

**OPHTHALMOLOGY
RESIDENT POLICY MANUAL**

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

DEPARTMENT OF OPHTHALMOLOGY

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Last updated 11/10/2000

**RESIDENCY ACCEPTANCE FORM
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
DEPARTMENT OF OPHTHALMOLOGY**

In accepting the appointment of resident at the University of Arkansas for Medical Sciences, I acknowledge that I have received and read the Ophthalmology Resident Manual and the rules and regulations of the manual entitled "Information for Housestaff", UAMS, College of Medicine (attached).

I agree to be bound by the terms thereof during my residency period.

Signature

Date

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INTRODUCTION

This manual has been prepared to assist the resident for an orderly and scholarly approach to the study of ophthalmology at the University of Arkansas for Medical Sciences. There is no attempt to include all the guidelines, rules and regulations that might be appropriate at the various hospitals where you will work. However, if it is initially read carefully and then used as a reference, it should be helpful in answering many questions.

GOALS AND EXPECTATIONS OF RESIDENTS IN THE DEPARTMENT OF OPHTHALMOLOGY

We are very pleased that you have been selected to join the ophthalmology residency program at the University of Arkansas for Medical Sciences. Your selection from a very competitive group of candidates was based upon many factors, not the least being your outstanding performance as a medical student. The members of our department are committed to provide you with an opportunity to reach your full potential and to ensure that before you graduate you will be skilled in both the art and science of ophthalmology. We are proud of our program and specialty, and we know that you will want to help us maintain the high standards that are expected from all of our residents. Ophthalmology, like medicine in general, is not a cold scientific discipline, but a unique mixture wherein art and science are applied in treating patients. Scientific knowledge must be coupled with judgment and sensitivity so that the individual patient is treated, not an isolated eye disease. At a minimum, patients must receive respect, consideration, and empathy which is manifested by attitude, professional manner, truthfulness, appearance, and by adhering to the ethical codes which govern our profession. These principles apply to discussions and relationships with patients, personnel, peers, faculty, and scientific investigations. You are expected to share these commitments with us and to provide the best possible medical care to all patients.

The faculty of the Department of Ophthalmology is happy that you are joining our program. We are confident that the program will meet your expectations, and we look forward to a close association with you over the next three years and a continued association with you in the years to come.

Welcome!

GENERAL INFORMATION

The ophthalmology residency program at the University of Arkansas for Medical Sciences is a three-year program sponsored by the UAMS College of Medicine with rotations at three participating institutions, including the University of Arkansas for Medical Sciences (UAMS), Central Arkansas Veteran's Healthcare System (VA) and Arkansas Children's Hospital (ACH). Every four months you will be advancing to a new position that carries increased responsibilities and challenges. Your patient responsibilities start slow and progressively increase. Each resident has his/her own lane and equipment at each hospital. You are expected to care for the equipment as if it were your own.

You will quickly find that your fellow residents are an excellent source of information, both for the fine points of your responsibilities and the management of patients. Use them and the faculty by asking questions. All department members are expected to be available to help you, but the amount of information that you receive will depend in a large part on the initiative you show by asking questions.

The only equipment that you are required to purchase is a 20 diopter indirect lens, however, you are encouraged to also obtain a 28 or 30 diopter indirect lens and a 78 or 90 lens. Information about brands and where to order can be obtained from your chief resident.

Required and suggested journals and textbooks are listed on a separate enclosure in this manual.

Some materials will be sent to you prior to your starting date. Please read them carefully and comply promptly with any request.

When your starting date arrives, report to the Ophthalmology office for orientation by the Program Director, Department Chairman, and the Residency Program Coordinator. If you have any questions please call Linda Higdon, the Residency Program Coordinator at (501) 686-5150.

ACADEMIC GOALS

There is a basic fund of ophthalmic knowledge that each resident is expected to master as they advance in the residency program. Learning is a day to day endeavor, and unless you approach your education with a great deal of self-discipline, you will be disappointed with the final result. Assessment of each resident's knowledge and ability to deal with patients in a meaningful and professional manner occurs daily by the faculty and your fellow residents. There is an intense and sincere interest in your continued growth and development.

Formal academic sessions such as Morning Conference, Problem Case Conference, Visiting Professor Lectures, and Journal Club, etc., are designed to emphasize the important areas of each ophthalmic subject so that more in depth study can be done individually by each resident.

These sessions are required during your time in the residency program, the following topics will be covered once to several times at Morning Conference by presentations from your fellow residents and faculty:

Ocular Anatomy, Embryology, Physiology, Biochemistry, Pharmacology
External Disease and Cornea
Optics, Refraction and Contact Lenses
Binocular Vision and Ocular Motility
Neuro-ophthalmology
Orbit, Plastics and Trauma
Ocular Pathology
Retina and Vitreous
Intraocular Inflammation, Uveitis, Ocular Tumors
Glaucoma, Cataract, and Anterior Segment

You are expected to read the assigned material and be prepared to answer questions. Concurrently, from your first day in the program you are expected to set aside several hours a week for study that will ensure that you are developing the basic skills to examine patients thoroughly, to arrive at a reasonable diagnosis, and to formulate a plan for care. A set of goals and objectives that detail the knowledge and skills that you are expected to master for each year will be provided. This will be the minimum standard for each level that will be acceptable by the faculty and your fellow residents.

One of the best ways to learn clinical medicine is to read about your patients on the same day that you see them. This means that new residents will require more concentrated textbook study than older residents. On the other hand, older residents should spend more time reviewing in depth subjects of interest, reading journal articles, and reviewing surgical techniques. It is suggested that you keep a notebook that contains checklists and important “pearls” for ready reference.

Your knowledge will grow steadily if you:

1. Thoroughly evaluate your patients, read about your findings, and share your information with fellow residents.
2. Have frequent one-to-one exchange of information and questions with the faculty, your fellow residents, visiting professors and local practitioners.
3. Attend all scheduled conferences.
4. Study standard textbooks, ophthalmic journals, home study courses, and the vast array of audiovisual aids located in the main library and eye library.
5. Prepare talks for conferences and articles for publication.
6. Attend local and national meetings.
7. Perform ophthalmic research.
8. Take the OKAP examination.

During each academic year the Ophthalmic Knowledge Assessment Program Examination, “OKAP”, will be given and all residents must attend. Each resident who has been in the training program for at least one year is expected to rank overall above the 20 percentile to avoid being placed on academic probation.

Attached for your reading (appendix I) is an article by William H. Havener, M.D., entitled “Platitudes on Beginning a Residency”. This article makes some excellent points that we hope you will find useful as your progress through your training.

FIRST ROTATION

Welcome to Ophthalmology! We are very pleased that you are now a member of our department. We know that you have been looking forward to starting your residency for a long time, and we hope that by the time you finish you will feel that the hard work has been worth it and that your stay has been enjoyable.

Most ophthalmologists will say the first four to six months of their residency required considerable adjustments, and this is understandable. Exposure to ophthalmology during medical school and internship for most physicians is quite limited, and consequently at the beginning one is faced with an unfamiliar vocabulary, a vast array of new equipment, and an entirely new group of disease processes to understand. To make things worse, your fellow residents seem to know so much, while you seem to know so little. Initially, it can be quite discouraging, but with the proper frame of mind it should not be overwhelming. Just remember that every doctor in the department was once in your place and understands your dilemma.

The vast amount of knowledge that rapidly advances in biomedical research and technology makes it impossible for everyone to know all the factual information available, even about their specialty. The key to your development and continued success will be your ability to learn independently, to acquire critical analytical skills, and to develop, if not already present, values and attitudes that are essential for members of a caring profession. This active, self-directed learning requires the ability to identify, formulate, and solve problems, to grasp and use basic concepts and principles, and to gather and assess data rigorously and critically. The staff and your fellow residents are here to guide you and encourage you; the rest will be up to you.

Attached you will find a list of topics to be covered. We are hopeful that this will be a stimulating and productive four months. Please comment on your experience by the end of the rotation to both the resident coordinator and the departmental chairman.

Starting your first week you will be meeting on weekly basis with Dr. Richard Harper to review an assigned topic. You will be expected to have read about the topic and be prepared to ask questions and to answer questions.

