Virginia Commonwealth University Health System Medical College of Virginia Campus
DEPARTMENT OF OPHTHALMOLOGY

RESIDENT HANDBOOK
2012-2013

William H. Benson, M.D., Professor and Chair
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WELCOME

Welcome to the Virginia Commonwealth University, Department of Ophthalmology. This handbook has been prepared to familiarize you with the institutional and departmental policies and procedures, and our residency educational program.

It contains information that all residents should know and understand before entering into the clinic, operating room, conferences and other education venues.

The information contained in this resident handbook pertains to all residents within the department’s program.

DEPARTMENT and PROGRAM MISSION STATEMENT

Mission Statement

The Department of Ophthalmology at the Virginia Commonwealth University, shall provide the highest quality consultative ophthalmology clinical education to physicians in an environment that promotes excellence in teaching, research and patient care.

Patient Service: The Ophthalmology Department is committed to providing the highest quality cost effective tertiary care in all ophthalmic subspecialties using the most advanced knowledge available. Services are provided in both ambulatory and in-patient settings, primarily at VCUHS Nelson Clinic and the Hunter McGuire Veteran Affairs Medical Clinic.

Education: The department is a major resource for Virginia’s training of future ophthalmologists. It is committed to attracting excellent residents and to recruiting and retaining outstanding faculty to provide clinical, surgical and didactic training for resident physicians in ophthalmology. The department promotes continuing medical education for practicing ophthalmologists through courses and conferences. The department strives to be the educational hub for all community ophthalmologists and eye care providers.

Research: The department provides leadership in research and actively promotes dissemination of knowledge.
EDUCATIONAL GOALS

a. To recruit and retain outstanding faculty.

b. To provide clinical and didactic training for residents in order to prepare him/her for the clinical practice of ophthalmology.

c. To educate and provide an outpatient experience for medical students in ophthalmology.

d. To promote continuing medical education for the practicing ophthalmologist with courses, conferences and visitations within the department.

e. To provide opportunities for research and to encourage participation in research by the medical student, residents and staff.

f. To provide continuing education in didactic lectures for ophthalmic technicians.

g. To provide a clinical facility of sufficient size, adequately equipped, and staffed with the highest caliber of clinical and support staff.
Graduate Medical Education Mission Statement

The Virginia Commonwealth University Health System (VCUHS) is committed to excellence in graduate medical education (GME).

The Virginia Commonwealth University Health System is an urban, comprehensive academic medical center in central Virginia established to preserve and restore health for all people, to seek the cause and cure of diseases through innovative research, and to educate those who serve humanity.

GME programs sponsored by VCUHS are designed to produce skillful physicians and dentists with ingrained habits of life-long learning and well-formed ethical and professional modes of practice. The Schools of Medicine and Dentistry and the Health System have a robust process of oversight through its Graduate Medical Education Committee (GMEC) to assure that the necessary educational, financial, and human resources to support GME are provided.

This commitment to GME is supported by the Vice President for Health Sciences and CEO of the Health System, Deans, Hospital Administration, Department Chairs, Medical Directors of the participating institutions and the teaching staffs. The GMEC submits recommendations to the Executive Committee of the Faculty and the Medical Executive Committee regarding all matters pertaining to the oversight of GME within VCUHS. The Vice President for Health Sciences is directly responsible for decisions pertaining to GME and is in turn accountable to the VCUHS Board of Directors and the President of Virginia Commonwealth University.

The overall responsibility for GME is delegated to the Associate Dean & Director of Graduate Medical Education/Designated Institutional Official, who works in concert with the Deans, the Chief Medical Officer, GME Administration, Department Chairs, Program Directors, the GMEC and the Housestaff Council. These individuals and groups collaborate to assure compliance with GME accrediting organizations and to promote outstanding GME programs producing exemplary graduates.

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<td>Sheldon M. Retchin, M.D., M.S.P.H.</td>
<td>Michael Rao, Ph.D.</td>
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<tr>
<td>Chief Executive Officer, VCU Health System</td>
<td>President</td>
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<tr>
<td>VCU Vice President for Health Sciences</td>
<td>Virginia Commonwealth University and VCU Health System</td>
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Signature on file
Stephen A. Cohen, M.D. Date
Chair, GMEC
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Sheldon M. Retchin, M.D., M.S.P.H. Michael Rao, Ph.D.
Chief Executive Officer, VCU Health System President
VCU Vice President for Health Sciences Virginia Commonwealth University
and
VCU Health System

Date
Signature on file
Stephen A. Cohen, M.D. Date

ELIGIBILITY AND SELECTION

VIRGINIA COMMONWEALTH UNIVERSITY DEPARTMENT OF OPHTHALMOLOGY GRADUATE MEDICAL EDUCATION RESIDENT ELIGIBILITY AND SELECTION POLICY

The Department of Ophthalmology selects its residents through the Ophthalmology Matching Program. The Ophthalmology Residency Matching Program (OMP) was established in 1977 by the Association of University of Professors of Ophthalmology (AUPO) to coordinate the PGY-2
appointments for Ophthalmology programs and to relieve the pressure on applicants and program directors resulting from early appointments and uncoordinated appointment dates. The program supplements the PGY-1 matching services of the National Residency Matching Program (NRMP). It is timed to allow applicants to know their PGY-2 placement in Ophthalmology before they submit their rank list for PGY-1 choices. The Association of University Professors of Ophthalmology (AUPO) sponsors the matching process and is responsible for enforcement of applicable rules.

Each year, three residents are selected. Selection occurs approximately 18 months prior to the starting date.

*The VCU Department of Ophthalmology is a member of the San Francisco Match (SF Match) Program.* Interested candidates must contact SF Match to register and apply through the Central Application Service (CAS).

**SF Match**
PO Box 7584
San Francisco, CA 94120-7584
Phone: (415) 923-3907
Fax: (415) 561-8535
Web site: [www.sfmatch.org](http://www.sfmatch.org)

**CENTRAL APPLICATION SERVICE REQUIREMENTS:**

Applicants are required fill out a CAS application form, provide a set of required documents, and select programs for distribution. Applicants are responsible for assembling a complete CAS application package which includes the following documents:

- CAS Application Form (online form available after registration is concluded)
- College Transcript(s)
- Medical School Transcript(s)
- USMLE Score Report or Transcript(s)
- ECFMG Certificate (applicable to International Medical Graduates)
- Three letters of reference
- Dean's letter

Residents selected through this matching program, will meet the eligibility and selection criteria listed below. The following requirements must be met in order to be considered for a residency position:

1. **Medical Degree:** Applicants must be one of the following:
   a. Graduate of a medical school in the United States (US) or Canada accredited by the Liaison Committee on Medical Education (LCME).
   b. Graduate of a college of osteopathic medicine in the US accredited by the
American Osteopathic Association (AOA).

c. Graduate of a medical school outside the US or Canada approved by the World Health Organization or equivalent accrediting body and possessing a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG).

d. Graduate of a medical school outside the US who has completed a Fifth Pathway program provided by an LCME-accredited medical school.

2. Minimum criteria for the specialty

a. All applicants for the residency program must meet minimum eligibility requirements as established by the ACGME, AOA, or other accrediting body for the specialty.

b. Applicants will not be considered for post-graduate education if they will not meet criteria for board certification upon program completion.

3. Certifying Examinations

a. All applicants for a residency program at the PGY2 level must have passed Steps 1 and 2 CK and CS of the USMLE or NBOME.

b. All applicants for a residency program at the PGY3 level or higher must have passed Steps 1, 2 CK and CS, and 3 of the USMLE.

4. Letters of Reference

a. All applicants must have three letters of reference from US or Canadian physicians who have personal knowledge of the applicant’s clinical abilities and personal characteristics.

5. Patient Care Experience

a. All applicants must be within 4 years of graduation from Medical School or direct patient care activity.

b. Documentation of at least 3 months of direct patient care in the US or Canada is required (within the last 4 years).

6. Language Skills

a. All applicants must have sufficient written and spoken English language skills required for safe and effective patient care, and effective participation in training and educational activities.

7. Visa Requirements

a. Only J1 Visas are accepted for medical residency positions at VCU Health System.
8. Employment Requirements

a. Applicants must have one of the following:

- US Citizenship
- Valid US resident alien card (green card)
- Valid passport, valid 1-94 card and J-1 visa sponsorship form the ECFMG or other visa as approved.
- Valid employment authorization document (EAD).

** The Department of Ophthalmology follows the Institutional Policy on Resident eligibility and Selection. For more information regarding eligibility and selection criteria please visit our GME website at [http://www.medschool.vcu.edu/gme/index.html](http://www.medschool.vcu.edu/gme/index.html).

**TRAINING REQUIREMENTS:**

Certification of INDIVIDUALS trained in Ophthalmology is provided by the American Board of Ophthalmology (ABO). To be eligible for examination you must have satisfactorily completed 12 months of broad clinical training (PGY-1) and a formal residency training program in Ophthalmology of at least 36 months (some programs require 48 months). All training must be in accredited programs in the U.S. or in Canada. It is possible that a State Licensing Board will give you credit for foreign training, whereas the ABO will not. You should check with the ABO about this before you enter the match or start your training.

The Board Certification process must be completed not more than 6 years after your training. All Certificates require completion of a designated renewal program every 10 years. For more detailed information visit the American Board of Ophthalmology's website at [www.abop.org](http://www.abop.org).

Accreditation of Ophthalmology training PROGRAMS is provided by the Accreditation Council for Graduate Medical Education (ACGME). The ACGME sets general requirements for all residency training programs as well as special requirement and prerequisite information for each specialty. These requirements are enforced by the various Residency Review Committees (RRC). For additional information visit [www.acgme.org](http://www.acgme.org).

REVISION APPROVED BY PROGRAM DIRECTOR 10/31/11

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**COMPACT BETWEEN RESIDENT PHYSICIANS AND THEIR TEACHERS**

January 2006

[www.aamc.org/residentcompact](http://www.aamc.org/residentcompact)

The Compact Between Resident Physicians and Their Teachers is a declaration of the fundamental principles of graduate medical education (GME) and the major commitments of both residents and faculty to the educational process, to each other and to the patients they serve. The Compact’s purpose is to provide institutional GME sponsors, program directors and residents with a model statement that will foster more open communication, clarify expectations and re-energize the commitment to the primary educational mission of training tomorrow’s doctors. The Compact was originated by the AAMC and its
principles are supported by the following organizations:

Accreditation Council for Graduate Medical Education
American Academy of Allergy, Asthma and Immunology
American Academy of Dermatology
American Academy of Family Physicians
American Academy of Physical Medicine and Rehabilitation
American Association for Thoracic Surgery
American Board of Medical Specialties
American College of Obstetricians and Gynecologists
American College of Physicians
American Gastroenterological Association
American Hospital Association, Committee on Health Professions
American Medical Women’s Association
American Orthopaedic Association
American Osteopathic Association
American Pediatric Society
American Society for Reproductive Medicine
Association of Academic Health Centers
Association of Academic Physiatrists
Association of American Medical Colleges
Association of Departments of Family Medicine
Association of Medical School Pediatric Department Chairs
Association of Professors of Dermatology
Association of Professors of Gynecology and Obstetrics
Association of University Anesthesiologists
Association of University Professors of Ophthalmology
Association of University Radiologists
Council of Medical Specialty Societies
Federation of State Medical Boards
National Board of Medical Examiners-
National Resident Matching Program
Society of Chairmen of Academic Radiology Departments
Society of Teachers of Family Medicine
Society of University Otolaryngologists-Head and Neck Surgeons

Compact Between Resident Physicians and Their Teachers
Residency is an integral component of the formal education of physicians. In order to practice medicine independently, physicians must receive a medical degree and complete a supervised period of residency training in a specialty area. To meet their educational goals, resident physicians must participate actively in the care of patients and must assume progressively more responsibility for that care as they advance through their training. In supervising resident education, faculty must ensure that trainees acquire the knowledge and special skills of their respective disciplines while adhering to the highest standards of quality and safety in the delivery of patient care services. In addition, faculty are charged with nurturing those values and behaviors that strengthen the doctor-patient relationship and that sustain the profession of medicine as an ethical enterprise.

Core Tenets of Residency Education

Excellence in Medical Education
Institutional sponsors of residency programs and program faculty must be committed to
maintaining high standards of educational quality. Resident physicians are first and foremost learners. Accordingly, a resident’s educational needs should be the primary determinant of any assigned patient care services. Residents must, however, remain mindful of their oath as physicians and recognize that their responsibilities to their patients always take priority over purely educational considerations.

**Highest Quality Patient Care and Safety**
Preparing future physicians to meet patients’ expectations for optimal care requires that they learn in clinical settings epitomizing the highest standards of medical practice. Indeed, the primary obligation of institutions and individuals providing resident education is the provision of high quality, safe patient care. By allowing resident physicians to participate in the care of their patients, faculty accept an obligation to ensure high quality medical care in all learning environments.

**Respect for Residents’ Well-Being**
Fundamental to the ethic of medicine is respect for every individual. In keeping with their status as trainees, resident physicians are especially vulnerable and their well-being must be accorded the highest priority. Given the uncommon stresses inherent in fulfilling the demands of their training program, residents must be allowed sufficient opportunities to meet personal and family obligations, to pursue recreational activities, and to obtain adequate rest.

**Commitments of Faculty**
1. As role models for our residents, we will maintain the highest standards of care, respect the needs and expectations of patients, and embrace the contributions of all members of the healthcare team.
2. We pledge our utmost effort to ensure that all components of the educational program for resident physicians are of high quality, including our own contributions as teachers.
3. In fulfilling our responsibility to nurture both the intellectual and the personal development of residents, we commit to fostering academic excellence, exemplary professionalism, cultural sensitivity, and a commitment to maintaining competence through life-long learning.
4. We will demonstrate respect for all residents as individuals, without regard to gender, race, national origin, religion, disability or sexual orientation; and we will cultivate a culture of tolerance among the entire staff.
5. We will do our utmost to ensure that resident physicians have opportunities to participate in patient care activities of sufficient variety and with sufficient frequency to achieve the competencies required by their chosen discipline. We also will do our utmost to ensure that residents are not assigned excessive clinical responsibilities and are not overburdened with services of little or no educational value.

6. We will provide resident physicians with opportunities to exercise graded, progressive responsibility for the care of patients, so that they can learn how to practice their specialty and recognize when, and under what circumstances, they should seek assistance from colleagues. We will do our utmost to prepare residents to function effectively as members of healthcare teams.
7. In fulfilling the essential responsibility we have to our patients, we will ensure that residents receive appropriate supervision for all of the care they provide during their training.
8. We will evaluate each resident’s performance on a regular basis, provide appropriate verbal and written feedback, and document achievement of the competencies required to meet all educational objectives.
9. We will ensure that resident physicians have opportunities to partake in required conferences, seminars and other non-patient care learning experiences and that they have sufficient time to pursue the independent, self-directed learning essential for acquiring the knowledge, skills, attitudes, and behaviors required for practice.
10. We will nurture and support residents in their role as teachers of other residents and of medical students.

