>
<td>3</td>
</tr>
<tr>
<td>Oculoplastic and orbit – Chalazia Excision (S)</td>
<td>3</td>
</tr>
<tr>
<td>Oculoplastic and orbit – Ptosis/Blepharoplasty (S)</td>
<td>3</td>
</tr>
<tr>
<td>Globe Trauma – Total (S)</td>
<td>4</td>
</tr>
</tbody>
</table>

**V.D NEW ACCREDITATION SYSTEM - MILESTONES**
http://www.acgme-nas.org/assets/pdf/NEJMfinal.pdf

**V.E DUTY HOURS**
http://www.acgme.org/acgmeweb/tabid/271/GraduateMedicalEducation/DutyHours.aspx

**APPENDIX VI - SLU GME DOCUMENTS**

VI. GME POLICIES AT SAINT LOUIS UNIVERSITY