TEXTBOOKS PROVIDED TO RESIDENTS

Beginning in 2000, all residents will be provided with a copy of Albert and Jakobiac's **PRINCIPLES AND PRACTICE OF OPHTHALMOLOGY**. In addition, all residents (beginning July 1998 and thereafter) will be provided a copy of the **BASIC AND CLINICAL SCIENCE** Series produced by the American Academy of Ophthalmology. Residents will be responsible for obtaining yearly updates and/or new edition volumes.

These books are provided through the generosity of the Arkansas Eye Bank and Laboratory and its Director, Lindell Howdeshell. They are presented in memory of Joe Smith, MD, a clinician who practiced for many years at the VA and in the community. His quiet demeanor, commitment, and unwavering stance for truth have had an unmistakable influence on all who knew him.

SUGGESTED BIBLIOGRAPHY

1. **OPHTHALMOLOGY PRINCIPLES AND CONCEPTS**, by Frank W. Newell, publisher C.V. Mosby Co.
2. **GENERAL OPHTHALMOLOGY**, 15th Edition, by D. Vaughan and T. Asbury, publisher Lange Medical Publications.
3. **MANUAL OF OCULAR DIAGNOSIS AND THERAPY**, edited by Deborah Tavan-Langston, M.D., published by Little and Brown.
4. **REFRACTION: a PROGRAMMED TEXT**, 2nd Edition, by Robert D. Reinecke, M.D., and Robert J. Herm, M.D., published by Appleton-Century-Crofts, New York.

Of course this list is not all-inclusive. There will be many other books you will want to purchase for your library during your training period. Check with faculty and senior residents for suggestions.

OPHTHALMIC JOURNALS

1. Required Journals:

- a. Archives of Ophthalmology
American Medical Association
Circulation Fulfillment Department
535 North Dearborn Street
- b. American Journal of Ophthalmology
(Covered in the Journal Club. Access thru UAMS and VA libraries)
Ophthalmic Publishing Company
Tribune Tower, Suite 1415
435 North Michigan Avenue
Chicago, IL 60611
- c. Ophthalmology - The Journal of the American Academy of
Ophthalmology (Included with membership in AAO)
Lippincott-Harper
2350 Virginia Avenue
Hagerstown, MD 21740

2. Suggested Ophthalmic Journals

- a. Survey of Ophthalmology
Survey of Ophthalmology, Inc.
80 Boylston Street, Suite 825
Boston, MA 02116
- b. Journal of Pediatric Ophthalmology & Strabismus Slack Inc.
6900 Grove Road
Thorofare, NJ 08086

NOTE: Some journals have special rates for residents. Check for this in a current issue or contact the publisher.

RESIDENT'S LIBRARY

The resident's library is located in the Eye clinic. The books placed in the library are to remain there so all residents can have access to them. Overnight or over weekend checkout of books is not allowed.

FACULTY LIBRARY

The faculty library is located on the 2nd floor of the Jones Eye Institute. On occasions, when books are not available in the resident or main library, ophthalmology residents may check a book out overnight or over a weekend provided a checkout card is signed and left with the residency secretary. You will be responsible for replacement cost for any lost or damaged books checked out under your name.

UNIVERSITY LIBRARY

The best source of ophthalmology reading material is the main University Library. Additional books can often be ordered for the library at the request of a staff physician. If you would like the main library to acquire a particular book, provide the resident director with the necessary information and it will be requested.

ROTATION SCHEDULE

The program is broken into four-month rotations according to the following schedule:

FIRST YEAR: MEDICAL CENTER
 VETERAN'S ADMINISTRATION HOSPITAL
 MEDICAL CENTER

SECOND YEAR: VETERAN'S ADMINISTRATION
 ARKANSAS CHILDRENS HOSPITAL
 MEDICAL CENTER

THIRD YEAR: CHIEF AT VETERAN'S ADMINISTRATION HOSPITAL
 CHIEF AT MEDICAL CENTER
 CHIEF AT ARKANSAS CHILDREN'S HOSPITAL

The rotations occur on July 1, November 1, and March 1. A master schedule of your three-year residency can be reviewed in the ophthalmology office.

Prior to initiation of your first VA rotation, it is important that you visit the office of the Chief of Surgery at the VA to begin your check-in procedure. The VA cannot pay you until your check-in has been properly completed. It is to your advantage to see that it has been completed before your rotation actually starts.

GRAND ROUNDS

Grand Rounds is an extremely important conference. It is the only regularly scheduled meeting devoted exclusively to the management of ophthalmic patients, where findings and recommendations are shared with other members of the department. Problem cases, interesting teaching cases, and unique patients are presented during the conference for discussion. It is the obligation of every department member to place a high priority on this session and attempt to improve its quality.

Grand Rounds are held every Thursday afternoon. This conference can only be canceled by the chairman of the department or his designee. Residents are not to cancel Grand Rounds unless permission from the departmental chairman or his designee has been granted.

Grand Rounds starts promptly at 4:00 p.m. and terminates promptly at 6:00 p.m. Attendance by all residents is mandatory and punctuality is required.

GRAND ROUNDS FORMAT

1. All patients ready for examination by 4:00 p.m.
2. All residents in clinic by 4:00 p.m. to start examining patients.
3. Patients discharged and conference begins by 4:50.
4. All residents are expected to attend unless on vacation, in OR, or seeing emergency patients. All staff is encouraged to attend.
5. The resident second to the chief at the University will be responsible for scheduling patients. Their designee will keep a log book listing patients scheduled for each conference and have it available for staff review.
7. A different faculty member, on a rotational basis, will be responsible for conducting the Grand Rounds that emphasizes their subspecialty.
8. At least three patients scheduled for each conference should be related to subspecialty field of staff member conducting the conference.
9. Additional problem patients that require attention, but are unrelated to the subspecialty may also be scheduled at the discretion of the Chief Resident, UAMS. The department chairman or his designee will be responsible for conducting this portion of the conference.
10. Subspecialty staff will assist in recommending patients for GR for their day.
11. Subspecialty staff may also desire to present clinical slides, unknowns, or give a short lecture.
12. It is imperative that all residents assist the Staff and the Chief Resident at the University in identifying patients for each conference, i.e. residents at ACH for pediatric ophthalmology. A record will be kept in a logbook as to which residents refer patients.

JOURNAL CLUB

Journal club meets during the evening of the third Tuesday of each month. The meetings generally take place in the JEI library conference room. Dinner is provided. The Journals discussed are those published during the preceding month. All residents are required to attend.

Journal Club Protocol

1. Journals reviewed: *Ophthalmology*, *Archives of Ophthalmology*, *American Journal of Ophthalmology* and one “review” or “classic” article from the attached list. Preference should be given to selecting articles from the “Recommended Reading” articles list.

2. All residents will read **all four** articles and be prepared to discuss them.

3. Presentation of articles: Each of the four articles will have two residents assigned to it:

ACH: Chief and 2nd year

UAMS: Chief and Res 2

Res 3 and VA 2nd year

(The Chief Resident at UAMS will be responsible for assigning which resident team will present the “review” or “classic” article.)

VA: Chief and 1st year

(The newest resident will read all of the articles, but will not be required to present during the first four month rotation.)

4. Each resident will answer the questions on the “Journal Club Guideline” form (see pages 75-76) for their **assigned** article and bring the completed form to turn in. The more junior resident will present the paper initially and discuss the topics from the “Journal Club Guidelines” on page 1 through **Results**. The more senior resident will discuss the remaining topics from the “Journal Club Guidelines” on page 2.

5. Journal assignments: In general, UAMS residents will select articles from *Ophthalmology*, VA residents will select from *Archives of Ophthalmology*, and ACH residents will select from *American Journal of Ophthalmology*. The review article assignment will follow the below rotation schedule.

July – VA

August – UAMS

September – ACH

October – VA

November – UAMS

December – ACH

January – VA

February – UAMS

March – ACH

April – VA

May – UAMS

June – ACH

6. If only one member of a team is present, they will be responsible for presenting the above mentioned material. The group as a whole will discuss the material that would have been presented by the absent resident.