**Commitments of Residents**

1. We acknowledge our fundamental obligation as physicians—to place our patients’ welfare uppermost; quality health care and patient safety will always be our prime objectives.
2. We pledge our utmost effort to acquire the knowledge, clinical skills, attitudes and behaviors required to fulfill all objectives of the educational program and to achieve the competencies deemed appropriate for our chosen discipline.
3. We embrace the professional values of honesty, compassion, integrity, and dependability.
4. We will adhere to the highest standards of the medical profession and pledge to conduct ourselves accordingly in all of our interactions. We will demonstrate respect for all patients and members of the health care team without regard to gender, race, national origin, religion, economic status, disability or sexual orientation.
5. As physicians in training, we learn most from being involved in the direct care of patients and from the guidance of faculty and other members of the healthcare team. We understand the need for faculty to supervise all of our interactions with patients.
6. We accept our obligation to secure direct assistance from faculty or appropriately experienced residents whenever we are confronted with high-risk situations or with clinical decisions that exceed our confidence or skill to handle alone.
7. We welcome candid and constructive feedback from faculty and all others who observe our performance, recognizing that objective assessments are indispensable guides to improving our skills as physicians.
8. We also will provide candid and constructive feedback on the performance of our fellow residents, of students, and of faculty, recognizing our life-long obligation as physicians to participate in peer evaluation and quality improvement.
9. We recognize the rapid pace of change in medical knowledge and the consequent need to prepare ourselves to maintain our expertise and competency throughout our professional lifetimes.

10. In fulfilling our own obligations as professionals, we pledge to assist both medical students and fellow residents in meeting their professional obligations by serving as their teachers and role models.

*This compact serves both as a pledge and as a reminder to resident physicians and their teachers that their conduct in fulfilling their obligations to one another is the medium through which the profession perpetuates its standards and inculcates its ethical values.*

For more information about the Compact, go to [www.aamc.org/residentcompact](http://www.aamc.org/residentcompact)

**Health Information Portability and Accountability Act (HIPAA)**
All residents are required to complete on-line HIPAA training prior to beginning clinical rotations. See GME website for instructions on how to complete on-line training. If you have individual questions, you may contact the HIPPA compliance manager at (804) 628-1853 or PO Box 980471.

**Reporting of Other Learners in a Program**

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students) in the training program must not interfere with the appointed resident/fellow’s education. The presence of other learners during the current academic year must be reported in the program’s Annual Report to the GME.

**Moonlighting**

The Department of Ophthalmology otherwise follows the institutional policies on resident moonlighting. Highlights for the Department of Ophthalmology’s moonlighting criteria are as follows:
Moonlighting is not permitted during the residency training.
Duty Hours Policy

It is the policy of the Virginia Commonwealth University Health System (VCUHS), the Graduate Medical Education (GME) office, and the Department of Ophthalmology to follow requirements established by the Accreditation Council of Graduate Medical Education (ACGME) regarding duty hours for residents and fellows in all training programs (herewith referred to as housestaff).

The following delineates the specific ACGME standards for resident duty hours.

1. Duty hours are defined as all clinical and academic activities related to the training program, i.e., patient care (both inpatient and outpatient), 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.

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

3. Housestaff are provided with 1 day in 7 free from all educational and clinical responsibilities (at-home call cannot be assigned), 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.

4. Adequate time for rest and personal activities is provided. There should be at least a 10-hour time period provided between all daily duty periods and after in-house call. Program directors will assure that all housestaff are in compliance with RRC specialty requirements.

5. Program Directors are required to take corrective action to prevent repetitive duty hours violations.

On-Call Activities *(In-House Call is NOT applicable to Ophthalmology)*

1. The objective of on-call activities is to provide housestaff with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal workday when housestaff are required to be immediately available in the assigned institution.

2. In-house call is no more frequent than every third night, averaged over a four-week period.

3. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Housestaff may remain on duty for up to four 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.

4. No new patients may be accepted after 24 hours of continuous duty.
5. At-home call (pager call) is defined as call taken from outside the assigned institution.

   a. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Housestaff taking at-home call are provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

   b. When housestaff are called into the hospital from home, the hours housestaff spend in-house are counted toward the 80-hour limit.

   c. The program director and the faculty monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

The Department of Ophthalmology duty hours will be monitored in accordance with the ACGME guidelines. Individual ophthalmology duty hours will be monitoring by the Residency Program Director, Chairman and/or Residency Coordinator. Residents will be responsible for entering their duty hours using New Innovations.

Medical Student Duty Hours: Medical Students must adhere to the same duty hour policy and procedures as residents.

For details concerning the institutional policy, please refer to the Graduate Medical Education website.

**Leave / Vacations**

**Sick Leave:** For illness, emergencies or other significant absences, please inform the residency coordinator at (804) 828-5208 and one of the staff ophthalmologists whose service you are currently rotating on.

**Family & Medical Leave:** Family and Medical leave for members of the housestaff complies with the Family and Medical Leave policy established by Virginia Commonwealth University and the Medical College of Virginia Hospitals. It allows for up to 12 weeks of paid [sick or vacation] and/or unpaid leave within the guidelines of the policy. A major consideration for this leave is its potential effect on training completion to be determined by the Program Director, Chairman, and faculty.

**Vacation:** All housestaff receive three (3) weeks of vacation. Additional compensation is not provided in lieu of vacation. It may not carry forward.

**Holiday and Compensatory Time:** The resident follows the rotation schedule of the service to which he or she is assigned for that month. For example if a clinic is closed on Saturday and/or Sunday, the resident is not required to work unless otherwise assigned. The same is true with holidays. The resident is not eligible for compensatory time.
Leave of Absence: Residents may request a leave of absence from their program director. The decision to grant the leave will be reviewed by the program director and the Director of Graduate Medical Education. Part of the review will be based upon the impact of this leave to the program and to the resident’s completion of training.

Bereavement Leave/Family Sick Leave: A resident may be allowed up to three (3) days per year of Bereavement Leave or Family Sick for an immediate family member. This leave is to come from Sick leave.

First and Second Year Residents:
1. For first and second year residents, there will be a total of three weeks of vacation allowed per year. One week is defined as Sunday through Saturday.

2. Two of the three weeks must be taken in weeklong blocks, with one full week allowed per four-month period. The third week of vacation may be taken in either four-month period, and may be used as follows:
   a. As a weeklong block. Two full weeks will not be allowed while on the same service unless approved by staff.
   b. Split into 2 or 3 periods of any combination of days that can be used at any time of the year.
      For example:  2 weekdays + 3 weekdays
                  3 weekdays + 1 weekday + 1 weekday

Third Year Residents:
3. The vacation policy for 3rd year residents will continue as before with one week allowed in a four-month rotation. An attempt will be made to offer flexibility in scheduling interviews for jobs/fellowships. No resident will be allowed to take more than two weeks (combination vacation and/or meeting time) away from any four-month rotation unless with written permission by the staff person(s) affected by this leave, the program director and the chairman.

All Residents:
4. Vacation will not be allowed during the first or last week of a four-month period except at the discretion of the program director and chairman. An annual leave is NOT to be taken during the selected dates below:
   a. July 1st – July 31st
   b. Resident Interview dates
   c. The month of February (Basic Science Course)
   d. The week preceding the OKAP examination
   e. June 15th – June 30th
   f. Scheduled site reviews by RRC or ACGME
   g. Graduation Day
   h. Visiting professor dates
   i. Tri-state Lectures: EVMS, UVA, VCU Wet Lab
   j. VSO Lecture

Note: First year residents start dates for vacation will commence on September 1st.
5. To avoid conflicts, ONLY one resident may be away on a given service at a given time. Additionally, ONLY one resident may be on leave at a given time, if rotating at the VAMC.

6. If a resident is the sole person on a particular rotation, it is the responsibility of the resident to inform the attending of his/her absence during the desired time period. This will allow the attending to adjust schedules accordingly.

7. Vacation cannot be carried over year to year.

8. The residency coordinator in the Department distributes a calendar for OKAPs, Research Day, Visiting Professor, Resident Interview Days, CME Courses to all residents so that they can avoid scheduling vacation on these dates. Residents are required to attend all of these events.

9. All residents are to give a copy of their vacation requests to the residency coordinator for approval and to allow tracking of vacation time. Coordinator will confirm leave balances, timely submission, and availability. Once approved, coordinator will email the resident confirming dates.

10. Problems with vacation scheduling should be discussed with the Residency Program Coordinator and Director.

11. Residents must take at least one week of their vacation while on a VAMC rotation. Leave requests for time off during the VAMC rotations must be submitted at least 45 days prior to the requested leave.

For leave requests during the VAMC rotation, the following requirements must be followed:

1. Residents are allowed 1 weeks’ vacation during their VAMC rotation.
2. Only one resident can be away at any given time.
3. Leave request forms must be submitted to the coordinator.
4. The coordinator will confirm leave balances and obtain approval from Dr. Mahmood at the VAMC.

12. Within each year of residents, no preference will be made as to who receives the particular vacation days. Each request will be on a first come first serve basis.

a. In the event everyone submits their vacation requests at the same time, a lottery will be issues for order of particular days. It is strongly encouraged that the residents communicate with each other to assure a well distributed and equitable vacation schedule is maintained.

b. All disputes will be settled expeditiously by the residency program director as determined strictly by the resident handbook guidelines. The residency program director has the authority to see passed these guidelines as appropriately deemed on an individual basis.
c. Exceptions for multiple resident absences will be taken under consideration by the residency coordinator, program director and chairman especially under the following circumstances:
   ii. Personal or family illnesses, deaths or milestone celebrations.
   iii. Meetings or educational activities
   iv. Job or fellowship interviews
   v. Individual needs particular to a situation

You are expected to attend scheduled educational functions at the University on the Friday afternoon preceding your vacation, which begins on a weekend or Monday. We do not want people leaving early and missing the Friday afternoon education time. This is critical to your education and required for approval of our residency program by the Residency Review Committee. We have limited educational time, and we expect everyone to attend unless the vacation specifically includes that day.

In planning, please consider the following:

1. The Leave Request Form provided by the residency coordinator is to be submitted no less than 8 weeks in advance. In the event this is not possible, the program director will determine approval status on a case-by-case basis.
2. Notify any residents who are on the same service of your proposed vacation.
3. Residents should not be away on leave at the same time.
4. No vacation time will be granted without the proper notification or approval. **Unexcused leave will prompt severe and formal citations to be placed in the resident official file.**
5. Absences for personal reasons, such as observing religious holidays that may fall on a day when the hospital and clinics are in operation, are chargeable to annual leave. A calendar of recognized hospital holidays is available through the GME office.

**Note:** Exceptions to the detailed above vacation policy will be granted on an individual basis by the program director and chair.

**Policy on effect of Leave for Satisfying Completion of Program**

The length of time of residency training for a particular resident may be extended at the discretion of the program director and the GME office if a resident is granted personal or an academic leave. If the extension is only six months or less, the program director must notify the Residency Review Committee of the extension and must describe the proposed curriculum for that resident and the measures taken to minimize the impact on other residents governed by the ACMGE.
The Department of Ophthalmology follows the institutional policy regarding the assessment of residents in Graduate Medical Education Programs.

The Assessment Policy governs the qualification of residents to remain in training as well as their completion of residency certification requirements, and its provisions apply in all instances in which such qualification and/or certification is at question. The Department of Ophthalmology continuously evaluates its residents, faculty, and program for the purpose of assessing competency, compliance, and need for improvement.

The program director is primarily responsible for monitoring the competence and professionalism of the ophthalmology residents. Various assessment methods are utilized throughout the academic year. Evaluation methods include:

Evaluation of Residents:
- Bi-Annual Review
- 360 Evaluation
- Grand Rounds / Journal Club Assessment
- Rotation evaluation by Faculty
- OCEX
- Surgical Skills Assessment
- Exit Evaluation
- Milestones

Evaluation of Faculty:
- Evaluation of Faculty by Resident

Evaluation of Program:
- Evaluation of Program by Resident
- Evaluation of Program by Faculty

The performance criteria on which the residents are evaluated is based on the 6 ACGME core competencies and the goals and objectives listed in the Resident Handbook. Each resident is provided with a hard copy of the handbook during orientation and are required to review the goals and objectives prior to each rotation.

In addition to the evaluation methods listed above, residents are provided with direct one-on-one verbal communication as an integral assessment method utilized in daily resident education. During the biannual program director’s meeting, a review of expected and achieved resident milestones provide structure for evaluating the individual’s education accomplishments based on the core competencies. In addition, the ophthalmic clinical evaluation exercise (OCEX) serves as an important assessment tool in evaluation residents.
Faculty evaluators are educated about core competency-based assessment methods during the year. Faculty review educational goals and objectives and make any necessary changes on an annual basis. In order that evaluations are completed in a timely fashion, email reminders are sent to faculty advising them of the opened evaluation period in New Innovations. A follow-up email is sent at the end of each rotation reminding those evaluators who have not yet completed the evaluations of the deadline. Every measure is taken to assure that evaluation compliance is taken seriously. Faculty evaluation compliance reports are generated by the program coordinator and reviewed with the Program Director. Faculty members that fail to complete evaluations by the allowed time will be addressed by the Program Director and Chair.

The Program Director evaluates each resident twice a year as part of the bi-annual program director’s meeting. Prior to this meeting, residents complete a self-assessment/reflection questionnaire which is reviewed with the program director. During this meeting, residents review various reports including: all faculty rotational evaluations, procedural report cards, conference attendance reports, duty hours compliance, chart audit results, surgical assessments, operative case logs and developmental milestones. The program director and resident review the overall performance and formulate an individual education plan (IEP) for the subsequent six months. This is reviewed again in the upcoming semiannual meeting. Evaluations are signed by both the program director and resident and are kept in the resident’s portfolio located in the program coordinator’s office. The residents portfolio can be reviewed at any time during the residency training.

Faculty members are evaluated by the residents annually. The confidential results are tabulated and compiled for review by the program coordinator to assure anonymity. The compiled data is then reviewed by the program chair, program director, and faculty member; at which time a faculty evaluation review form is completed.

Finally, the residency program is evaluated by both the resident and faculty members. The results are tabulated and compiled for review at the annual Resident Education Committee Meeting. Residents’ performance and program evaluation results are discussed in detail including OKAP results and board pass rates. Corrective measures are taken to improve the program.