PATHOLOGY CONFERENCE

The ophthalmic pathology conference is held every 6 weeks, or as scheduled, on Thursday from 4:00 - 6:00 p.m.

RESIDENT'S DAY

Last updated 6/28/2004

Resident's Day is held yearly, usually the Friday before Memorial Day in May. Each resident is required to present 10-minute paper relating to their research or an interesting patient(s). The only resident excused from presenting a paper at each Resident's Day is the new resident who started in March of that year.

The purpose of Resident's Day is to give each resident the opportunity to present a short paper to fellow residents, staff, and visiting ophthalmologists. We consider this to be a very important part of our training program for a wide variety of reasons. Your enthusiastic participation is appreciated. Each resident is to submit a title of his presentation to the chairman of the department by March 1 and is to submit a brief summary by April 1. Practice presentations will take place during the month of May. Each resident will be assigned a specific day to present their paper to the staff. The resident is expected to have his final paper fully prepared for presentation on his assigned date. Do not come to this practice session unprepared.

The residency coordinator will help you prepare your slides. These may be done as computer generated slides (Power Point, etc.) or as 35mm projected slides. You must have these ready for the secretary no later than 2 weeks prior to your practice session. Your slides will be done in the order they arrive to the secretary. Larry Merin will make any slides needed for your presentation. You are to submit to him the slides to be made no later than 2 weeks prior to the date of your practice presentation.

SUMMARY

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March 1 Deadline for title submission to the chairman

April 1 Deadline for brief summary

May 1 Practice presentations

Two weeks before your practice presentation date is the deadline for slide submission to Larry Merin

RESIDENT'S PAPER

Each resident is strongly encouraged to write one paper suitable for publication during the residency. The staff of the department is more than eager to help you with this paper.

RESIDENT DUTIES AND RESPONSIBILITIES

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Supervisory Lines of Responsibility

For each rotation, each resident is directly responsible to the Chief of Service at that hospital for clinical aspects of patient care: UAMS – Dr. Shock

: VA – Dr. Brown

: ACH – Dr. Westfall

The service chiefs at ACH and VA are responsible to Dr. Shock.

Supervisory process for each hospital:

UAMS: PGY2 and 3 residents will be supervised by the Chief Resident and faculty attending physician assigned to the clinic for that day. If for any reason the assigned faculty member is not available, contact Dr. Harper or the faculty member on-call for that week.

ACH: the PGY3 resident will be supervised by the Chief Resident and the faculty attending physician assigned to the clinic for that day. If for any reason the assigned faculty member is not available, contact Dr. Westfall, Dr. Harper or the faculty member on-call for that week.

VA: the PGY2 and 3 residents will be supervised by the Chief Resident and the faculty attending physician assigned to the clinic for that day. If for any reason the assigned faculty member is not available, contact Dr. Brown, Dr. Harper or the faculty member on-call for that week.

Duty Hours

Residents are expected to be present for all departmental activities including: conferences, clinics, surgery, and consultations. Hours will, to some extent, be determined by the specific rotation; however, in general, duty hours are from 7:30 a.m. to approximately 6:00 p.m. Monday through Friday. Weekend hours are variable, depending on the call schedule, special conferences, etc. Residents are off duty on weekend days unless they are on call, have special patient care responsibilities, or attending weekend conferences.

a. Duty hours are defined as all clinical and academic activities related to ~~the rotation~~, patient care (both inpatient and outpatient),

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administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

- b. Duty hours will be limited to 80 hours per week, averaged over a four week period.
- c. Residents will be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
- d. Adequate time for rest and personal activities will be provided. This should consist of a 10 hour time period provided between all daily duty periods.

On-Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period.

- a. Continuous on-site duty will not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined in Specialty and Subspecialty Program Requirements.
- b. No new patients, as defined in Specialty and Subspecialty Program Requirements, may be accepted after 24 hours of continuous duty.
- c. At-home call (pager call) is defined as call taken from outside the assigned institution.
 - 1.) Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
 - 2.) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
 - 3.) The program director and the faculty will monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

Work Environment

Last updated 3/24/2004

Staff physicians are available to residents during clinic hours, and after hours on an on-call basis, at all times. Appropriate technical support is provided in each outpatient clinic to provide proper care to patients.

Morning Conference

Resident Morning conference is conducted from 7:30 a.m. to 8:15 a.m. every Monday, Wednesday and Friday. The residency director or the faculty member responsible for the topic determines the topics covered during conference, and a schedule of their presentations will be placed in resident mailboxes. Punctuality is expected. Repeated late arrival or non-attendance can result in disciplinary action.

Surgery scheduled for 7:30 a.m. on Monday, Wednesday and Friday conflicts with morning conference. In order to minimize the amount of time a resident misses morning conference, residents will rotate on a weekly basis to assist on these 7:30 a.m. cases so that only one resident per hospital is absent from morning conference. If no surgery is scheduled on these days, all residents are expected to attend morning conference.

CLINIC HOURS

The clinic is open from 8:30 a.m. to 4:30 p.m. daily. The residents are expected to be in the clinic by 8:45 a.m. and not leave until 4:30 p.m. The clinic will not close early unless specified by the department chairman or his designee. The clinic is never left unattended during the above work hours.

WEEKDAY ROUNDS

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Morning in-patient exams will be conducted by all residents not in surgery as a group prior to morning clinics. Any problems that arise will be presented to the chief resident in the OR immediately upon conclusion of the rounds. The chief resident will round on his/her patients each day. If in surgery he/she may round between cases or prior to starting surgery. Attendance at rounds is required and punctuality is expected.

INPATIENT CONSULTATIONS

All inpatient consultations must be seen within 24 hours after the request has been received or sooner if possible. All consults are to be seen by either the chief resident or the 2nd year resident. Consults may be screened by a junior resident, but is the responsibility of the chief resident or the 2nd year resident to examine the patient, determine the plan of care, and to sign the consult report. All consults must be presented to a staff member after the chief resident or 2nd year has evaluated the patient and has written his diagnosis and plan on the consult form.

OPERATING ROOM DUTIES AND RESPONSIBILITIES

The resident who is to be the operating surgeon is expected to obtain the operative permit for that patient. The resident assisting or performing the surgery will be in the OR no later than 7:15 a.m.

On resident cases, the primary surgeon is responsible for dictating the operative report. The note must indicate the presence and involvement of the attending faculty member in the case. The assistant surgeon is responsible for the operative note and the postoperative orders. On staff private patients, the assistant surgeon is responsible for the dictated operative report, the op note and the post-op orders

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signates otherwise.

The residents are to conduct themselves in a professional and ethical manner at all times in the operating room. Undue socializing, levity or other action that distracts from total concentration on the procedure at hand is not condoned.

Surgical instruments are expensive and delicate. Extreme care of the surgical instruments is to be taken at all times.

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WORK-UP OF RESIDENT SURGICAL PATIENTS

- 1) A complete ophthalmic work-up (including a physician's refraction, intraocular pressure, slit-lamp exam and dilated fundus) must have been performed and recorded in the clinic chart before the patient is to be scheduled for surgery.
- 2) All resident cases are to be presented to the staff who will be staffing the surgery prior to scheduling the patient or prior to admission.
- 3) The operating resident will evaluate his/her patient prior to surgery and write a pre-operative note.

The resident performing the surgery is responsible for obtaining the results of the:

- *EKG,
- *Chest x-ray, and
- *All lab reports.

Also, whether or not the permit has been signed, which surgery is to be performed, and on which eye.

STAFF SURGICAL PATIENTS

Assistant Surgeon Responsibilities

At the discretion of the surgeon, it is the responsibility of the assistant to:

- 1) Write post-op note, D/C orders and prescriptions
- 2) Dictate operative report
- 3) See the patient in follow-up with the surgeon

CALL SCHEDULE

Weekday call begins at 4:30 p.m. and ends at 7:30 a.m. of the next day. On weekends, the call begins at 4:30 p.m. on Friday and ends at 7:30 a.m. on Monday. The chief resident at Children's Hospital will make up the call schedule at least one month prior to initiation of that rotation. The schedule is to cover the 4 months of that rotation.