**Revision Approved by Program Director 10/31/11**

**Policy for Processing Anonymous Evaluations**

The ACGME requires that faculty members sign evaluations they complete of training physicians. Programs may elect to have additional health care staff evaluate the training physician, including peers or other co-workers (i.e., technicians, supervisors, etc.). These evaluations should be kept anonymous from the training physician being evaluated, to the extent possible under the law. Anonymity may be maintained by having a summary of these evaluations prepared by the program director or coordinator, which is then placed in the training physician file. The evaluation instrument itself may be destroyed or, if kept, assurance should be made that the anonymity of the evaluator is maintained.
VCUHS Medical Staff Impairment Policy - VCU Policy

I. Purpose: To define the VCU Health Systems’ policy and procedure for addressing potential impairment among physicians, dentists, and other practitioner medical staff.

II. Philosophy: The VCU Health System leadership recognizes that the knowledge and skills possessed by the medical staff are a vital asset in fulfilling the mission and vision of the academic medical center. In addition, leadership recognizes that physical, psychiatric, and behavioral disorders among physicians, dentists, and other practitioner medical staff can jeopardize the health of the provider as well as that of their patients. Thus, the VCU Health System strives to create an environment in which impairment among providers is recognized and addressed in a fair, confidential, and effective manner, while preserving both the practitioner’s dignity and the patient’s right to safe and effective health care.

III. Policy: The VCU Health System shall maintain a Medical Staff Health Committee (MSHC) to which any member of the medical staff, employee, patient, or guest may refer concerns about a potentially impaired practitioner. The MSHC will evaluate such concerns and ensure follow-up and referral as appropriate and consistent with applicable regulations.

IV. Definitions:

1. Medical staff: any physician, dentist, or other practitioner credentialed to provide patient care by VCU Health System.
2. Impairment: any physical or mental disability which substantially alters the ability of a practitioner to practice his or her profession with safety to his/her patients and the public.

V. Procedure:

1. Medical Staff Health Committee Membership: The VCU Health System Medical Staff shall maintain a Medical Staff Health Committee. The committee will be comprised of one physician member of the medical staff from each of the following departments: Anesthesiology, Emergency Medicine, Family Practice, Internal Medicine, Neurology, Ophthalmology, Orthopedics, PM&R, Psychiatry and Surgery. The committee chair and vice-chair will be appointed by the Medical Staff Executive Committee.

2. Contacting the Medical Staff Health Committee: VCUHS shall publish a telephone number, 828-2200, that can be used to leave confidential messages regarding potentially impaired providers. In addition, referrals may be made to the Medical Staff Health Committee by addressing written correspondence to: Medical Staff Health Committee, Box 980510, Richmond, Virginia, 23298-0510.

3. Educational role of the Medical Staff Health Committee: The MSHC will periodically distribute to the medical staff and VCUHS employees information regarding the recognition of potential impairment among health care providers. In addition, the MSHC will educate the medical staff and employees regarding the available resources for reporting concerns regarding potentially impaired providers, and for self-referral for treatment.
4. **Referrals to the Medical Staff Health Committee:** The MSHC staff will receive written and telephone referrals and notify the chair of the committee or his/her designee and the appropriate department chair regarding the referral. The staff will then conduct a preliminary investigation, the purpose of which is to obtain enough information to determine if there is a basis for the concern and if there is potential for eminent harm to patients, staff, or others. The investigation will be done in as confidential a manner as possible.

a. Upon completion of the preliminary investigation, MSHC staff will contact the MSHC chair or designee and the department chair (or Chief Medical Officer or Dean if the issue concerns a department chair) and apprise them of the results of their initial investigation. The department chair and MSHC chair will determine if a reasonable potential for patient harm due to possible impairment exists, and if so, the medical staff member will be placed immediately on administrative leave by the department chair pending further investigation.

b. If the possibility of impairment due to drug or alcohol abuse exists, further evaluation will be performed according to the attached “Guidelines for Evaluating Possible Use of Alcohol or other Substances among VCU Health System Medical Staff”.

c. For potential impairment unrelated to alcohol or drug use, further investigation will proceed as follows:

   i. The MSHC chair or designee and department chair will interview the medical staff member regarding the concern.

   ii. If the medical staff member can provide a satisfactory explanation regarding the concerns raised, the matter will be dropped with no further evaluation needed.

   iii. The medical staff member can agree that an issue exists and work with the MSHC chair and department chair and MSHC staff to obtain appropriate follow-up.

   iv. If the department chair and/or MSHC chair find the medical staff member’s explanation unsatisfactory, the MSHC chair will refer the case to the full MSHC for review.

   v. The MSHC will conduct a review of the matter to include all of the material, information, interviews that it deems reasonable and necessary in order to determine if an impairment exists. Based on its findings, the committee will vote to:

      (1) close the case (no issue exists or no way to verify the concern raised);

      (2) refer the medical staff member for intervention
d. If the MSHC recommends referral for intervention, the chair of the MSHC and the department chair will meet with the involved medical staff member and inform him/her of the committee’s decision.

e. If the medical staff member agrees with the committee’s recommendation, he/she will follow-up as recommended. If the physician disagrees, the matter will be referred to the Medical Staff Executive Committee for review. The decision of the Executive Committee will be final.

f. If a medical staff member fails to follow through with a referral as recommended by the committee, the chair of the MSHC will report this to the Chief Medical Officer (CMO) and the Chair of the Credentials Committee. The CMO will make the necessary reports to the appropriate licensing board and determine along with the Credential’s Committee Chair if actions need to be taken with regard to the medical staff member’s clinical privileges.

5. Reporting
As required by Virginia Code §54.1-2906-9, the Chief Medical Officer may be required to report investigation results to the Virginia Board of Health Professions, the National Practitioner Data Bank as required under U.S.C. § 11101 et seq. and/or other regulatory agencies as required by law or regulations. In such cases, the medical staff member will be provided a copy of the report as applicable to the law or regulation.
VIRGINIA COMMONWEALTH UNIVERSITY DEPARTMENT OF OPHTHALMOLOGY
GRADUATE MEDICAL EDUCATION SUPERVISION POLICY

The Department of Ophthalmology must provide appropriate supervision for all residents that is consistent with patient safety and quality of patient care, the educational needs of residents and the pertinent program requirements. Residents are supervised in accordance with the policies and procedures of the VCU Health System GME committee, as described on their website (http://www.medschool.vcu.edu/gme/policies/index.html) and in accordance with the Accreditation Council for Graduate Medical Education (ACGME) Program Requirements (www.acgme.org).

GENERAL PRINCIPLES

As outlined in the Joint Statement on Supervision by the Virginia medical schools, the Department of Ophthalmology at Virginia Commonwealth University agrees with the philosophy that the most effective learning environment for post-graduate medical trainees is one that allows sufficient freedom for residents and fellows to assume primary responsibility for decision-making in patient care, and yet provides adequate faculty presence and involvement in order to provide feedback to trainees about their actions, and to guarantee the quality and safety of the care rendered to patients.

In order to preserve this type of learning environment for its teaching program, the Department of Ophthalmology advocates the following principles as elements of its policy on housestaff education and supervision. The provisions of this policy also apply to teaching activities at other affiliated teaching sites. These other sites may supplement this policy with additional rules as dictated by their own governance structure.

1) All residents, without exception, will function under the supervision of attending physicians including: outpatient clinic, inpatient consultations, and procedures in clinic and operating room. All surgical procedures which occur in the operating room must be have direct supervision by the attending physician. The attending physician retains the overall obligation of supervision (indirect and direct) and therefore, must be immediately available to the resident. The Residency Program Director is responsible for ensuring, coordinating and documenting adequate supervision of residents at all times.

2) Attending physicians maintain the ultimate responsibility for the patient’s care.

   a. All residents are provided with a list of all faculty members’ contact information, which include home, cell, and/or pager numbers through which they can be contacted directly.

   b. Residents must call the attending of record immediately (regardless of the time of day) in the event that they have questions or are uncomfortable with the care of their patients. This includes, but are not limited to the following situations:

      i. Uncertainty of substantial controversy about clinical care decisions

      ii. Change in service for management of an acute medical condition
iii. Need for surgical intervention
iv. Change in level of care
v. Unexpected death of a patient
vi. Any other serious change in clinical condition
vii. Patient insistence on leaving facility against medical advice

c. Residents MUST examine the patient AND call the attending of record prior to scheduling ANY procedure.

3) On-call schedules for teaching faculty will be structured to ensure indirect supervision with direct supervision immediately available.

4) Faculty and residents are educated to recognize the signs of fatigue and will adopt and apply policies to prevent and counteract the potential negative effects. A list of resources concerning sleep deprivation is available at http://www.acgme.org/acWebsite/dutyHours/dh_sleepdepbib2.pdf.

a. Additionally, faculty and residents are provided with an annual lecture on recognizing and addressing the signs and symptoms of fatigue/sleep deprivation.
b. A learning activity on fatigue is also included in our annual residency retreat.

LEVELS OF SUPERVISION DEFINED

For the purpose of this policy document, the levels of supervision will be characterized using the terms defined by the ACGME. The terms are defined as follows:

1) Direct Supervision – the supervising physician is physically present with the resident and patient.
2) Indirect Supervision with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
3) Indirect Supervision with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
4) Oversight - the supervising physician is available to provide review of procedures.

OUTPATIENT EYE CLINICS at VCUHS and VAMC

a. General Eye Clinic & Subspecialty Clinic:
   i. All patient encounters in the ambulatory setting will be supervised by an attending physician who will serve as the attending of record the patient encounter. This physician is ultimately responsible for the care provided to the patient during the encounter. This attending physician should be identified easily in the patient record and should sign off on all documentation for the encounter. The level of supervision required varies by state of training as noted below:
ii. All PGY2 residents function under Direct Supervision for the first six months of training in all ambulatory settings. Supervision MUST be provided by an attending physician.

iii. All PGY3 and PGY4 residents will function under Indirect Supervision with Direct Supervision immediately available (at a minimum). Supervision MUST be provided by an attending physician.

iv. PGY3 and PGY4 residents are expected to assume leadership role in the teaching of PGY2 residents and other medical students present in the clinic.

b. Hospital Consultations

i. PGY2 & PGY3 residents are responsible for hospital consults. Residents will function under Indirect Supervision with Direct Supervision immediately available (at a minimum). Supervision MUST be provided by an attending physician.

ii. All initial consult, follow-up consult, and procedure notes generated by a housestaff member are to be forwarded to the responsible supervising attending for review and signature regardless of whether a billable service was produced by the attending physician for the purpose of supervision.

PROCEDURAL RESPONSIBILITIES

Level of supervision requirements for procedures are independent of year of training. In all settings, trainees at all levels will perform procedures under Direct Supervision until they have demonstrated proficiency in that procedure, as required by the individual department for that specific procedure. All residents will be supervised by an attending physician proficient in the specific procedure.

Once proficiency in a procedure is identified, the trainee is “credentialed” in that procedure in an electronic tracking system (New Innovations) and may perform that procedure with Direct Supervision available.

For patient safety purposes, scope of practice for independent performance of procedures is identified in an electronic logging system (New Innovations) which is updated continuously and available for review by any healthcare practitioner in all practice settings. In this system, any provider (nurses, residents, physicians, others) responsible for the patient’s management, is able to independently confirm the credential status in advance of the procedure being performed as necessary.

A) Clinic Procedures

a. Procedures performed in the clinic will be directly and indirectly supervised.
   i. Direct supervision will be provided for residents not credentialed in a given procedure.
   ii. Indirect supervision will provided for residents who are “credentialed”.

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B) Operating Room Procedures
   a. ALL procedures performed in the operating room REQUIRE Direct Supervision. Procedure notes generated by a housestaff member are to be forwarded to the responsible supervising attending for review and signature regardless of whether a billable service was produced by the attending physician for the purpose of supervision.

AT HOME CALL

1) All ophthalmology call is “at-home” call. PGY2 and PGY3 residents serve as primary call with a PGY4 backup, and indirect supervision is provided by an attending physician – with Direct Supervision immediately available.

2) Procedure notes generated by a housestaff member are to be forwarded to the responsible supervising attending for review and signature regardless of whether a billable service was produced by the attending physician for the purpose of supervision.

GRADED RESPONSIBILITY

All patients are under the direct care and supervision of the faculty. Although, residents have varying levels of responsibility, depending on their level of training, the attending physician is ultimately responsible for the patient’s care. In the outpatient setting, direct supervision of residents is required for all first year residents (PGY-2). Over time, as residents mature clinically, supervision is graduated from direct to indirect in order to develop independence and responsibility for patient care.

Over the course of the three year Ophthalmology Residency Training Program, a resident is expected to be able to perform an increasing level of clinical function and responsibility. Maturation is determined through an objective evaluation process and is tailored to the residents post-graduate year. Over the course of training, residents will be required to meet the milestones set forth by the department of ophthalmology to demonstrate progression and independence. Achievement of these milestones will be observed and documented by the faculty members.

For example: Prior to beginning their residency training, rising first year residents are sent the “Practical Ophthalmology: A Manual for Beginning Residents”, a handbook for ophthalmic instrumentation, exam techniques and physical diagnosis in addition to a 13 volume “Basic and Clinical Science in Ophthalmology” book series. During the first month of their residency they will be oriented to the department and have practical exposure to instrumentation and ophthalmic examination. At the conclusion of their first month, first year residents will be required to pass a written and practical examination covering these topics after which they will be allowed to participate in patient care. Further, during the first six months of their training, a special course for first year residents only, will be provided by the Program Director to reinforce these concepts.
As residents progress through the residency program, they are encouraged to assume increasing levels of responsibility with regard to patient care, commensurate with their individual progress in experience, skill, knowledge and judgment. This includes the supervision of junior residents and medical students. Members of the attending staff are always available for consultation in these settings. The overriding consideration must be the safe and effective care of the patient which is the personal responsibility of the supervising attending physician.

SUPERVISION POLICY REVISED and APPROVED BY PROGRAM DIRECTOR 10/20/2011

**Monitoring of Resident Well-Being (Departmental Policy)**

The program director is responsible for monitoring resident stress, including mental or emotional conditions inhibiting performance or leaning, and drug or alcohol-related dysfunction. Both the program director and faculty should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. Situations that demand excessive service or that consistently produce undesirable stress on residents must be evaluated and modified. If a resident is especially fatigued or stressed and unable to provide safe patient care they should contact the program director immediately.

**DISCIPLINARY AND GRIEVANCE PROCEDURES**

**Grievance:** Grievance is defined as any unresolved dispute or complaint a resident or fellow has with the policies or procedures of the Residency Training Program or any unresolved dispute or complaint with his or her Program Director or other faculty member.

**Purpose**

To provide a mechanism for resolving disputes and complaints which may arise between postgraduate residents and fellows and their program director or other faculty member

**Policy**

Housestaff may appeal disagreements, disputes, or conflicts with their program using the procedure outlined below. This grievance procedure does not cover controversies or complaints arising out of (1) termination of a resident/fellow during an annual contract period; (2) alleged discrimination; (3) sexual harassment; (4) salary or benefit issues.