Once the final call schedule has been printed it is not to be changed except under extenuating circumstances. Should it be necessary to alter the schedule, it is the responsibility of the resident requesting the change to notify the program coordinator as soon as possible, so that the proper notices can be sent out to all the appropriate offices.

First call is rotated equally among the residents comprising the first 2 years. Holiday call is equally shared according to the following schedule:

JULY RESIDENT

1. New Year's - 1st year
2. Arkansas Ophthalmology Society Fall Meeting - 1st year
3. Veteran's Day - 1st year

NOVEMBER RESIDENT

1. Christmas - 1st year
2. Washington's Birthday - 1st year
3. Labor Day - 1st year

MARCH RESIDENT

1. Thanksgiving - 1st year
2. July 4th - 1st year
3. Memorial Day, including Resident's Day - 1st year

Second call is rotated equally among the chief residents. Holiday call is also rotated equally.

MAJOR HOLIDAYS

1. Christmas Eve and Christmas
2. New Year's Day
3. Thanksgiving Day

MINOR HOLIDAYS

1. Arkansas Ophthalmology Society Fall Meeting
2. Veteran's Day
3. Washington' Birthday
4. Memorial Day
5. Independence Day
6. Labor Day

These holidays apply to the U of A Med Center rotations only. Several of these holidays are not official holidays at the Children's or VA Hospitals. You are only allowed to take holidays that are recognized holidays by the HOSPITAL to which you are assigned. For example, Washington's Birthday is not an official holiday at the Children's Hospital. Therefore, Children's Hospital residents will work as usual during Washington's Birthday.

ON CALL RESPONSIBILITIES

First call Resident

- A) Will be available at all times - either on beeper or via home phone
- B) Will never refuse to see a patient regardless of how mundane it sounds
- C) There is no excuse for someone not being able to locate the resident on call
- D) Must attend weekend rounds at all hospitals with the chief resident on call
- E) Must attend weekend rounds with each faculty when faculty is seeing patients

- F) All emergency admissions
- G) Weekend admission of patients to include:
 - 1. Pre-op note - any abnormalities found in admission lab are to be reported to responsible staff.
 - 2. Admission orders
 - 3. Admission H&P
 - 4. Admission note
- H) The chief resident on call is to be contacted prior to taking any patient to OR, before suturing any patient in the ER, or prior to admission

CHIEF RESIDENT

- A) Will always be available either by phone or by beeper
- B) Will see all emergency patients requested to be seen by the junior resident
- C) Will see all patients before emergency surgery whether performed in the OR or in the ER
- D) Contact staff on call before the decision is made to admit or take any patient to the OR
- E) Weekend Rounds- Weekend rounds will be performed by the Chief resident on call with the junior resident on call at all 3 hospitals. These weekend rounds are to be made together, not as individuals

WEEKEND ROUNDS

It is the responsibility of the chief resident at the various hospitals to provide to the 1st resident on call, on Friday, a list of inpatients on their service, the location and all pertinent information about the patient's condition. The 1st resident on call and the chief resident on call are responsible for making at least once daily weekend rounds at the U of A Medical Sciences, Children's and Veteran's Hospitals. More frequent rounds will be made if a patient's condition warrants closer observation. The junior resident and the chief resident on call will make these rounds together at all three hospitals.

DRESS ATTIRE

Residents must maintain a professional appearance both in clinics and on call. Male residents are expected to wear shirt and tie while in clinic, whereas female residents should dress in correspondingly professional attire. On call, workout attire or poorly maintained clothing is not appropriate.

VACATION POLICY

Ophthalmology residents are allowed only five vacation days during each rotation of their residency. No more than one resident may be on vacation from any service at one time.

UAMS residents will submit the Blue Vacation/Meeting Request Form (which is provided in the Resident Library at UAMS or you can obtain this form from the Program Coordinator) at least four weeks prior to the first day of their vacation. The request must be signed by (1) the Chief Resident, (2) the Clinic Director and then by (3) Dr. Richard Harper for approval.

ACH residents will submit a written request to Dr. Westfall, the chief resident, and the appointment clerk at least six weeks prior to the first day of their vacation. You will also need to notify the Program Coordinator of any time scheduled off during your rotation at ACH so that proper payroll records can be maintained.

VA residents are expected to give four weeks written notice to Dr. Brown, the chief resident and the appointment clerk. You will also need to notify the Program Coordinator of any time scheduled off during your rotation at the VA so that proper payroll records can be maintained.

Requests will be approved by the chief resident in the order in which they are received. If a resident cancels vacation after obtaining approval through the departmental office, he/she must notify the program coordinator prior to the beginning date of the vacation, and notify the clinic where he/she works so patients can be scheduled. It is your responsibility to be certain that patients are not scheduled for you during your vacation.

SICK LEAVE

UAMS Sick Leave Policy:

I. Purpose

To define the policy and procedures as well as the related responsibilities of the University and Housestaff regard to sick leave.

II. Policy

It is the policy of the University of Arkansas for Medical Sciences to provide a reasonable amount of paid sick leave to members of the housestaff who are unable to work because of illness.

III. Definition

Sick leave is paid in the absence from scheduled work for reasons of illness, maternity, or accident.

IV. Eligible Housestaff Members

All interns, residents and fellows whose primary appointment is to the housestaff of the University of Arkansas for Medical Sciences.

V. Use of Sick Leave

A member of the housestaff can be placed on sick leave in excess of one consecutive week only by the approval of the training program director.

Leave of absence for medical reasons will be granted with pay for a maximum of 12 working days with the approval of the program director. Leave of absence for medical reasons may be extended beyond 12 days with pay when the nature of the illness is job-related. It may not exceed the termination date of the appointment.

A. Excess Sick Leave - Exceeding 12 Days

A sick leave request in excess of 12 days requires a special review by the Associate Dean for Postdoctoral Education and the Director of Training Program. The personal physician of the housestaff member must provide a letter stating the nature of the illness and the reason for the requested extension of sick leave.

1. Salary considerations

- a) Unused vacation time can be used to extend the pay period, but when maximum sick leave and vacation time have been exhausted, the housestaff member is placed on leave without pay.

- b) Termination of the training position: When the housestaff has been absent for longer than 8 consecutive weeks, a decision about the ability to return to full duties must be reached and a decision made based upon the circumstances involved. The personnel needs of the department will be given primary consideration, and it may be necessary to terminate the housestaff member and employ another to fulfill the housestaff duties.

- VI. Record Keeping - (need to use vacation/sick form for residents)

It is the responsibility of the Program Director to keep accurate records of sick leave, vacation leave and training status so as to have adequate information for Board Certification. The Associate Dean for Postdoctoral Education should also be informed so that certificates may be accurately prepared.

The Director of the Training Program will determine whether or not the trainee will be required to spend additional time in training to compensate for the leave period and be eligible for certification for a full training year. That decision will be based upon the requirements of the individual specialty boards.

VII. Special Provisions for Pregnancy

In recognition of the variations in physical demand among the various housestaff positions through affiliated hospitals and to insure optimum consideration for both the mother and the unborn child, the following provisions are suggested:

A) The housestaff member should see a physician as soon as she believes there may be a pregnancy. When the pregnancy is confirmed, she should notify the director of her training program so as to permit mutual cooperation in planning future training assignments. She should also provide the date on which she will most likely temporarily cease the training program responsibility.

B) By the end of the sixth month of pregnancy, the housestaff member should provide the Program Director with a statement from her attending physician certifying the expected date of delivery, her physical ability to continue working and the date to which she is permitted to work. Any change in medical condition subsequently that might alter these health guidelines is to be documented with an additional statement from her physician.

The maximum period of maternity leave with pay has been set by the Board of Trustees of the University of Arkansas (for faculty, staff and housestaff) as 12 days of unused sick leave plus 14 days (two weeks of unused vacation time). Time off duty beyond that amount will be without compensation.

C) Under special circumstances, most commonly for reasons of pregnancy, the resident may request to take one year of training over a two-year period. Requests must be made in advance to the program director. Approval will depend on feasibility of the request in each program.

VIII. It is up to the judgment of the Department of Ophthalmology whether to grant sick leave or not. Under certain circumstance, the Department of Ophthalmology can require a physician's statement concerning the illness. Failure to comply with this policy can result in loss of pay and/or vacation time.