**Procedure:**

A. Informal Resolution - Step I:

A good faith effort will be made by an aggrieved resident/fellow and the Program Director to resolve a grievance at an informal level which will begin with the aggrieved resident/fellow notifying the Program Director, in writing, of the grievance. This notification should include all pertinent information and evidence which supports the grievance. Within seven (7) calendar days after notice of the grievance is given to the Program Director, the resident/fellow and the Program Director will set a mutually convenient time to discuss the complaint and attempt to reach a solution. Step I of the informal process of the grievance procedure will be deemed complete when the Program Director informs the aggrieved resident/fellow in writing of the final decision. A copy of the Program Director’s final decision will be sent to the Department Chair and to the Director of Graduate Medical Education.

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B. Informal Resolution - Step II

If the Program Director’s final written decision is not acceptable to the aggrieved resident/fellow, the resident/fellow may choose to proceed to a second informal resolution step which will begin with the aggrieved resident/fellow notifying the Department Chairman of the grievance in writing. Such notification must occur within 10 work days of receipt of the Program Director’s final decision. This notification should include all pertinent information, including a copy of the Program Director’s final written decision, and evidence which supports the grievance. Within seven (7) calendar days of receipt of the grievance, the resident/fellow and the Department Chairman will set a mutually convenient time to discuss the complaint and attempt to reach a solution. Step two of the informal process of this grievance procedure will be deemed complete when the Department Chairman informs the aggrieved resident/fellow in writing of the final decision. Copies of this decision will be kept on file in the Chairman’s office and sent to the Director of Graduate Medical Education.

C. Formal Resolution

If the resident/fellow disagrees with the Department Chairman’s final decision, he or she may pursue formal resolution of the grievance. The aggrieved resident/fellow must initiate the formal resolution process by presenting their grievance, in writing, along with copies of the final written decisions from the Program Director and Department Chairman and any other pertinent information, to the office of the Associate Dean of Graduate Medical Education within fifteen days of receipt of Department Chairman’s final written decision. Failure to submit the grievance in the fifteen-day time frame will result in the resident/fellow waiving his or her right to proceed further with this procedure. In this situation, the decision of the Department Chairman will be final.

Upon timely receipt of the written grievance, the Associate Dean of Graduate Medical Education will appoint a Grievance Committee and will contact the aggrieved resident/fellow to set a mutually convenient time to meet. The Grievance Committee will review and carefully consider all material presented by the resident/fellow and his or her Program Director or the grieveable party at the scheduled meeting, following the protocol outlined in Section E.

The Grievance Committee will provide the aggrieved resident/fellow with a written decision within five days of the meeting and a copy will be placed on file in the Graduate Medical Education Office. The decision of the Grievance Committee will be final.

D. The Grievance Committee

Upon request for a formal resolution, the Associate Dean of GME will form a Grievance Committee composed of two Housestaff Council members, two Program Directors, and the Director of the GME office. No members of this committee will be from the aggrieved resident’s/fellow’s own department. The Associate Dean of GME will choose a member to be the chair of the committee.
E. Grievance Committee Procedure

1. Attendance: All committee members should be present throughout the hearing. The resident/fellow must personally appear at the Grievance Committee meeting.

2. Conduct of Hearing: The chair will preside over the hearing, determine procedure, assure there is reasonable opportunity to present relevant oral or written information, and maintain decorum. The Chair will determine if information is relevant to the hearing and should be presented or excluded. The chair is authorized to exclude or remove any person who is disruptive.

3. Recesses and Adjournment: The committee chair may recess and reconvene the hearing. Upon conclusion of the presentation of oral and written information, the hearing record is closed. The Grievance Committee will deliberate outside the presence of the involved parties.

4. Decisions: Decisions are determined by a majority of members of the Committee and are final. After deliberation, the decision will be reviewed and signed by the Committee members.

5. Meeting Record: A secretary/transcriptionist may be present for the purpose of recording the meeting minutes. Minutes and the final written decision of the Committee will be placed on file in the GME office.

Confidentiality:

All participants in the grievance are expected to maintain confidentiality of the grievance process by not discussing the matter under review with any third party except as may be required for purposes of the grievance procedures.

(Please refer to website for Graduate Medical Education Medical School Policy on the following in the Housestaff Manual: Discipline/Dismissal of Residents, Regents’ Student Academic Grievance Policy, University Senate Policy on Sexual Harassment, Resident Procedure for Reporting Sexual Harassment and Discrimination, and Sexual Assault Victim’s Rights Policy.)

Promotion, Probation and Dismissal

Policies and procedures regarding academic promotion, probation, and dismissal are the same as those of the VCUHS Graduate Medical Education Committee. They are:

Each rotational faculty member has the responsibility for a written evaluation of each of their residents every four months (rotational trimester). These evaluations should cover all areas of performance that are crucial to the practice of medicine in the stated specialty. Evaluations of ethical, professional, and personal conduct toward patients, peers and staff should be noted.
Each department chair shall appoint a department committee or use the entire faculty of the department to review these evaluations. This committee shall be responsible for all decisions involving academic promotion, probation and/or dismissal.

The evaluations, when performed by faculty and/or faculty committee for each resident, shall be reviewed at least every six months by the chair or a designee. Summary evaluations for residents with deficiencies shall be issued within six months and final evaluations on all residents within twelve months. These summary evaluations shall reflect the review of the evaluations and the final recommendations of the committee.

At the six-month interval, recommendations can be satisfactory (or more), less than satisfactory, warning or probation. At the twelve-month evaluation, promotion, dismissal or probational repeat of a specified portion of the year can be made. During any portion of the residency year, evaluations that provide written evidence of serious deficiencies shall be brought to the attention of the chair and the department committee. If the committee and the chair agree that there are serious deficiencies, the resident shall be warned within 10 days after such deficiencies are brought to the attention of the committee. The resident may be placed on probational status, in which case the following will be specified:

- Specifications of all deficiencies
- Length of time given to show positive change in these deficiencies
- Methods by which these deficiencies will be evaluated

The resident will be counseled and the document signed by the resident and faculty counselor. A minimum length of time for a probational period and evaluation is three months. At the end of that time, the committee must evaluate the resident.

At this point, the committee and the chair can dismiss the resident, continue the probation for at least another three months or remove the probation. The resident will again be counseled and the document signed as before. The action of the committee must be documented in the evaluation. If a resident is to be dismissed from the program, notification must be at least three months in advance of the effective date of the decision.

**Appeals: Policy and Procedure**

**Resident Training Committee and Department Chair**

Within 10 days of the receipt of notification of dismissal, a resident has the right to appeal this decision to the committee and to the chair. In both cases he has the right to provide written evidence, or to have others provide oral evidence and appear in person in support of his appeal of the action taken. If the resident is not satisfied with this level of appeal, he can proceed within 10 days to the next level.
Appeal to Director of Graduate Medical Education

The resident may appeal to the associate dean within 10 days of the final decision of the department chair and committee. The associate dean must gather all evidence, hear all presentations, and hear the appeal from the resident within 10 days of receipt of the request. The resident must be notified of the associate dean’s decision within 10 days. If he remains dissatisfied with the decision, he may appeal to the next level.

Appeal to the Dean of School of medicine

The resident may appeal to the Dean of the School of Medicine within 10 days after the associate dean has rendered his/her decision. The dean appoints a graduate medical education appeals committee to review and hear all evidence from others as well as the resident. The appeals committee must reach a final recommendation within 14 days of the receipt of the appeal. The dean is provided with the final recommendation of the appeals committee and has 14 days to review all of these recommendations, reach a decision, and notify the resident of the final decision.

Suspension

It is the prerogative of the department to suspend the resident from any clinical activity during the time of the appeals process. Reinstatement of activities does not guarantee successful completion of the program, or that the candidate will be recommended for specialty board examination.

Administration

Please refer to [www.vcu.edu](http://www.vcu.edu) for Medical School Policy on the following: University Physicians, Administrative Contact List, Medical School Organizational Chart, and GME Organization Chart.)
Professional Attire

VCU Health System
Graduate Medical Education Guideline

I. Purpose
To provide guidance on appropriate attire to individuals enrolled in graduate medical education programs and their supervisors. Each clinical department or division should establish dress codes specific for their areas and patient population.

II. Background
A patient’s perception of a provider’s competence may be influenced by the provider’s attire and appearance. Inappropriate appearance or attire can make the patient uncomfortable and interfere with the establishment of effective communication and/or rapport with them. The ability to develop effective interpersonal relationships and communication may be impacted by inappropriate attire and appearance and this may ultimately impact patient care. Therefore the ACGME General Competencies of Professionalism, Patient Care, and Interpersonal Relationships and Communication are each potentially affected by the attire and appearance of the provider. It is therefore appropriate for supervisors to monitor and evaluate provider attire and appearance.

III. General Guidelines
- All attire should be clean, neat and of appropriate size.
- Scrubs should only be worn in designated areas. If they must be worn outside of these areas, a white coat should be worn over the scrubs.
- Females should wear dresses or skirts of knee length or longer or dress pants and blouses. Exposure of the abdomen or chest due to low cut shirts or pants is not appropriate.
- Jewelry and perfume/cologne should be worn at a minimum or not at all.
- Earrings should be worn in a professional manner and are limited to 1-2 per ear.
- With the exception of ear piercing, there should be no visible body piercing, including but not limited to tongue piercing, nose piercing, and eyebrow rings / bars.
- Hair should be clean, well groomed, and worn in such a manner that it will not interfere with patient care or job duties and will present a professional image. Facial hair must be trimmed and kept clean.
- Head coverings worn for religious purposes are permitted. Hats are otherwise not allowed.
- Make-up may be worn in moderation.
- Fingernails should kept short, clean, neatly manicured and not extend ¼ inch past the fingertips. Artificial nails and nail jewelry are prohibited per Health
Department regulations in any patient care role. Artificial nails are defined as any application of a product to the nail to include, but not limited to, acrylic, overlay, tips or silk wraps (does not refer to nail polish). Chipped nail polish is not permitted.

- There will be no visible tattoos; any visible tattoo must be covered with a bandage or clothing.
- Low or moderate heel shoes are recommended.
- The VCUCARD MUST be worn at all times.

IV. Process

Program directors and supervisors should monitor and address inappropriate attire by their subordinates as it may negatively impact patient care activities. Persistent inappropriate attire and appearance should be addressed as outlined in “The Assessment, Promotion, Discipline and Dismissal of Residents in Graduate Medical Education Programs” policy.

Reviewed, updated and approved GMEC September 12, 2006

Departmental Highlight for Professional Dress

Residents are expected to dress according to general accepted professional standards for their training program. Residents are expected to be neat, clean and orderly at all times during performance of training program activities. Jewelry, clothes, hairstyles and fragrances should be appropriate for the performance of duties in the hospital or clinic. A white coat must be worn over the scrub suit when not in the operating room. Scrubs are not to be worn in during regular duty hours unless it is the intent to return to the operating room in that same day.

The resident identification badge is to be worn whenever the resident is involved in clinical or administrative duties.

Weekend and off-hours dress code

Residents at the VCHHS often have to see patients on weekends and after normal duty hours. Common sense should dictate what the residents wear. Shorts and tee shirts are not acceptable. Jeans can be worn but should be in good condition (not faded, no holes). Shirts should have a collar. A tie is not mandatory. A white coat is encouraged.

Scrubs can be worn to see patients on weekends or off-hours.
Health and Dental Insurance Coverage

Contact Health Services for information and questions or contact Cathy Kercheval with Insurance Benefits at (804) 628-3724.

Long-Term Disability Coverage

See GME website for information and questions or contact Cathy Kercheval with Insurance Benefits at (804) 628-3724.

Short Disability Coverage

Information is available on the GME website or contact Cathy Kercheval with Benefits at (804) 628-3724.

Professional Liability Insurance

See GME website for information and questions or contact the department of risk management at (804) 828-1707.

Life Insurance

Information is available on the GME website or contact Cathy Kercheval with Benefits at (804) 628-3724.

On Call Meal Allowances

On call meal allowances are determined by the GME office based on the on-call schedule. An amount is allocated two times a year (July and December). Balances will not carry over from year to year. Allowances are to be used at the resident’s discretion in the hospital cafeteria, Chick fillet, Alpine bagels and Subway. The cards are considered the personal responsibility of the resident/fellow, and cannot be borrowed or loaned. If a Resident forgets their card; they must pay cash for that meal. There is no alternative system to pay for meals.

Laundry Responsibilities

The residents are responsible for laundering their own white coats throughout the year.

Parking

While rotating at the University, residents will be granted subsidized parking for the D Deck level of the Parking garage. These parking cards need to be renewed annually. Parking decal are issues during orientation through the GME office.
STIPEND POLICY FOR RESIDENT/FELLOW POSITIONS

The stipend of residents/fellows shall be based on the appropriate Post Graduate Year (PGY) in the residency training program, according to specialty or subspecialty Board requirements for certification. The following shall not affect the level of payment:

1. Advanced Training – a resident enters a training program with more years experience than required as clinical base according to Board requirements for certification. In the event that a resident changes his/her specialty, he/she shall receive credit for only those years which are acceptable as Board requirements for certification in that specialty or subspecialty.
2. Dual Training – a resident enters a training program after completing Board requirements in another specialty. He/She shall receive credit for only those years which are acceptable as Board requirements for certification in that specialty which s/he is entering.
3. Repeat years(s) – A resident is requested to repeat a year in the training program due to inadequate performance. S/he will not receive credit for that year and will continue to be paid at the same PGY level.
4. Research year(s) – A resident enters research training year(s), under current policy, research year(s) are not funded by MCVH or the VA. Upon returning to full-time clinical training and hospital funding, s/he will receive credit only for the number of research years approved by the Board for certification, required by the training program, and/or completed consistently by residents in the training program.

Other issues for pay:
   a. Chief residents shall receive compensation at the PGY level plus one.
   b. Residents shall be advanced to the next PGY level at the completion of the year unless receiving advanced credit from the Board for other training.
   c. All residents must be paid at the same PGY level unless approved by the GME Policy & Advisory Committee.
   d. All residents must be in funded positions.

Approved 1/22/96 GME Policy & Advisory Committee
Reviewed & Approved Program Directors Council 11/7/01
Reviewed & Approved Program GME Committee 11/13/01

Please refer to the website for Graduate Medical Education (GME) (www.medschool.vcu.edu) regarding Stipend Policy

Direct deposit is a condition of employment for all VCUHS employees paid by VCUHS payroll. Please see the GME office if you have any questions.