FUNERAL LEAVE

No set number of days is allowed for funeral leave. However, in the case of a death of a close family member, allowances may be made for funeral leave. If a resident desires a funeral leave, he/she is to contact the staff of the Department of Ophthalmology and provide the following information:

1. Location of funeral
2. Date of funeral
3. Relationship to the deceased

It is up to the judgment of the department whether to grant funeral leave or not. If funeral leave is granted, the department will state the specific number of days that funeral leave will be allowed. Failure to comply with this policy can result in loss of pay and/or vacation time.

EMERGENCY LEAVE

No set number of days is provided for emergency leave. However, in the event of a family emergency, allowances may be made within reason. Before emergency leave will be granted, the resident must contact the staff of the clinic and provide the following information:

1. Nature of the emergency
2. Desired time off

It is up to the judgment of the department chairman whether to grant emergency leave time or not. Failure to comply with this policy can result in loss of pay and/or vacation time.

MEETING TIME AND MONEY

- 1) As of July 1, 2001, a travel stipend of \$1500 per year per resident will be provided, with maximal \$250 carry over and \$250 AFIP bonus.
- 2) All residents are strongly encouraged to attend the AFIP meeting during their residency.
- 3) Dr. Shock or his faculty designee must approve all meetings attended by residents before meeting registration. A standardized form will be provided for these requests.
- 4) Residents who are first authors on abstracts accepted in peer-review meetings will be encouraged to attend their presentations with time and expense provided by the department with the following qualifications:
 - a) All meeting proposals will be submitted to the chairman or his faculty designee before the abstract is submitted to the program committee of the meeting.
 - b) The maximal reimbursement for each research meeting will be \$1500.
 - c) All research meetings will be within the continental United States.

The Program Coordinator will need to be notified as soon as you are aware of the dates you leave and return so that a Request for Authorization of Travel Expenses can be completed and submitted to the UAMS Travel Department. Upon receipt of the approved request, a month in advance, she will then process your registration fees and airline ticket on a purchase order so that you will not have to send the money personally. You are expected to make your own arrangements for your trip, however, the program coordinator will be available to advise you on the issue of travel agencies, receipts, hotel reservations, etc. Reimbursement for accommodations, meals, and any other expenses not paid by a purchase order require that original receipts be turned into the program coordinator within 60 days of travel dates or reimbursement may not be granted, even with prior authorization. (You are still required to separately submit your Vacation/Travel request as outlined in the Vacation Policy on page 28.)

SECRETARIAL SERVICES

- 1) Transcription of letters
- 2) Typing manuscripts for publication
- 3) Travel authorizations and reimbursements
- 4) Leave request, approval by staff and recording of leave days
- 5) Type call schedule after UAMS chief resident completes rough draft
- 6) Type material for slides
- 7) General typing
- 8) Handles pay stipends and deliver checks

Please present all handwritten work in a legible fashion. Allow a reasonable amount of time for work to be completed. Staff typing will take precedence over resident typing.

SUGGESTED FORMAT FOR DICTATING

- 1) Speak clearly.
- 2) Turn the recorder off when pausing or reviewing the chart.
- 3) Punctuate as you dictate.
- 4) Spell all names.
- 5) Name and address of the person to whom the letter will be sent. If the address is unknown, try to give title and city of person.
- 6) Give unit number of patient.

EVALUATIONS

As indicated on the evaluation form (Performance Report page 72), each resident will be evaluated in the following areas: Knowledge, Skills, Communications, Technical abilities, and Attitudes. Each area will be rated as: B – Below expectations; M – Meets expectations; E – Exceeds expectations; or N – Not observed. Evaluation forms will be filled out by each faculty member who directly supervised residents on that rotation, and by the chief resident of that rotation.

An oral exam will be given at the end of each rotation. The purpose of the exam is to ensure that each resident has gained the necessary knowledge base from each rotation and to give the resident experience in taking oral examinations in preparation for eventual board certification. The exam will be taken at the site of your rotation. Only the following subject areas will be covered on the examination:

ACH: Strabismus and General Ophthalmic Pediatrics

VA: External Disease and Retina

JEI: Optics, Anterior Segment, Neuro-Ophthalmology

Each subject will be taken in a twenty minute session. Hence, residents ending a JEI rotation will have three twenty minute exams, whereas a resident ending a VA rotation will have two twenty minute exams. A resident must successfully complete three of the four cases available in order to pass a subject. If a particular case is troublesome to the resident during the exam, the resident has the option to "pass" to the next case. This option may be used only once during a subject exam. Overall exam performance will be reviewed with each resident by the residency director.

The junior-most and senior-most resident will be excused from the exam in order to cover call starting 1 hour prior to the examination until the examination is completed. The examination will be held the last week of the rotation. No vacation is to be scheduled during this time unless approved by the residency director.

Each resident will have 360 degree global evaluations completed at the end of 6, 12, 18, 24 and 30 months. The 360 degree global includes evaluations completed by administrative staff, nurses, peers, self and patients (see evaluations entitled Administrative Staff, Nurses' Survey, Peer Evaluation, Resident Self Evaluation

and Patient Satisfaction Survey pages 64-71). These evaluations are used to evaluate the resident in the area of professionalism & interpersonal and communication skills.

At least, on an annual basis (usually in the summer), the department chairman will formally review with each resident their rotation evaluations and academic performance; in addition, written evaluations will be reviewed by the residency program director with each resident on, at least, an annual basis (usually in the winter) and signed by the resident to indicate that he/she has seen the evaluations. The evaluations will be maintained in confidential files and only available to authorized personnel. Upon request, the resident may review his/her evaluation file at any time during the year.

The resident may appeal an unsatisfactory evaluation by submitting a written request to the Program Director. The Program Director then reviews a summary of the deficiencies of the resident, and the resident has the opportunity to explain or refute the unsatisfactory evaluation. After review with the faculty, a final decision will be made.

At the completion of the training program the Program Director prepares a final evaluation of the clinical competence of the resident (see Final Evaluation of Terminating Resident pages 73-74). This evaluation stipulates the degree to which the resident has mastered each component of clinical competence – clinical judgment, medical knowledge, clinical skills, humanistic qualities, professional attitudes and behavior, and provision of medical care. This evaluation verifies the resident has demonstrated sufficient professional ability to practice competently and independently. This evaluation remains in the program's files to substantiate future judgments in hospital credentialing, board certification, agency licensing, and in the actions of other bodies.

Refer to attachments 1-7, pages 64 – 74, to view a copy of resident evaluations described above.

REAPPOINTMENT AND PROMOTION

Housestaff appointments are for a period not exceeding one year. A housestaff agreement outlining the general mutual responsibility of the College of Medicine and the housestaff member is signed at the beginning of the term of service and is in effect for the full term of service. Renewal of agreement for an additional term of service is at the discretion of the chief of service. Promotion to the next level of training is dependent upon the resident performing at an acceptable level.

MOONLIGHTING

In order to be eligible for moonlighting activities, the resident must follow the procedure as outlined in the UAMS College of Medicine GME Committee policy, Moonlighting and Malpractice Insurance Coverage while Moonlighting. Residents are not required to moonlight. The resident must submit a written request (you may obtain the Moonlighting Request Form from the Program Coordinator) to the Program Director and obtain his written approval. This information is contained in the resident's file. Professional liability coverage (malpractice insurance) provided through UAMS does not cover moonlighting activities. Malpractice insurance for such activities is the sole responsibility of the resident. It is the responsibility of the clinical facility hiring the resident to determine whether the appropriate credentials, adequate liability coverage and appropriate skill levels are in place.

Moonlighting privileges will be withdrawn if the resident is no longer performing satisfactorily in the program. In the event permission to moonlight is withdrawn by the program director, the obligation to notify an outside employer is the responsibility of the resident who established that employment and not the responsibility of the program director or UAMS.

ACADEMIC AND OTHER DISCIPLINARY ACTIONS

Last updated 3/24/2004

All of the disciplinary actions listed below are done in compliance with UAMS COM GME policy on disciplinary actions.