The 2012/2013 base stipend rates are as follows:

<table>
<thead>
<tr>
<th></th>
<th>PGY-2</th>
<th>PGY-3</th>
<th>PGY-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annually</td>
<td>$51,042</td>
<td>$52,880</td>
<td>$54,404</td>
</tr>
</tbody>
</table>
CLINIC POLICIES AND PROCEDURES

The goals of the clinic are to provide our patients with the best medical eye care possible and to provide residents with a comprehensive educational experience. The structure of the clinic is designed to achieve these goals. Other factors that influence decisions regarding the structure of the clinic are room availability, staffing needs, operating room availability and requirements for accreditation.

ROLES, DUTIES, and RESPONSIBILITIES OF OPHTHALMOLOGY RESIDENTS

First Year Ophthalmology Resident (PGY-2)

- Comprehensive Eye Examination (including Indirect Ophthalmoscopy, Manifest and Cycloplegic Refraction)
- Writes inpatient and outpatient orders
- Instrumentation:
  - Lensometry, Automated Keratometry, Automated Refraction
  - Tonometry, Gonioscopy, Ultrasonic Pachymetry
  - Static & Kinetic Perimetry (Humphrey, Goldmann)
  - A&B scan Ultrasonography, Specular Microscopy
  - IOL Master and Immersion A-scan
  - Corneal Topography, Slit-Lamp & Fundus Photography
  - Rust ring remover, Electro-epilator
- Injections:
  - Intraocular, Periocular/Retrobulbar, Dermal, Intravenous (including Fluorescein Angiogram) for diagnosis and therapy
- Laser surgery:
  - YAG capsulotomy, Peripheral Iridotomy
  - Argon Panretinal Photocoagulation (PRP), Argon Laser Trabeculectomy (ALT), Peripheral Iridotomy (PI), other
- Surgery:
  - Cataract surgery, Glaucoma surgery, Strabismus surgery
  - Eyelid surgery, Retina surgery, Cornea surgery, Temporal Artery Byopsy

Second AND Third Year Ophthalmology Resident (PGY-3 & PGY-4)

- Above independent after deemed competent, plus:
- Surgery (direct supervision by faculty of key components):
  - Cataract surgery, Glaucoma surgery, Strabismus surgery
  - Eyelid surgery, Retina surgery, Cornea surgery, Temporal Artery Byopsy
Attendance

Attendance is mandatory. Clinic at the MCV Campus begins at 8:00 a.m., Monday through Friday. You are responsible for the preliminary work-up of your patients, and for this reason it is important that you arrive at 8:00 a.m. each morning. Please refer to the VAMC Policies regarding attendance.

IF YOU ARE ILL: Contact a live voice, if possible, first thing in the morning.
Anna Cerrato’s Office: 828-5208 AND Hannah Qizilbash 628-3097

Equipment

Necessary equipment will be provided for the residents at all facilities. The equipment will be signed out at the beginning of the PGY-2 year and returned at the time of graduation. The resident is responsible for replacement charge of any missing equipment. Graduation certificates will not be given until all equipment is accounted for or paid for. Equipment includes, but is not limited to:

Equipment List

1. Lenses: 20 Diopter and 90 Diopter
2. Welch Allyn Retinoscope head
3. Muscle Light Head
4. Welch Allyn Direct Ophthalmoscope head
5. Gonioscopy Lens
6. Adult speculum
7. Curette
8. Forceps (x3) (m.5, .12, and Paufique)
9. Scissors (Wescott & Stevens)
10. Punctum Dilator (medium, fine)
11. Needle Holder
12. Westcott Scissor
13. Chalazion Clamp
14. Punctal Dilator
15. Instrument Case
Health System Pagers

The hospital provides the Department with beepers for each resident working at the University. Pagers will be provided by the residency coordinator during the department’s orientation. Each resident will be required to sign a form in the Ophthalmology Department making him/her responsible for that particular beeper. If a beeper has been declared lost or broken due to avoidable negligence, the resident is responsible for the cost of the pager. If the beeper breaks due to a circumstance unavoidable to the resident involved in patient care responsibilities, the department will cover the cost of damage.

At the end of your residency, you must return your beeper to the Ophthalmology residency coordinator.

Please consult the Ophthalmology Directory for resident pager numbers. These may be obtained from our office receptionist or the clinic. They can also be obtained on the VCUHS Intranet by clicking on the beeper icon and entering either the physicians name.

- To page someone within the VCU Health System (VCUHS) from a push button telephone:
  - Dial *60 then enter the pager ID number.
- To beep someone outside the VCUHS, you must:
  - Dial “(804) 828-4999” then enter the pager ID number or “(804) 828-0951” for telepage.

Batteries for beepers are available at the front desk (cabinets above fax machine).

SCHEDULES

Clinical schedules will be distributed the first week in July. Surgical schedules will be provided by our surgical coordinator prior to the surgery date. If you have any questions regarding the schedule, please contact the Program Coordinator at 828-5208.

PATIENT PHONE MESSAGES

Often, Patient Service Representatives will take a call from a patient that they cannot resolve. They will then generate a “Telephone Encounter” through the IDX System. These messages are posted at the front of the clinic and triaged by the staff throughout the day. Often, staff will elect to order the patient’s chart and then place the message and chart in the appropriate doctor’s box throughout the day for the doctor’s resolution, i.e. refills on meds and post-op complaints. When resolving a patient message, please be sure to sign the form at the bottom of the page and note the action/reply you took. Messages MUST be responded by the end of the clinic day. These should NOT be left to be done the next morning.

When returning patient phone calls please take precaution when using your own cell phone. You can block your cell phone number by dialing *67 prior to dialing the telephone number. If you are attempting to contact a person that does not accept blocked calls contact the hospital operator at 828-0951 or 828-9000 and request that the operator connect you with the patient. For your security, do not give patients access to your personal phone number.

In the event you experience harassing phone calls from a patient please advise the patient of the inappropriate behavior and notify the Program Director and/or the Program Chair immediately. VCU Health System will not tolerate resident harassment by patients and this will be taken seriously and dealt with immediately.
General Policies and Procedures

RESIDENCY PROGRAM CURRICULUM

Resident Didactic Afternoon

Teaching Conferences are held Friday afternoons primarily at the Nelson Clinic. Residents are to be released from their clinical responsibilities at the affiliated teaching hospitals as well as the University. Conference is to begin promptly at 1:00 p.m. with a resident meeting and review of an interesting recent case. This is to be followed by 2 clinical pathology conferences (CPC) including a small didactic session. At 3 pm a 2 hour attending lecture will be scheduled as determined by the comprehensive core curriculum schedule. Residents MUST attend all conferences unless scheduled out for vacation. If unable to make Teaching Conferences it is the responsibility of the resident to personally contact the program coordinator or director with an explanation of why he/she is unable to attend.

Residents need to personally sign in for didactic day sessions or individual lecture. At the end of the sessions, the chief resident or designee is responsible for getting the sign in sheet to the residency coordinator. Occasionally conferences are scheduled at the affiliated hospitals. The same rules as above apply on these occasions. All lecture attendance MUST be documented.

A clinical case conference-resident organizer will be designated for each Friday teaching conference. The senior and second year residents will take turns being the resident organizer for Clinical Case Conferences. The resident organizer is responsible for making sure that there are:

1. Two clinical cases presented, one of which may, but does not have to be an active patient CPC.
2. The resident organizer may present all of the cases if he/she so desires, or may simply coordinate the presentation of cases.
3. The cases are to be presented by the residents, and discussed by the faculty. All cases presented must have a faculty discussant. Do not present cases for which there is no faculty in town on that Friday. It is the resident organizer’s responsibility to make sure that a faculty discussant will be present.

Four times a year, a conference will be dedicated toward Surgical Case Review (previously known as M&M) in regards to clinical and surgical cases. Anyone can present a case if asked to do so by an attending. All surgical complications will be reviewed. This portion will not be open to medical students and ancillary staff to respect the privacy of the operating surgeons and their patients. The intent of this forum is to apply a retrospective constructive critique of complicated surgical and medical cases.

In addition to the Friday didactic session, daily lectures will be scheduled for the residents.
Subspecialty Lectures

Residents will be exposed to lectures in areas of subspecialty each morning from 7AM – 8AM with occasional lectures after hours. These lectures will be structured in conjunction with the comprehensive curriculum of the Friday afternoon lecture series.

Additionally, there will be a Neuro-Ophthalmology conference held by Dr. Warren L. Felton and Dr. Scott Haines on alternating Fridays. This conference is to be attended by all ophthalmology residents not on vacation. Both the neurology residents and ophthalmology residents will attend along with any medical students on the service. The first part of this series will include Dr. Felton or Haines’ presentations and the second part of this series will include resident (ophthalmology and neurology) presentations in neuro-ophthalmology. The format of this series is at the discretion of Dr. Warren Felton.

Grand Rounds

Grand Rounds will take place on the first Tuesday of every month at the VCU Larrick Center conference room starting promptly at 6:15pm and ending no later than 8:30 pm. In the event that the first Tuesday of the month falls on a holiday, Grand Round will be cancelled for that month. If this occurs in 2 consecutive months, the conference will be rescheduled on an individual basis. Food will be made available for this meeting. It is the responsibility of a designated resident to assure the conference room is clean prior to leaving the meeting that evening. If the conference room is left in an uncleanly manor, food will no longer be provided.

It is the intent of Grand Rounds to serve as a community continuing medical educational meeting, promote University and community ophthalmologist interactions and help establish the University as a focal point for the ophthalmic community as a leading learning institution and resource. By acknowledging these intentions, it is recommended to choose cases with these thoughts in mind:

1. Classic diagnostic and/ or interesting patients are encouraged to be brought to Grand Rounds for examination by the attending faculty if at all possible.

2. All cases presented must have a faculty discussant. If the involved faculty member cannot be present; it is recommended that another case be presented. It is the resident organizer’s responsibility to make sure that a faculty discussant will be present.

3. Case presentations should be concise and brief exposing all pertinent positive and negative historical and physical exam findings. This portion should run no longer than 10 minutes. Please be prepared to elaborate with questions from the audience.

4. After the short Case presentation, discussion about the differential diagnosis should commence. Residents are encouraged to volunteer their thoughts as to the differential diagnosis. Attending involvement is highly desired and anticipated.

5. After a lengthy and healthy discussion about the differential diagnosis and plan, a short (5 minute) summary slide will conclude the case presentation. Additional summary slides consisting of take home points and photos should be prepared to distinguish the diagnosis from the other top five differential diagnoses. Only list at most the top five with the essential take home information needed to recall this particular case/ disease process and how it is different from the presenting diagnosis. Do not cover a lengthy didactic section here.
6. The residents will present 2 CPCs at each Grand Rounds as set up on a rotational basis.

Journal Club

Journal Club will be held on the third Tuesday of each month. In the event that Grand Rounds is immediately adjacent to the third Tuesday of the month, the Journal club will be moved to the fourth Tuesday of the month. If this Tuesday falls on a holiday, the journal club will be cancelled. If this occurs in two consecutive months, the journal club will be rescheduled. Journal club will begin promptly at 6:00 pm. Clinic schedules should accommodate this time slot. Journal club will be held primarily at the conference room on the fourth floor of the Nelson Clinic.

It is the intent of Journal Club to review the current literature and peer review these articles from a scientific, knowledge and practical basis. In order to accomplish this, four articles will be presented. One article should be a landmark article in the field of the attending of the month. This will be an exemplary article as set forth by its study design and practicality. The other three articles will be chosen as bridging articles between the attending of the month’s field and different subspecialty. For example, one may choose to review portions of the Herpetic Eye Disease Study and its implications on our daily practice. The other two articles could be “Glaucoma after LASIK surgery” and “Keratoconus and strabismus” and “OCT: comparing anterior segment photos to retinal photos”. The goal is to involve many people in discussions and encourage multiple subspecialty attendance and participation in discussion by all those who attend.

Journals articles should be presented with 7 basic questions in mind:

1. What is the purpose of this paper?
2. What type of paper is it?
3. Who was considered eligible for this study (inclusion/exclusion criteria)?
4. How were the results measured (what were the outcome measures)?
5. What were the findings of the paper?
6. How would this change my clinical practice?
7. Based on the study and its supporting results, can I trust this information?

Any food/refreshments provided at Journal Club are the responsibility of the resident designee to remove from the venue where it is held.

It is the cooperation and participation of the residents and faculty that will produce an excellent educational environment not only for the program but also for the ophthalmic community.

Resident attendance and involvement at all journal club conferences is mandatory unless on vacation or actively involved in on call responsibilities. Any resident on-call presenting at Journal Club should arrange appropriate temporary coverage by fellow resident in the event of an emergent call responsibility.
Conference Attendance Documentation

An Attendance Roster is prepared for each conference. The roster has the name of each resident and attending with a section for their signature. The roster sheets are kept in the resident library above the resident mailboxes. The Chief Resident is responsible for ensuring these sheets are signed and given to the Program Coordinator.

Resident Participation In Medical Student Teaching

The residents participate in second year medical student education of ophthalmic physical diagnosis of the eye. We have third and fourth year medical students, both from the VCU and from other universities who choose to come to the VCU for their ophthalmology electives. The students are assigned to a resident and/or faculty member to observe in clinic and surgery.

Pathology

The residents will be exposed to monthly live web cast lectures during the academic year. Dr. Deepak Edward will provide lectures on the 3rd or 4th Thursday of the month; 7-8 AM/ET. Dr. Edward will also provide an onsite grossing and microscopic specimens review in the month of December. In addition, there will be Pathology specific OKAP review which will be provided in the month of April.

When available, Dr. Andrew Ferry will conduct one-on-one sessions with the pathology resident to review relevant microscopic specimens. The residents are also exposed to a week of pathology at the Houston Basic Science Course during their first year.

Surgical Program Goals and Objectives

Education: The Department of Ophthalmology is committed to attracting excellent students and to recruiting and retaining outstanding faculty to provide clinical, surgical and didactic training for resident physicians in ophthalmology. The department promotes continuing medical education for practicing ophthalmologists through courses and conferences.

Surgical Requirements

Summary of Surgical Requirements for Successful Completion of Ophthalmology Residency (effective 04/2011)

The Accredited Council for Graduate Medical Education requires that residents complete the following number of ophthalmic procedures before they can be recommended for board certification:

<table>
<thead>
<tr>
<th>Ophthalmology Resident Operative Procedure</th>
<th>Current Minimum Requirement (*Surgeon) (**Surgeon and Assistant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cataract</td>
<td>86</td>
</tr>
<tr>
<td>Strabismus</td>
<td>10</td>
</tr>
<tr>
<td>Corneal Surgery</td>
<td>3</td>
</tr>
<tr>
<td>Refractive Surgery</td>
<td>6</td>
</tr>
<tr>
<td>Glaucoma *</td>
<td>5</td>
</tr>
<tr>
<td>Glaucoma Laser*</td>
<td>9</td>
</tr>
<tr>
<td>Specialties</td>
<td>Minimums</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Retina/Vitreous**</td>
<td>10</td>
</tr>
<tr>
<td>Retina Lasers*</td>
<td>25</td>
</tr>
<tr>
<td>Oculoplastics/Orbit*</td>
<td>28</td>
</tr>
<tr>
<td>Globe Trauma*</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>364</strong></td>
</tr>
</tbody>
</table>

*Operative minimums per class of procedures are now established only for cases where the resident is the primary surgeon.

**Operative minimums per class of procedures are established for cases where the resident is either the primary surgeon and/or the assistant.

Residents are expected to input surgeries on which they are the first assistant as well as cases on which they are the primary surgeon. This is necessary for the program to show a progressive graduated and broad surgical experience. At least 364 total procedures (surgeon + assistant) should be completed at the end of the residency.

Completing the minimum number of required procedures does not, in and of itself, guarantee competency. In addition to completing the minimum number of surgeries, we require that the resident demonstrate competency in performing these procedures, as evaluated by the attending surgeons. Failure to either complete the minimum number of required surgeries or failure to demonstrate competency at these procedures could result in the extension of residency to meet these requirements. Competency is evaluated on an ongoing basis throughout the period of training. Completion and up-keep of resident surgical logs will be monitored by the Program Director at biannual meetings.

**Surgery**

**Goal:** To ensure a graduated surgical experience with a proficient comprehensive and subspecialty surgical exposure and mastery of ophthalmic surgical requirements as defined by the ACGME. The graduating resident should be able to perform all comprehensive surgical procedures and be familiar to more advanced subspecialty cases.

**First Year Experience:** First years will be exposed to surgical trauma and assist senior resident with all types of traumatic surgical cases. In doing this, they will learn the basic of surgical trauma by observing and eventually participating in cases. It is encouraged for the third year residents along with attending staff to involve first year residents in preliminary trauma cases to graduate them toward participating more so as a second year. The first year resident should be familiar with pre-op history and physical exams, prepping the patient, dressing the wound and post-operative orders necessary for inpatient needs. On an individual and cases by case means, the first year resident will become more involved in the primary repair of the trauma. First year residents will also have dedicated observational time to assist with various types of ophthalmic surgery including comprehensive surgery and subspecialty cases.

**Second Year Residents:** Second year residents will begin their subspecialty service rotations, which will have dedicated operating room time. From their experience in first year, they will increase their surgical involvement by transitioning from assistants to primary surgeons. On an individual and case-by-case means, the second year resident will become more involved as the primary surgeon as the attending deems appropriate. It is encouraged for the second years to attend as many cases as possible to get comfortable in the OR and move forward in their surgical training.
Third Year Residents: Third year residents will complete the majority of their primary cases during this rotational year of training. They will have learned through their first two years the proper pre-operative, intraoperative and post-operative management of cases and will have the opportunity to schedule resident cases for which they are the primary surgeons. At no time will a resident ever go to the operating room without direct and active attending supervision. It is the job of the third year resident to demonstrate mastery of the surgical skills needed to graduate an ophthalmic residency. By the completion of the program, the graduating third year residents will fulfill all of the ACGME Class I and Class III requirements for surgical cases. Any deficiencies in completing these requirements will result in an inability to graduate on time. If a resident feels that they may be deficient and in jeopardy of not completing these requirements, the resident should meet with the program director immediately and resolve this issue. While in the OR with the third year resident, at any time the attending staff members can request to take over cases and assist the resident if the staff member feels the patients overall wellbeing is at risk. All residents are encouraged to ask for assistance if they are performing a part of a case they do not feel comfortable with. The staff is there to help educate and assist residents learning these skills without putting patients in harm’s way.

These surgical guideline/ objectives will be monitored throughout the residents’ 36 months at the semi-annual resident program director meetings.

All residents are required to keep a hard copy surgical log book which will be distributed by the Department of Ophthalmology. These log books should contain the basic pieces of information to supplement their ACGME website logs:

1) Pt last initial and last four of SSN  
2) Date of surgery  
3) Place of surgery  
4) Attending present  
5) Type of case (retina/ plastics/ cornea etc.)  
6) Resident role in case (Class I or Class III)  
7) Procedure performed  
8) Which eye was operated on

As mentions, residents are responsible for updating the ACGME website surgical log and their hard copy logs. The two of these logs will be compared periodically throughout the program by the program director especially at each semi-annual meeting. It is encouraged to update your log each day, but it is mandatory to update surgical logs by no later than the Friday afternoon lectures each week.

Safety/ Security

Security concerns at VCUHS should be directed to (804) 828-4300. Please see affiliated hospitals for specific information.
ACGME COMPETENCIES

By the completion of the residency each resident will be expected to demonstrate competence in the following seven categories:

Medical Knowledge

General Competency: Resident must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavior) sciences and the application of this knowledge to patient care.

- Exhibits knowledge that is current and cites literature appropriately.
- Prepared and investigates topics needed for clinical assignments.
- Applies knowledge and applicability toward clinical assignments.
- Clearly demonstrates analytical thinking.

Practice-Based Learning and Improvement

General Competency: Resident must be able to investigate and evaluate his or her patient care practices, appraise and assimilate scientific evidence, and improve patient care practices.

- Appraises usefulness of scientific evidence in care of patients’ problems.
- Demonstrates knowledge of study designs and statistical methods necessary to evaluate scientific studies.
- Analyses effectiveness of own practices regularly.
- Regularly improves own practice based on appropriately gathered data and feedback.
- Teaches students, staff, and colleagues effectively & adequately.
- Consistently uses available information technology to obtain and manage information.

Patient Care/Clinical Skills

General competency: Resident must be able to provide care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

- Gathers essential information efficiently. Histories are comprehensive and Purposeful
- Examinations are accurate and complete. Displays mastery of examination skills
- Formulates thorough differential diagnosis.
- Develops & initiates appropriate management
- Effectively counsels and educates patients and their families

Patient Care/Surgical Skills

- Excellent preoperative understanding/decision-making for procedures to be performed
- Excellent presentation to patient of risks, benefits, and alternatives to procedures (informed consent).
- Excellent dexterity/tissue handling.
- Is surgically efficient in operative maneuvers.
- Follows sterile technique
- Fully understands instruments and their names.
- Is fully aware of possible discomforts/risks related to procedure.
• Excellent suturing technique
• Is confident in knowledge of pertinent anatomy.
• Excellent technical surgical competence.
• Provides appropriate postoperative care, including recognition & management of complications.

**Interpersonal & Communication Skills: Relationships with Patients/Colleagues**

**General Competency:** Resident must be able to demonstrate interpersonal skills that result in effective information exchange and teaming with patients, their families, and professional associates.

• Demonstrates compassion for patients and their families.
• Provides adequate counseling and education to patients.
• Carefully listens/includes patients in treatment decisions.
• Interacts well with staff, faculty, and colleagues.
• Documents accurately and completely.
• Maintains timely and legible medical records
• Presents patients effectively and succinctly.

**Professionalism**

**General Competency:** Resident must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

• Overtly altruistic
• Behaves respectfully and compassionately
• Sensitive to cultural/age/gender/disability
• Fulfills assigned clinical & on-call responsibilities (Reliable)
• Displays ethical behavior consistently.
• Respects other members of the healthcare team.
• Is accountable for own actions.
• Is punctual.
• Is committed to excellence.

**Systems-Based Practice**

**General Competency:** Resident must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

• Consistently practices cost-effective care.
• Consistently acts as advocate for patients within the healthcare system.
• Appropriately/adequately refers and collaborates with other health care professionals
• Consistently obtains appropriate assistance within the healthcare system for coordination and management of ongoing care.
Resident Call & Call Schedule Policy

Call Schedule and Responsibility

It is the responsibility of the chief resident to determine the call schedules. After the call schedule has been constructed, the chief resident will then provide this information to the Program Coordinator who will then update the telepage schedule and disseminate this to the proper institutions and staff. All changes made in the call schedule must be reported to the Program Coordinator immediately as it is her responsibility to make sure the appropriate institutions are notified. Furthermore, it is the responsibility of the chief resident to make sure that any changes to the schedule are communicated directly to the residency coordinator by either him/her or a designated resident.

Call hours start at 4:30 pm and continue until 8AM the next business day. Emergency calls during regular duty hours will be assigned by the senior most resident in the clinic. Any non-emergent calls given to the on call resident will be dealt with after regular duty hours. Note; in hospital consults of a non-emergent type will not be the responsibility of the on call resident, but the resident covering the consults. If an in house consult is emergent during regular duty hours, the senior most resident will determine who will go to see the patient.

After 4:30 pm, hospital consultations are the responsibility of the resident on call. These consultations must be completed by the on call resident before 8 AM the next morning as long as the referring doctor feels that a few hours delay is not a problem. Note: if a resident is unable to see the consultation, it is the responsibility of the on call resident to assure coverage has been arranged for a designated resident to see this patient.

If you miss call for whatever reason, you are responsible for making coverage arrangements. If you are unable to make arrangements, please contact the Chief Resident or Program Director and arrangements will be made to cover your call. All missed calls will be paid back equal of greater value without exceptions.

Please be aware that in the coming months you may be receiving phone calls, while on call, from Institutions or providers not within the VCUHS. Please be advised that it is not the policy of the Department of Ophthalmology to comment on patients not seen by our faculty. It is advised not to treat any patients without first evaluating their states.

Absolutely no phone triage will be allowed unless permitted by an attending. Residents should not accept any patients in transfer to our facility. It is the responsibility of the ER physicians to accept these patients and notify the residents of their arrival.

For any given call day there is a primary call junior resident and secondary backup senior resident. For any given senior resident, there is a backup faculty available. In the event the junior resident is not available to take primary call for whatever reason; it is the responsibility of the senior resident to take the place. In this case, the attending will still act as back up to the senior resident.

For the most part, the first year residents will cover the majority of primary call. They will cover 9 days of call a month including weekend call. Second year residents not including weekends will cover the remaining days. Third year residents will cover all days as back up for the junior residents without exception.
The faculty will cover resident call the night before OKAPS and during the examination. This will be in a revolving status. All non-emergent calls will be triaged until after the examination is completed. All residents are encouraged to assist the on call resident after this examination is completed.

There are three attendings on call to assist the housestaff at all times; Anterior Segment, Retina and Oculoplastics. Coverage includes VCUHS and the Hunter McGuire VAMC. Junior residents are expected to examine any referred patient and call their senior backup for assistance when needed. Only senior residents should contact the housestaff after personally examining the patient.

**Graduated Call Transitioning**

In an effort to adequately educate new residents and graduate their skills to allow for more independence when on call, the following guidelines will be in place for their protection:

1. July: First & second year residents participate on all calls together at all times.
   i. For the first two weeks the second year resident accompanies the first year resident at all times.
   ii. Starting the third week, the first year resident evaluates the patient and develops a treatment plan before the second year resident comes in to evaluate the patient to confirm the diagnosis and treatment plan.
2. August: First year resident calls the third year backup resident on everything. The third year resident comes into emergency department for all calls.
3. September: First year resident calls the third year backup on all major traumas and surgery.
4. October: First year resident calls the third year resident as needed.

All graduations in responsibility are to be directed by the chief resident and conferred with the program director. It is understandable that some residents may require longer supervision depending on abilities. It is encouraged to lengthen these suggest dates but not to shorten them.

**Note:** It is the policy of the Department of Ophthalmology to perform complete ophthalmic examinations on all patients including a dilated fundus examination unless refused by the patient or contraindicated by another subspecialty (i.e.: CNS monitoring of pupils). Furthermore, on-call residents are responsible for seeing all patients when asked without exception. Phone triage is prohibited as a means to not see patients. If emergency room patients are not seen within 20 minutes, the resident will inform the requesting physician of his/her delay. It is the discretion of the on call resident to triage the order as to which patients are to be seen. This should be determined by severity of the case and possibility of permanent visual compromise. If multiple sight threatening cases present at one time, the backup resident should assist the on call resident in seeing patients.

**On Call After Hours Clinic Usage**

Please do not take patients to clinic after hours without security escort. Security Escort can be reached at 828-walk or 828-4300
In-Patient Consults: During Clinic Hours

A second year resident will be responsible for the inpatient consults at MCVH. Similarly, the 2nd year resident at the VAMC will be responsible for seeing inpatient consults at the VA.

When a consult is called between the hours of 8:00 am and 4:30 pm, it will be the consult resident’s responsibility to see and manage these patients. Should a consult be called outside of these hours, it will be the responsibility of the on-call resident to see and manage these patients.

Specifically, should a consult be called between the hours of 6 am and 8 am, the on-call resident should be notified and request that the patient come to the clinic at 8:00 am (if possible). If the patient is unable to come to the clinic at 8:00 am, the on-call resident should see this patient immediately. If a consult is called during the AM clinic, the patient should be told to report to the clinic at 1:00 pm. If a consult is called AFTER 2:30 pm, the patient should be seen on the unit floor (after clinic hours).

When the patient comes to the clinic, the clinic supervisor will be alerted and she will find the consult resident. After finishing with the current patient, the resident will immediately see the consult patient. If there are technicians available to see this patient prior to the resident, they are responsible for the workup. However, if technicians are not available, the resident will NOT wait for the technicians to work up the patient as a general rule.

After the resident sees the patient, he will immediately deliver the chart to the attending.

There will be NO MORE than 5 total in-patient consults per clinic day. Furthermore, there will be no more than 3 per half day allowed. If there are more than 5 total inpatients in a given day, the overflow will need to be seen in the hospital after clinic hours.

In the event that the consult patient CANNOT be seen in our clinic due to some type of precaution or any other condition for which the patient is unable to be transported to the eye clinic, the consult resident will notify the chief resident and/or attending physician. The chief resident and/or attending will then determine whether the consult resident can leave the clinic and see the consult patient.

The purpose of this policy is to help preserve the flow of previously scheduled patients and prevent interrupting the daily activities of the clinic.

In general, all in-patient consults should be reviewed with an attending in the clinic or with the attending on-call on the day of exam.
Educational Allowances & Benefits

University of Texas Basic Science Course

All first year residents are required to attend the Basic Science Course in Ophthalmology at the University of Texas in Houston for four weeks in February. The course is sponsored by the Department of Ophthalmology and Visual Science at the University of Texas Houston Medical School. This course is designed to provide an increased fund of knowledge for handling the added responsibilities of the second and third year of residency. The course consists of a total of four weeks in Houston Texas which will include the following lecture subjects: Basic Anatomy; Surgical Anatomy; Embryology; Orbital Anatomy; Low Vision; Ultrasound; Optics; Motility; Biochemistry; Contact Lenses; Genetics; Retina; Pathology; Immunology; Visual Fields; Glaucoma; Eternal Disease; Oculoplastics; and Neuro-Ophthalmology. Lectures emphasize the application of basic scientific principles to clinical situations. Course tuition and airfare and a stipend to cover part of living expenses are provided to the residents by the Department of Ophthalmology. Any additional funding for housing, meals, and any other subsistence necessary for the four weeks in Houston is the responsibility of the resident.