ACADEMIC WARNING STATUS – is defined as the initial trial period in which a resident is permitted to redeem academic performance or behavioral conduct (before being placed on probation) for any one or more of the reasons cited below:

1. Failure to attend and perform satisfactorily at all scheduled conferences, morning rounds, the outpatient clinic, the operating room.
2. Failure to score at least above the 20 percentile on the annual OKAP examination after being in the program for at least one year. Where appropriate, allowances will be made for the staggered entry date.
3. Repeated reports of “below expectations” on the resident evaluation forms.

When a resident is placed on academic warning status, the Program Director will provide specific remedial steps to correct the deficiency or problem and will indicate the timeframe allowed to make the correction.

PROBATION – is defined as the trial period in which a resident is permitted to redeem academic performance or behavioral conduct for any one or more of the following:

1. Failure to correct the deficiency or problem mentioned during the time allowed when previously placed on academic warning status.
2. Failure to comply with the policies and procedures of the Training Program, the GME Committee, UAMS Medical Center or the participating institutions.
3. Misconduct that infringes on the principles and guidelines set forth by this training program.
4. Documented and recurrent failure to complete medical records in a timely and appropriate manner.
5. When reasonably documented professional misconduct or ethical charges are brought against the resident which bears on his/her fitness to participate in the training program.

Last updated 11/10/2000

When a resident is placed on probation, the Program Director shall provide specific remedial steps to the resident in a written statement within a week of the notification. The statement will specify the period of time in which the resident must correct a deficiency or problem, the specific remedial steps and the consequences of non-compliance with the remediation. Based upon the resident's compliance with remedial steps, the resident may be:

1. Continued on probation
2. Removed from probation
3. Suspended, or
4. Dismissed from the residency program

SUSPENSION – is defined as a period of time in which a resident is not allowed to take part in all or some of the activities of the training program. A resident may be suspended from clinical or other activities of the training program for reasons including, but not limited to, any of the following:

1. Failure to meet the requirements of probation.
2. Failure to meet the performance standards of the training program.
3. Failure to comply with the policies and procedures of the Training Program, the GME Committee, the UAMS Medical Center, or the participating institutions.
4. Misconduct that infringes on the principles and guidelines set forth by this training program.
5. Documented and recurrent failure to complete medical records in a timely and appropriate manner defined as above.
6. Misconduct or failure to meet ethical standards which bear on his/her fitness to participate in the training program.
7. When reasonably documented legal charges have been brought against a resident which bears on his/her fitness to participate in the training program.
8. If a resident is deemed an immediate danger to patients, himself/herself or others.
9. If a resident fails to comply with the medical licensure laws of the State of

Arkansas

Last updated 11/10/2000

If suspension is deemed necessary, the Program Director notifies the resident through a written statement, with a copy to the Associate Dean for GME, to include:

1. Reasons for the action
2. Specific and appropriate measures to assure satisfactory resolution of the problem(s)
3. Activities of the program in which the resident may and may not participate
4. The date the suspension becomes effective
5. Determination of leave with or without pay
6. Consequences of non-compliance with the terms of suspension
7. Whether the resident is required to spend additional time in training to compensate for the period of suspension and be eligible for certification for a full training year

During the suspension, the resident will be placed on leave, with or without pay as appropriate depending on the circumstances. At any time during or after the suspension, the resident may be reinstated with no qualifications, reinstated on probation, continued on suspension or dismissed from the program.

DISMISSAL - is the condition in which a resident is directed to leave the training program, with no award of credit for the current training year. Dismissal from the training program may occur for reasons including, but not limited to, any of the following:

- Failure to meet the performance standards of the training program
- Failure to comply with the policies and procedures of the training program, the GME Committee, the UAMS Medical Center, or the participating institutions
- Illegal conduct
- Unethical conduct
- Performance and behavior which compromise the welfare of patients, self, or others
- Failure to comply with the medical licensure laws of the State of Arkansas
- Inability of the resident to pass the requisite examinations for licensure to

Last updated 11/10/2000

United States

1. If dismissal is planned, the Program Director shall contact the Associate Dean for Graduate Medical Education and provide written documentation, which led to the proposed action.
2. Immediate dismissal can occur at any time without prior notification in instances of gross misconduct (e.g., theft of money or property; physical violence directed at an employee, visitor or patient; use of alcohol/drugs while on duty; other illegal conduct).
3. When dismissal is being considered because of performance or conduct, the Program Director shall notify the resident in writing of the basis of the action, the proposed action, the requirements for the resident and timeframe for satisfactory resolution of the problem(s).
4. In the event the situation is not improved within the timeframe, the resident will be dismissed.

A resident involved in the disciplinary actions of probation, suspension and dismissal has the right to appeal according to the GME Committee policy Adjudication of Resident Grievances. Please see the manual entitled General Manual for Housestaff, University of Arkansas for Medical Sciences, College of Medicine, for a full discussion of these procedures. These are the guidelines that will be used by the department.

Last updated 11/10/2000

APPENDIX I

PLATITUDES ON BEGINNING A RESIDENCY

William H. Havener, M.D.
Columbus, Ohio

I have been assigned the responsibility of assembling all the time worn platitudes appropriate to introduce you into Ophthalmology. Obviously, this is going to result in something like a commencement address. Let me start by defining my objectives as extending a sincere welcome to you and offering some suggestions for our guidance during the coming years.

The ophthalmology staff does welcome you. You will enjoy a much closer relationship with this staff than you developed with your medical school professor. This is because of the smaller student/teacher ratio, because of the long time of contact, and because of our common and close interests. We know that at the end of this time you will be a practicing ophthalmologist, and we want to help you become the best ophthalmologist possible.

Ophthalmology will reveal itself to be even more complicated than you have anticipated. As a matter of fact, you will never learn everything known about the eye. No one can. However, during the coming years you will acquire an enormous amount knowledge. Perhaps I am qualified to make helpful suggestions about your learning on the basis of having gone through an ophthalmology residency myself and having observed almost two decades of resident do so.

You will find that a complex teaching structure has been developed for you in the residency program. You already have received an outline of these residency rotations, and during the next years you will be paced through the teaching steps designed for your predecessors. Despite this formal educational framework a very large part of your education (if not all) will depend upon your personal initiative.

Initially, everything will be new and confusing. The solution to this confusion is simple-- ask questions. The residency program is designed to offer you, at almost all time, the availability of someone who knows some of the answers you seek. This source of information may be a senior resident, a staff man, an experienced nurse, perhaps a subspecialist--but whoever it is, he won't answer your questions unless you ask them. Sometimes the pressures of patient care may postpone the immediate asking or answering of questions, but save them and find out later. Do

not misinterpret the apparent brusqueness forced by the demands of time as representing unwillingness to help. We solicit the opportunity of helping you.

The second source of information is reading. Don't read everything--you can't anyway. Read selectively. Look up and read about the problem or the patient you have encountered today. When you are learning refraction, read an introductory textbook on refraction. When you see a patient with syphilitic corneal disease, look up interstitial keratitis. Read it today--tomorrow never comes.

During the first year, read only good textbooks. Exceptionally, you may find an unusually valuable journal article. Intelligent and productive journal reading requires a basic amount of information you do not yet possess. Postpone journal reading until your second of the residency--and then read the journals regularly and faithfully for the rest of your life.

Unless you remember the facts you read, your reading is a waste of time. You remember through selective reading--concerning subjects encountered today. You remember through repetition--when the same facts recur in anatomy, physiology, pathology, and the discussion of today's patient. You remember best of all when you teach. Verbalize the facts you learned yesterday. Tell the medical students. Tell your fellow residents. Tell the staff. Tell anyone who will listen. To repeat is to remember. Who knows--if you tell your fellow resident a pearl, he may tell you another one.

The third source of information is the patient. Evaluate his history thoughtfully. Discard the red herrings. Select pertinent complaints and attempt to interpret their meaning. You will find that many ophthalmological diagnoses can be made on the basis of typical history alone. Furthermore, the physical findings must explain the history. Discrepancy between history and examination findings signifies your error.

Examine the patient thoroughly, using all the skills you know. Observe as many details as you can. At first you will be shocked to find how many important features you will overlook. Much of this failure to recognize important details is due to your unfamiliarity with the eye and its examination. Be encouraged. Experience will remedy this.