Board Review Series

All didactics are being structured to cover the Basic and Clinical Science Course (BCSC) Series. All residents will received a BCSC series upon arrival to the program their first year. The department will pay for the entire BCSC series for the residents (over $1,000 each). It is the intent of the BCSC series to serve as a foundation of core academic and clinical knowledge for all ophthalmology residents. It is best utilized as a comprehensive reference for pre-reading on known lecture topics and is the basis for OKAP examination and written/oral Academy of Ophthalmology Board Certification Examinations. It is expected that the BCSC series be read at least by the end of the first year prior to the OKAP examination. The BCSC must be supplemented with additional readings specific to individual cases. This series alone will not give the breadth or depth of knowledge required for understanding the intricacies of complicated medical or surgical cases.

In an effort to help review for OKAP examinations, concentrated lectures on subspecialty and comprehensive topics will take place starting 3 weeks prior to OKAP exams. These lectures will be in the evenings given by staff members. The intent of these lectures is not to replace reading or studying the BCSC series, however, it is the responsibility of the resident to independently read and ask question to elucidate topic further. The board series review is intended to help the resident see frequent clinical vignettes, photos and buzz words immediately before the examination. No lecturing staff will be AAO board examiners or have any involvement with the Board of Ophthalmology examinations.

Library Services

Currently, there are two physical library locations available to the residents.

1. Harry and Kathryn Schwarzschild Learning Center for Ophthalmology and Vision Research: This library is located on the 4th floor of the Nelson Clinic and is available for the resident to use for journal review and major textbook reading. This library is intended to inspire a quiet environment for residents to reflect on cases, study for OKAPs and research recent literature. It is available during and after working hours. This space is intended to provide key ophthalmic journals, textbooks and atlases for residents and attending to reference during clinical hours. This library is to be maintained and used by the residents in a functional capacity. Recent textbooks have been purchased by the department will be placed in a locked cabinet for the residents to use. Disappearance of these
textbooks for whatever reason will make these references unavailable for future residents for the next several years. The library was last updated with textbooks in December 2005 and will be updated again no earlier than December 2010. The residents are required and encouraged to maintain this space and securely store their reference books.

2. **Tompkins-McCaw Library for Health Sciences** is the main medical school library located on at 509 North 12th Street. This library has an extensive textbook reference section for ophthalmology and all medical specialties. It has a comprehensive periodical section and is available to residents, students and staff. Each resident will be given an internet access code to be able to reference the library online services at any time of the day or night. Introductory instruction to library services is given to residents by the library staff if needed. There is also an online library orientation available on the GME website under house staff resources.

**E-Mail and Internet Access**

E-mail accounts are created for all eligible faculty, staff, residents and students during orientation by information systems technology. One can initiate their own email address by accessing the VCUHS intranet. All residents are required by the Medical School to use their University e-mail account. If using another service, you must forward your University account to it. Residents are responsible for the information sent to them via their University e-mail account. There are computers available in the Residents library on the fourth floor of the Nelson Clinic.

**Website Addresses**

Virginia Commonwealth University, Department of Ophthalmology: [http://www.eye.vcu.edu](http://www.eye.vcu.edu)
Virginia Commonwealth University, Graduate Medical Education: [http://www.medschool.vcu.edu/gme](http://www.medschool.vcu.edu/gme)
Virginia Commonwealth University, School of Medicine: [http://www.medschool.vcu.edu](http://www.medschool.vcu.edu)

**Campus mail**

Each resident is assigned two departmental mailboxes: one in the housestaff office (West Hospital, 6th Floor, South Wing) and one on the 4th Floor, Nelson Clinic for incoming mail. Mail should be check frequently by each resident.

The Department has an outgoing mail facility located in the 4th Floor of Nelson clinic and on the first floor of Nelson clinic for campus or U.S. mail. Campus mail envelopes are located here as well. If you need help obtaining a campus address, see the department receptionist. Mail pick-up time is at 2:00 p.m. daily on the first floor of Nelson clinic.

**Research**

Independent research is mandatory. All residents are required to participate in research, and to prepare (as first author) a manuscript suitable for a national meeting. Residents are required to find a staff member as a research mentor each year to collaborate with on this project. Individual research goals will be discussed with the program director at semi-annual meetings and with the director of scholarly activities, Dr. Christopher T. Leffler. Any individual who gets an abstract, manuscript or poster accepted for publication or presentation at a national meeting will be rewarded with a stipend and extra vacation day as outlined below.
Guidelines for Meetings

- Residents will be allowed one trip for Poster Presentations and/or manuscript draft acceptance to a peer review journal within the 36-month period. This stipend is intended to encourage, but not required presentations and/or publications. If more than one manuscript is accepted, a meeting stipend will be possible based on the number of participants at the time.
- Residents must be the presenting first author of a paper or poster at the meeting.
- Research must be in collaboration with a faculty advisor in the Department of Ophthalmology at VCUHS.
- A completed manuscript, suitable for publication, must be submitted to the faculty advisor PRIOR TO SUBMITTING THE ABSTRACT FOR A MEETING. The faculty advisor must approve both the manuscript and the abstract prior to submission. When travel is on behalf of an affiliated hospital, a copy of the abstract, completed manuscript and written verification that the affiliated hospital will be covering the travel expense must be submitted to the program director prior to submitting the abstract.
- Posters for presentation must be completed one week prior to departure.
- Meeting allowances can be earned at any level of education and taken in any year. Residents are encouraged to bank their granted travel stipend for their senior year where meetings frequently can allow for fellowship and job interviews.
- Travel must be in compliance with University and department travel policies; a pre-travel authorization must be completed, signed by the traveler, signed by his/her faculty advisor, and returned prior to making travel arrangements.
- Funding limitations will be set by department administration. This funding may be used for only travel-associated costs. Residents are encouraged to attend the ARVO meeting in the Spring. Funding for this trip will not exceed $750. Any remaining balance may not be used. Costs exceeding this limitation will be paid out of pocket by the traveler. THIS FUNDING CANNOT BE USED FOR BOOKS. Approved funding can be used for other national meetings however, the stipend regulations will be based on $750.
- An additional trip may be taken if all the previous and following guidelines are met and permission is granted by the chairman of the department.
- An additional vacation day will be granted for meetings or presentations when a poster presentation or manuscript abstract has been accepted. All other days away will be considered personal vacation days.
- A pre-travel authorization must be completed by the resident and given to the residency coordinator for approval by the chairman of the department. Upon returning from the trip, all receipts should be returned for reimbursement by the department to not to exceed $750. No monies will be allotted for without a receipt. All receipts should be turned in no later than 2 weeks after returning to the department. If returned later than this date, the resident may lose reimbursement for his/her expenses.

Conferences, Exams, and Related Policies

Residents are expected to attend ALL conferences.

Attendance Roster
Conference attendance must be attested to by the Program Director or Chairman at the conclusion of the training program.
Attendance rosters are available in the conference room to indicate your presence or absence from meetings. The chief resident forwards the attendance roster to the Resident Program Coordinator (Anna Cerrato) immediately following the conference for permanent record keeping. Attendance at all conferences, etc., must be PROMPT; **chronic tardiness may be considered an absence.**

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

Excused absences will be noted through submission of the Absence Request form or Report of Absence form, which are submitted to the Resident Program Coordinator.

**Intra-department Meetings**

1. **Journal Club**
   Excluding February, July, and August, the Journal Club meets on the third Tuesday of each month at 6:00 pm.

2. **Imaging and Fluorescein Conference**
   Imaging and Fluorescein Conference is to be determined for this year. Announcement of such conference will be provided at a later time.

3. **Subspecialty Lectures**
   Held every Monday through Thursday from 7:00 - 8:00 am. Each faculty member is designated to give a series of lectures on the topic of their choice. These lectures may occasionally be scheduled in the evening following clinic schedule.

4. **Grand Rounds**
   Grand Rounds is held the first Tuesday of each month.

5. **Residents’ Meeting**
   Held occasionally on certain Friday’s during the year at 1:00 pm. The Program Coordinator and/or Clinic Supervisor participate in this meeting.

6. **Visiting Lectureships**
   A guest lecturer is invited for a half-day Saturday conference, approximately twice a year.

7. **Residents and Alumni Day**
   Usually held the third Friday of June each year. Each resident is required to present a twenty-five minute presentation of their research project. A dinner honoring our senior residents is held that evening. The Outstanding Resident Presentation Award is presented that evening.

**Resident Orientation**

VCUHS resident orientation is conducted for new residents on the first business day in July. Following the institutional orientation, new residents will meet with the Program Director. Departmental orientation will follow on the second business day in July for a period of two weeks.
**OKAP Examination**
The Ophthalmic Knowledge Assessment Program (OKAP) was established in the late 1960s for the purpose of providing individual residents and training programs with a mechanism to measure academic performance, specific subject areas of success and any area needing improvement. This examination will be taken by all ophthalmology residents each year.

The results will be used by the Program Director as one of the many criteria in performing periodic resident evaluations. In addition, the results will be used by the department in identifying programmatic strengths and weaknesses.

The OKAP examination reports individual subject scores, overall scores and “core knowledge” scores as a percentile for all residents at the same level of training across the country.

**State Licensure**

All housestaff are required to obtain a temporary license to practice medicine in the Commonwealth of Virginia. The license must be renewed annually. The original application and annual renewals are handled by the GME office through your Program Coordinator. If a permanent Virginia license is obtained during the course of the residency program, copies of the license must be submitted to the GME office and to the Ophthalmology Residency Coordinator.

**Ophthalmology Calendar of Events**

A calendar of events will be provided by the Program Coordinator to ALL ophthalmology faculty and residents at the commencement of each academic year. Faculty and residents will be notified of any changes and/or additions made to the calendar as they are made.
CLINICAL ROTATIONS

Clinical and Surgical Rotation Schedules will be distributed the first week of July. If you have any questions regarding the schedule, please contact the Program Coordinator at 828-5208.

Guidelines for Clinical Rotations

IN GENERAL, residents should report to clinic no later than 8:15 AM and end approximately at 5:00 pm Monday through Friday. The last patient seen will dictate when clinic hours will end. The residents are expected to be in the clinic and available to see patients during that time. The resident clinic supervisor should be informed when leaving the clinic for any reason during clinic hours. Failure to inform the clinic supervisor when leaving the clinic to attend to another emergent concern is unacceptable.

Technicians are instructed to work up the third year residents’ patients and, when time permits, assist the second year and then first year residents with their patient workups. All residents are expected to voluntarily pick up charts regardless of year status to assist in fellow residents struggling to keep up on that particular day. If a particular resident struggles to maintain a patient load with respect to his/her peers, the program director should be noted and will address the reasons as to why this is.

The resident clinic supervisor is responsible for patient flow and clinic efficiency. It is to the responsibility of the clinic supervisor to inform individual residents of the need increase speed in order assist with patient flow. If a backup in the clinic is noted, the clinic supervisor should assign individual residents patients in a manner as the clinic supervisor sees fit to reduce a backlog of patients and/or help with clinic flow.

In general, upon beginning the selected PGY level, average resident patient load for a half day of clinic should be as following:
- PGY-4 residents: should see double the case load of a second year resident.
- PGY-3 residents should see double the case load of a first year resident.
- PGY-2 resident should see no less than 4 patients in a half-day clinic.

As residents mature through the PGY level, average resident patient load for a ½ day clinic should be the following:
- PGY-4 resident performance is minimally defined by accurately examining six patients per hour with technical work-ups or four patients per hour without technical work-ups.
- PGY-3 resident performance is minimally defined by accurately examining five patients per hour with technical work-ups or three patients per hour without technical work-ups.
- PGY-2 resident performance is minimally defined by accurately examining four patients per hour with technical work-ups or two patients per hour without technical work-ups.

These numbers may fluctuate based on individual resident abilities in particular areas. It is acknowledged by the department that the daily number of patients can fluctuate depending on the complexity of the patients seen by the residents; however, it is the overall trend in patient numbers that will be investigated by the program director when this issue is brought to his/her attention.

No resident is expected to leave the clinic for the day until all of the patients have been fully examined unless given permission by the staff person attending that clinic.

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Senior residents are expected to work closely with junior residents and supervise their management of walk-ins and emergencies. The third year resident is expected to notify a member of the faculty for any complicated patient management problems.

Emergent cases are to be taken by the junior resident attending the comprehensive clinic that day. All non-emergent cases referred to the department should be worked into the clinic schedule or seen after hours.

In hospital consults should be seen as described in the on-call section of this handbook.

Department of Corrections (DOC) patients will be worked up promptly and bumped to the top of the waiting list so that they will be seen and discharged from the clinic as soon as possible.

All patients, including post-op follow-ups, should be scheduled in the computer.

When appropriate, all clinical cases requiring subspecialty care should be referred within the department to the correct subspecialty clinic.

**Clinic Scheduling Changes**

If residents will be absent for whatever reason, residents must alert the Program Coordinator as to the date and times of the absence. Ample time must be given to arrange an individual clinic. In the event of an unforeseen absence, the resident should alert Joan Newton and his/her fellow residents and the clinic attending for that clinic. Absences without sufficient time to prepare will be highly discouraged and may be denied by the program director or chair.

**Rotations**

*Each year is divided into three four-month rotations...*

First Year Resident (PGY-2): This rotation is primarily comprehensive with some subspecialty experience. The main focus is trauma, call, consults, and comprehensive service.

Second Year Resident (PGY-3): During this rotation, residents are mainly exposed to subspecialty services with some surgical experience.

Third Year Resident (PGY-4): This is a surgical focus rotation with some comprehensive service.

*Rotation schedule is provided to residents on July of each academic year. For questions regarding this schedule, please contact the Program Coordinator.*
Goals and Objectives of the individual services of the Department of Ophthalmology

We have based our goals and objectives on the “Guidelines and Standards for Education of an Ophthalmologist: a Curricular Outline” presented by the International Council of Ophthalmology and the International Task Force on Ophthalmology for Resident and Specialist Training. These curriculum guidelines are available online at: www.icoph.org/ed/resgui.html. Each resident is expected to read and acknowledge these goals and objectives by signing below each section prior to the start of their respective rotation.

Comprehensive Service (Cataract and Lens/Uveitis)

Overall Objectives*:
The resident is expected to:

- Understand the normal anatomy, embryology, biochemistry, and physiology of the lens and to be able to identify congenital anomalies of the lens.

- Understand development and epidemiology of cataract, distinguish types of congenital and acquired cataracts, and describe the association of cataracts with aging, trauma, medications, and ocular and systemic diseases.

- Evaluate and manage all aspects of care for patients with cataract from pre-operative evaluation to intra-operative techniques to post-operative care and management of complications.