You will see that for which you look. You will miss the characteristic appearance of endothelial dystrophy--unless you recognize the typical stromal edema and then

look specifically at the endothelial surface. You will miss the arteriolar embolus-- unless you interpret history and visual field properly and seek out the critical part of the vascular field properly and seek out the critical part of the vascular tree. Do look specifically for an explanation of symptoms.

Consider not only history and findings of the patient, but also his clinical course. Does he respond as expected? If not, what happens and why?

Although the patient is an invaluable source of knowledge, come to no permanent conclusion from one patient. Chance, error, and misinterpretation prohibit making reliable deductions from a single case. However, a given patient who is a good example of a disease entity may be demonstrated as such, with great profit to the observant student. Be critical of teaching which starts out with "I saw a case once".

The fourth source of information is discussion. Talk about the knowledge you are acquiring. Participate in group discussions. Talk with your seniors. You will be rewarded by much better understanding of the subjects.

Whether obtained by questioning, reading, patient evaluation, or discussion, knowledge must be integrated usefully into your personal thought processes before it becomes valuable. Try to build a logical structure of ophthalmologic knowledge within your own mind. The foundation of this logical structure will be the basic sciences. You must know anatomy accurately. You must be able to explain anatomic structure on the basis of its embryologic origin. You must understand the physiology of the eye. Your interpretation of pathology must be compatible with your concepts of anatomy, physiology, and embryology. Pharmacology makes no sense without a foundation in these other basic sciences.

When you encounter a new fact, analyze its credibility in terms of the basic science foundation you have developed. If it is compatible, remember it in context. If it seems contradictory, the new fact may be wrong and should be rejected. Or perhaps your previous concepts are wrong and must be changed. Or both new fact and old concept may be true, but related in some complex fashion that requires consideration. Your conscious evaluation of new facts in relationship to your old basic memory is crucial. Your constant question should be, "does it make sense? If not, why not?" Do not accept any new knowledge unless it does make sense.

Factual knowledge, such as we have just discussed, is only one of the objectives of your ophthalmology residency. You must also acquire the skills of examination and surgery. You must learn to communicate effectively with your patient by both spoken and nonverbal channels. You must solve the practical problems of intraprofessional relationships. More important than anything else, you must continue the healthy growth of your own personality.

Skills are vital to your success as an ophthalmologist. You must deliberately work to perfect your ability to use the examining instruments of ophthalmology. Do not minimize the difficulty of this. Even a year from now you will not yet have mastered the intricacies of indirect ophthalmoscopy. Nevertheless, the level of your ability to use our diagnostic instruments will determine your quality as an ophthalmologist.

Of course, any surgical specialty requires skill and dexterity in use of the operating instruments. Dexterity is acquired only through practice. Try to duplicate upon practice eyes the surgery you observe. You will find this easier said than done. At first you will observe only the contact of the instruments with the patient's eye. When you try to practice surgery you will discover the positions of the surgeon's hands to be equally important. Further more, an instrument often performs several functions simultaneously. For instance, when placing a corneoscleral suture, the needle retracts the cornea even as it engages the sclera. Also, the proper sequence of steps is at least as important as the individual steps themselves. You will learn surgery by repeated watching long practice, and finally by actually operating. A suggestion--start now to eat left-handed. In six months you will be almost ambidextrous--which can be most useful to any eye surgeon. In summary, skills require long practice.

Communication with your patient is vital to being a successful physician. It matters not how good a physician you are; you cannot cure a patient unless he follows your instructions. You can communicate verbally, by explaining the disorder and your instructions. You can communicate in writing, by providing printed instructions for the patient. I have found such printed material to be invaluable and would recommend you select or prepare instructions appropriate for your future practice during the period of your residency.

A most important form of communication is by touch. Contact with the patient's face, eyelids, and eye is an essential part of an ophthalmology examination. Touch gently. Almost all examiners are thoughtlessly too rough for the patient's comfort.

Do not underestimate the significance of gentleness during the patient's contact with a man whom he will later permit to put a knife into his eye. Your attitude and that of your office personnel are also an important nonverbal communication to the patient. Watch your behavior.

A relatively minor, yet critical area of communication concerns your relationship to other physicians. You will commonly receive patient referrals from other physicians. Prompt, adequate, and understandable reports are your obligation to the referring physicians. Do not postpone your paperwork--it only takes longer when you have forgotten the patient. Write your consultations and letters today. Do not use abbreviations unfamiliar to non-ophthalmologists.

You may at times be critical of the errors of other physicians. At such times it is wholesome of you to contemplate the errors you will make during the coming years.

The continuing healthy growth of your own personality is vitally important to you and should be carefully cultivated. Description of your personality goals requires use of the time-honored "good" words--such as maturity, reliability, honesty, dedication, enthusiasm, etc. Actually, mention of such characteristics is almost unnecessary to this group. You wouldn't be here without having developed such strengths of character. Nevertheless, let me emphasize that the "hippies" have not inherited the earth, regardless of their newspaper publicity. The final rewards still go to the solid citizen who work and are faithful.

Do not compromise your own principles. Do what you believe to be right. Ultimately you must be happy with yourself or your life may see to have been a failure. Let me commend to you the noble precepts of the great religions of the world. If you do not already believe in the Creator, your disbelief will be seriously challenged by the complexity of the eye. After years of study the intricacies of this wonderful little organ of sight will still extend beyond your comprehension. Sooner or later you must admit that statistical science excludes the origin of an eye by chance. There is no other rational explanation except God. The most important thing I will ever say to you is that you should develop your life in firm belief that there is a God of love who cares for you and for each and every one of your future patients.

(Reprinted from the Eye, Ear, Nose and Throat Monthly, July 1969)

APPENDIX II

EYE EXAMINATION*

CC	Chief Complaint
HPI	History of present illness
Eye hx	Eye history - injuries, infection, surgery strabismus
FH	Ocular or systemic diseases in family
GH	General health, surgery, medications, allergies
PC	Present correction
Vs or c	Vision without and/or with correction
MR	Manifest refraction
CF	Confrontation fields
MB	Muscle balance
EOM	Extraocular motility
Ext	External (penlight) exam
Pupils	Direct, consensual, near, Marcus Gunn
Bio	Slit-lamp biomicroscopy
TAP	Applanation tension
CR	Cycloplegic refraction
Fundus	Disc, macula, vessels, periphery
Special tests	Where indicated

You should always check the right eye first.

* The attached outline is provided as a guide to assist new residents in performing their eye examinations. It was prepared by Dr. Alice Laule and was not intended to cover every possible test. It should serve, however, as a good starting point and frequent reference to it will help remind you of the many areas that need to be evaluated.

I. HISTORY OF PRESENT ILLNESS AND CHIEF COMPLAINT

A. General

1. Often get diagnosis here
2. Indicates special tests which may be indicated
3. Be sure to include patient's age

B. Loss of Vision

1. Duration
2. Nature of onset - sudden or slow
3. Associated symptoms (pain, redness, flashes, floaters, etc.)
4. Try to distinguish between pathology vs. refractive error by history

C. Many Other Complaints - some are vague

1. How much the complaint really bothers the patient - especially the vague complaints
2. Try to distinguish between pathological vs. inconsequential complaints - especially true for "headache"
3. Remember - you will have to answer to their complaint when the exam is done

II. EYE HISTORY

A. "Have you ever had any trouble with your eyes besides glasses?"
Most people say "no" so go on.

B. Ask specifically about injuries, crossed eye, lazy eye, surgery and infections.

III. FAMILY HISTORY

A. Eye disease or blindness in the family.

B. Systemic disease, such as diabetes.

IV. GENERAL HEALTH

- A. Ask about specific illnesses - hypertension, diabetes, heart disease, etc. & duration of illness.
- B. What medications is the patient on.
 - 1. Chloroquine, Hydroxychloroquine
 - 2. Steroids
 - 3. Phenothiazines
 - 4. Ethambutol
 - 5. Anticholinergics
 - 6. Many others
 - 7. Ask specifically about birth control pills - hardly anyone volunteers this information
- C. Allergies

V. VISION WITH AND/OR WITHOUT CORRECTION

- A. Usually, but not always, suffices to test with correction only
- B. Distance Vision
 - 1. As a rule, can start with 20/40 line
 - a. Larger line only if you suspect they can't read 20/40
 - b. People will fatigue and stop reading if you start too far up on the chart.
 - c. Push - insist they guess - develop techniques for getting the patient to read the smallest they can
- C. Near Vision
 - 1. Test each eye separately
 - 2. Jaeger notation implies at 14" test distance specify if a different distance is used
- D. For Children

1. Around 4 years, try to teach “E” game
 2. Younger children
 - a. Can they follow a moving small object with each eye?
 - b. Is fixation steady with each eye?
 - c. If strabismus is present, does the child constantly fixate with the same eye, or will they alternate fixation?
- E. Malingering or Hysteria
1. Start at small line -eg 20/10 - and work up to “large” 20/20 line
 2. Some tests for malingering - Survey of Ophthal. Vol 17, NO 4 (1973), pp 241-246
- F. If Patient Can’t Read 2/0400, Use Acuity Chart at a Closer Distance
1. Count fingers at what distance:
 2. Hand motion - make them tell you which way you are moving your hand
 3. Light perception - with or without light projection
- G. Evaluating Nerve and Retina with Opaque Material Such as Cataract
1. Light projection
 2. Red-green perception
 3. Rotating Maddox rod
 4. Two-point perception
 5. Entopic phenomenon

VI. PRESENT CORRECTION

- A. Record Lensometer Reading, Including Add
- B. How Old Are the Glasses

VII. MANIFEST REFRACTION

- A. Record Refraction and the Vision Achieved With It

- B. Important To Do Before Any Lights are Shone in Patient's Eyes (except when retinoscopy is necessary)
- C. Position the Phoropter in Front of the Patient with All the Lenses Out (plano position)

VIII. CONFRONTATION FIELDS

- A. Should Be Done On Every Patient
- B. Find a Technique That's Quick and Comfortable for You. (Count fingers in each quadrant is an excellent method)

IX. MUSCLE BALANCE

- A. Cover-Uncover to Identify Tropia Versus Phoria
- B. Cross Cover
- C. Prism Cover - to Quantitate Amount
- D. Hirschberg - Screening Test. Adequate for the Asymptomatic Adult
- E. Young Emmetropic Patients with Reading Problems May Have a Large Exophoria and Should Have Cover-Uncover with Near Fixation Performed
- F. Near Point of Accommodation
- G. Other Related Tests
 - 1. Worth 4-dot: confirms suppression, or verifies diplopia
 - 2. Stereo fly
 - 3. 4-diopter base out prism test for monofixation syndrome

X. EXTERNAL

- A. Unusual Head Positions - Head Tilt or Turn, Chin Elevation or Depression

- B. Exophthalmos, Enophthalmos
- C. Lacrimal
 - 1. Tear meniscus
 - 2. Epiphora
 - 3. Swelling or discharge - express sac
- D. Lids
 - 1. Ptosis- if present measure palpebral fissure
 - 2. Edema
 - 3. Blepharitis
 - 4. Entropion or ectropion
 - 5. Trichiasis
 - 6. Tumors
 - 7. Cosmetics
- E. Conjunctiva
 - 1. Injection
 - 2. Pigmentation
 - 3. Symblepharon
- F. Cornea
 - 1. Clarity - scars, band keratopathy, etc
 - 2. Edema or epithelial irregularity

XI. PUPILS

- A. Anisocoria
- B. Light Reflex - Direct and consensual

- C. Accommodation - Must Check if Light Reflex is Absent or Abnormal
- D. Afferent Pupillary Defect (Marcus Gunn Pupil) Do a “Swinging Flashlight Test” on Everyone

XII. BIOMICROSCOPY

- A. Lids
- B. Conjunctiva and Sclera
- C. Cornea - Examine All Layers
- D. Anterior Chamber - Depth, Clarity, Cell and Flare
- E. Iris - Nevi Tumors, Cysts, Rubeosis
- F. Lens - Examine All Layers
- G. Anterior Vitreous

XIII. INTRAOCULAR PRESSURE

- A. Applanation
- B. Shiotz (now rarely done)
- C. Tonopen - Most Accurate with Corneal Edema or Irregularity
- D. Warn Patient Not to Rub Eyes after Anesthetic is Instilled
- E. Don't Let Patients Replace Their Contacts for Preferably Two Hours after Anesthetic
- F. Record Tension, Method by Which it was Done, and Time of Day at Which it was Done

XIV. CYCLOPLEGIC REFRACTION

- A. Tropicamide - Short Acting; Short Duration of Maximum Action
- B. Cyclopentolate - Longer Duration, Slight Stronger; Cycloplegic - Used More in Very Young

XV. FUNDUS (DILATE with MYDRIACYL & NEO-SYNEPHRINE)

- A. Every Patient Deserves a Dilated Exam at Some Point, Most of the Time It Will Be First Visit
- B. Direct Ophthalmoscope - More Magnification
 - 1. Disc evaluation
 - 2. Macular evaluation
 - 3. Blood vessel detail
- C. Indirect Ophthalmoscope - Less Magnification; Larger Field
 - 1. A part of every dilated exam
 - 2. Should include scleral depression whenever there is a hint of peripheral retinal disease by history or exam

XVI. SPECIAL TESTS-FIND OUT WHERE THESE ARE & HOW TO USE

- A. Color Vision
 - 1. Certain medications
 - 2. Suspected optic nerve or macular disease
- B. Amsler Grid - Macular Disease
- C. Stereo Fly and Worth 4-dot Strabismus
- D. Optokinetic Nystagmus Drum or Tape
 - 1. Neurologic disorders

- 2. Malingering
- E. Placido Disc-Corneal Astigmatism, Especially Irregular
- F. Corneal Mapping
- G. Keratometry
 - 1. Irregular or regular corneal astigmatism
 - 2. Contact lens fitting
- H. Exophthalmometry -Hertel and Others
 - 1. Exophthalmos
 - 2. Enophthalmos
- I. Ophthalmodynamometry-Carotid Occlusive Disease
- J. Gonioscopy
 - 1. Preop Evaluation
 - 2. Post trauma, especially hyphema
 - 3. Possible intraocular foreign body
 - 4. Glaucoma
 - 5. Goldmann 3-mirror lens for peripheral fundus
- K. Visual Fields
 - 1. Neurologic disease
 - 2. Glaucoma
 - 3. Many indications-should be done whenever visual loss is unexplained
- L. Hruby Lens-for Study of Posterior Pole
- M. Ultrasound
- N. Photographs

- O. Fluorescein Angiography

XVII. PATIENT EXPLANATION

- A. Explain or Reassure about Their Chief Complaint and Any Proposed Treatment or Lack of Treatment
- B. Normal Exam-Reassure the Patient There are No Cataracts, No Glaucoma, Blood Vessels and Nerve Look Fine
- C. Reason for Continued Follow-up as in Glaucoma Suspect or Resolved Trauma-in Spite of Lack of Treatment Being Given

APPENDIX III

DISASTER PROTOCOL

CLINICAL DEPARTMENT INSTRUCTIONS

AREA: Ophthalmology Clinic

DUTIES

- I. The chief resident on call shall be notified by the Emergency Room during off-duty nights and weekends. Chief Resident will notify junior resident on call and faculty on call.
 - A. Minimum Need
 1. Staff on call - Ambulatory Care Center
 2. Chief Resident on call- Acute Care Area (Tunnel between ED II Building and Emergency Department)
 - B. In the event of insufficient personnel, the faculty member on call will notify Dr. Harper and Dr. Shock who will make the necessary adjustments.

- II. On-duty personnel will remain in or report to the eye Clinic. In-house staff will report to the clinic after being notified by clinic secretary.
 - A. Other Chief Residents and Junior Residents
 1. Report to the clinics as soon as notified of disaster. (faculty or resident)
 2. See all emergency patients brought to Operating Room
 3. Report to Acute Care Area. (faculty or resident)
 - B. Faculty on Call

1. Report to the eye Clinic as soon as notified of a disaster
2. Monitor arrival and departure of patients to and from clinics
3. Call out additional help when needed according to telephone recall system. (See chart in old manual)