- Identify general and specific pathophysiological processes that affect the structure and function of the uveal tract and other tissues in acute and chronic intraocular inflammation.

- Become knowledgeable in the differentiation and identification of the various infectious and non-infectious intraocular inflammatory disorders, and describe criteria that can be applied to differentiate true uveitis from the masquerade syndromes.

- Become comfortable with the principles of both medical and surgical management of infectious and non-infectious uveitis and related intraocular inflammation, including indications for and complications of immunosuppressive agents. This is learned in a graduated fashion over the three years of training.
Competency Based Goals and Objectives

MEDICAL KNOWLEDGE **:

Goals During PGY-2:

1. Cognitive Skills
   a. Identify causes and types of cataract (e.g. congenital, posterior subcapsular, traumatic, glaucoma-associated)
   b. Obtain basic history and perform pre-operative evaluation including determination of best-corrected refraction, slit lamp biomicroscopy, retinoscopy, direct and indirect ophthalmoscopy
   c. Use of instrumentation in cataract evaluation: lensometer, automated refractor, retinoscope, phoropter, keratometer, corneal pachymetry, A-scan biometry, potential acuity meter, glare and contrast sensitivity testing
   d. Learn components of visual function other than Snellen acuity (e.g. contrast sensitivity, glare)
   e. Understand and correlate functional vision with objective visual acuity and type of lens opacity
   f. Be familiar with various cataract extraction techniques (phacoemulsification, extra-capsular, intra-capsular)
   g. Describe basic principles of history taking and examination of patients with uveitis, and related ocular inflammatory diseases
   h. List signs and symptoms of anterior and posterior uveitis (e.g., red eye, blurred vision, anterior segment cell and flare, vitreous opacities, pars planitis, retinal or choroidal infiltrates).
   i. Describe the different types of uveitis (e.g., acute and chronic uveitis, granulomatous and non-granulomatous uveitis, anterior, intermediate, and posterior uveitis).
   j. Describe typical features and differential diagnosis of anterior uveitis including: infectious (e.g., bacterial, viral, protozoal, parasitic), inflammatory (e.g., sarcoid, HLA-B27-associated, Behcet’s disease, collagen vascular disease), neoplastic (masquerade syndromes), postsurgical, post-traumatic, Fuchs’ heterochromic uveitis, juvenile idiopathic arthritis.
   k. Describe typical features and differential diagnosis of posterior segment uveitis (e.g., toxoplasmosis, sarcoidosis, pars planitis, acute retinal necrosis, Vogt-Koyanagi-Harada
syndrome, large cell lymphoma, post-operative uveitis, endophthalmitis (e.g., postoperative, traumatic, endogenous, fungal, phacoanaphylactic, sympathetic ophthalmia), unusual infectious etiologies [e.g., human immunodeficiency virus, herpes simplex virus, herpes zoster virus, pneumocystis carinii, Lyme disease], acquired and congenital ocular syphilis, cytomegalovirus retinitis, multiple sclerosis).

2. **Technical Skills**
   a. Identifying instruments used in intraocular surgery (e.g. forceps, blades, hooks)
   b. Understand anesthetic techniques for intraocular surgery (e.g. general, retrobulbar, peribulbar, sub Tenon’s, topical, and intracameral)
   c. Perform an examination of the anterior and posterior segment for uveitis (e.g., slit lamp biomicroscopy, scleral depression, magnified posterior segment exam, vitreous evaluation for cells, retinal, choroidal, and pars plana evaluation).
   d. Describe indications for ancillary testing in the evaluation of uveitis (e.g., fluorescein angiography, ultrasound, laboratory testing, radiologic testing).

**Goals During PGY-3**

1. **Cognitive Skills**
   a. Identify the less common causes of cataract (e.g. ectopia lentis)
   b. Understand relationship of cataract with concurrent ocular and systemic disease
   c. Correlate functional vision with type of lens opacity and objective visual acuity
   d. Understand informed consent including risks, benefits, and alternatives for intraocular surgery
   e. Perform post-operative evaluation of cataract surgery patient
   f. Diagnose and participate in management of common post-operative complications of cataract surgery (e.g. intraocular pressure rise, wound leak, hypotony, hyphema, cystoid macular edema, intraocular lens dislocation).
   g. Describe more advanced principles of history taking and examination of patients with uveitis
      a. e.g., review of systems for Wegener’s granulomatosis, polyarteritis nodosa, lupus erythematosus, rheumatoid arthritis, inflammatory bowel disease, systemic necrotizing vasculitis
b. evaluation of skin, cardiac, respiratory, renal, pulmonary, musculoskeletal systems.

h. List less common signs and symptoms of anterior and posterior uveitis.

i. List differentiating signs of less common forms of uveitis (e.g., iris nodules).

j. Describe the differential diagnosis of less common forms of uveitis (e.g., chronic uveitis, intermediate uveitis [e.g., pars planitis], and infectious [e.g., Whipple disease, syphilis] or inflammatory posterior uveitis; masquerade syndromes, including large cell lymphoma).

k. Evaluate and treat common causes of anterior and posterior uveitis.

l. Describe the common causes of uveitis in specific age/ethnic groups of the general population

2. Technical Skills

a. Learn preparatory procedures for intraocular surgery: preparation and administration of anesthesia for intraocular surgery (e.g. retrobulbar, peribulbar, sub-Tenon’s), sterile prepping and draping of patient, gloving and gowning

b. Perform paracentesis of anterior chamber at slit lamp

c. Improve performance of examination skills acquired during PGY-2.

d. Know indications for specialized tests for the evaluation of uveitis and interpret their results

Goals During PGY-4

1. Cognitive Skills

a. Define more complex indications for cataract surgery (e.g. improved view of fundus to monitor for diabetic retinopathy)

b. Identify anterior segment pathology (e.g. pseudoexfoliation, small pupil, post-traumatic zonular dehiscence) which may be risk factors for operative complications during cataract surgery

c. Describe various methods for IOL calculation and use of A-scan ultrasonography and keratometry

d. List and understand relevance of steps involved in cataract surgery

e. Understand viscoelastic materials used in cataract surgery and their properties

f. Understand difference between various intraocular lenses: foldable and non-foldable, multi-focal, toric
g. Understand indications for combined triple intraocular procedures (corneal transplant with cataract extraction and intraocular lens implant, glaucoma filtering surgery with cataract extraction and intraocular lens implant)

h. Manage both common and complex post-operative care of patient (e.g. refraction, topical and systemic medications, corneal edema, wound leak, residual nuclear fragments or cortex, uveitis, cystoid macular edema, elevated intraocular pressure, hyphema, retinal detachment, early and late post-operative endophthalmitis)

i. Recognize, evaluate and treat uveitis associated with immunosuppressed individuals (e.g., active and recovered acquired immune deficiency syndrome, pharmacologic immunosuppression).

j. Recognize, evaluate, and treat acquired and congenital ocular syphilis.

k. Recognize, evaluate, and treat (or refer) less common, rare, or tropical conditions associated with uveitis (e.g., Leishmaniasis).

l. Describe indications and contraindications for corticosteroid treatment of uveitis (e.g., topical, local, systemic), including risks and benefits of therapy.

m. Describe indications and contraindications for immunosuppressive therapy in uveitis, use of antimetabolites, cyclosporine, alkylating agents

n. Evaluate and treat the complications of uveitis therapy (e.g., cataract, glaucoma).

2. Technical Skills
   a. Be fully proficient in preparatory care of patient

   b. Understand phacoemulsification settings (power, vacuum, aspiration, burst and pulse modes) and be able to trouble-shoot machine

   c. Administer steroids in treatment of uveitis by various routes.

   d. Administer immunosuppressive agents in uveitis (or refer for administration).

   e. Perform anterior chamber paracentesis and send sample to pathology

   f. Assist in or perform biopsy of the vitreous or uveal tract if indicated

   g. Understand indications for and assist in insertion of intravitreal implants containing antiviral or corticosteroid medications.

   h. Assist in glaucoma filtering surgery, vitrectomy or scleral buckling procedures for uveitis when indicated
SURGICAL SKILLS:

Goals During PGY-2
1. Practice basic steps of cataract surgery in wet-lab (e.g. eye-hand coordination under operating microscope: wound construction, capsulotomy or capsulorrhexis, injecting viscoelastic material, suturing)

Goals During PGY-3
1. Refine technical skills practiced in wet lab during PGY-2 and start using phacoemulsification machine to practice grooving, sculpting, cracking, and chopping on animal eyes
2. Assist in operating room during cataract extraction surgeries
3. Understand indications for and perform YAG capsulotomy

Goals During PGY-4
1. Perform phacoemulsification steps from start to finish in wet-lab under and then in operating room: paracentesis, use of viscoelastic material, wound construction, capsulorrhexis, hydrodissection, hydrodelineation, phacoemulsification, cortical clean-up/irrigation, posterior capsule polishing, intraocular lens implantation, wound closure
2. Practice various phacoemulsification techniques for nuclear removal: sculpting, cracking, divide and conquer, stop and chop, chip and flip, carouseling
3. Understand and perform management of intra-operative challenges: shallow anterior chamber, phacoemulsification burns, posterior capsule tears, positive posterior pressure, vitreous loss, dropped nuclear fragments, wound leak, choroidal effusion, expulsive choroidal hemorrhage, intraocular lens repositioning or exchange
4. Learn technique of anterior vitrectomy
5. Become fully proficient in YAG capsulotomy
6. Know indications and techniques for astigmatic keratotomy
7. Understand indications for and perform combined intraocular procedures (e.g. corneal transplant with cataract extraction and intraocular lens placement, glaucoma filtering surgery with cataract extraction and intraocular lens placement)
PATIENT CARE:

- The skills for this rotation are primarily learned in a graduated fashion in the general clinic at VCUHS and in the wet-lab during the PGY-2 and -3 years. The surgical skills for phacoemulsification are acquired mainly during the PGY-4 year.

- Perform an appropriate evaluation to determine visual impairment secondary to cataract beyond best-corrected visual acuity (e.g. glare, contrast sensitivity)

- Determine patient’s individual functional vision needs and correlate with cataract

- Residents see patients with uveitis in both the general clinic at BLHC as well as in the retina clinic under the direct supervision of an attending

- Residents learn the techniques of successfully instilling appropriate medication (e.g., eyedrops, various routes for steroids)

- Patients with chronic uveitis are followed closely long-term, providing residents the opportunity to observe any progression of disease as well as outcomes of medical or surgical intervention

- Residents are encouraged to be sensitive to the psychological and emotional aspects of living with chronic uveitis and associated systemic conditions, and be aware of the challenges encountered by such patients (e.g. photophobia, glare, inability to drive or read)

- To deliver appropriate medical eye care in this population, residents learn various ways to interact with:
  - an uncooperative patient
  - a non-English speaking patient
  - an immunocompromised patient
  - family member or caregiver, when appropriate

PRACTICE-BASED LEARNING AND IMPROVEMENT:

- Evaluate surgical outcomes using logs (e.g. post-operative refractive status with respect to choice of IOL power, intra- or post-operative complications)

- Morbidity and mortality conferences with faculty

INTER-PERSONAL AND COMMUNICATION SKILLS:

- Obtain a good history to determine patient’s specific visual complaints and functional needs

- Effectively communicate to patient risks, benefits, and alternatives of procedure

- Discuss with patients options for intraocular lens choice and power

- Teach junior residents evaluation, management, and potential complications of cataract surgery
Residents learn to effectively educate the patient, family, and/or caregiver regarding:

- the use of medication
  - instillation (methods and dosage)
  - storage
- medication side effects

The skills of effective listening and communication are stressed. Residents are taught to ask the patient/family member/caregiver for any questions, answer exactly what is asked, and clarify any uncertainties.

Given the ethnic and cultural diversity of our patient population in the Richmond area, residents frequently make use of the hospital’s official language line (translation service) if and when appropriate.

**PROFESSIONALISM:**

- Compassion and respect for the patient’s wishes based on visual function
- Honestly assess own surgical abilities and limitations in order to minimize operative risk to patient
- Practice successful communication with operating room staff
- Have honest discussions with patient regarding any intra-operative or post-operative complications and adverse outcomes
- Residents must be aware of their limitations with respect to accuracy of clinical skills and know when to ask, and be comfortable asking, for guidance or supervision
- Residents are taught to greet and address the patient, especially in cases of elderly patients who may be accompanied by a family member or care-giver, or children who may be with parents.
- Residents must be aware of their limitations with respect to language skills and know when to use the language line (as noted above)
- Upon the completion of an examination including dilated fundoscopy, residents are expected to document their findings in such a way that it is intelligible to other ophthalmic practitioners.
- Residents are taught the importance of providing feedback to the patient’s other health care providers (e.g., the primary care provider, rheumatologist, or pulmonologist), whether or not a referral was made, and to use understandable language when communicating
SYSTEM-BASED PRACTICE:

- Incorporate cost-awareness of intraocular lens choices for individual patient
- Identify any barriers to adequate post-operative care and enlist the aid of family members or social services to improve compliance
- Understand difference in delivery of care in various settings: hospital-based vs. ambulatory surgery center
- Residents should know when, how, and where to make appropriate referrals for or perform:
  - Fluorescein angiography
  - Ultrasonography
  - Optical coherence tomography
- Residents should know when, how, and where to make referrals for or perform:
  - Anterior chamber paracentesis
  - Vitreous biopsy
  - Chorioretinal biopsy
- Residents should know when and where to refer a low vision uveitis patient for visual rehabilitation services
- Residents should employ the aid of Social Services in difficult cases of non-compliance with therapy

Teaching Faculty:

William H. Benson, MD, Professor and Department Chair
Muneera A. Mahmood, MD, Associate Professor/Chief of Ophthalmology, VAMC
Dennis Pratt, MD, Assistant Professor, VAMC
Christopher T. Leffler, MD, Assistant Professor

Teaching Methods:

1. One-on-one teaching in clinic and in operating room

2. Didactics: Scheduled departmental lectures and extramural coursework in lens and cataract

3. Required reading:
   a. AAO BCSC Lens and Cataract section
   b. AAO BCSC Intraocular Inflammation and Uveitis section

4. Recommended Reading:
   c. Risk Management in Cataract Surgery. AAO Focal Points.
5. Surgical videos

6. Wet-lab: Suturing, wound construction, and phacoemulsification techniques

**Assessment Methods**: End of rotation evaluation, OKAP exam, ABO written and oral examinations, surgical skills assessment evaluation, surgical outcomes review, surgical case log, wet-lab, Journal Club tool, and 360-degree evaluation.

*Adapted from Objectives in AAO BCSC: Lens and Cataract & Intraocular Inflammation and Uveitis sections.

SUBSPECIALTY SERVICES:

**Cornea, External Disease, and Refractive Surgery**

Resident Responsibilities
This rotation is designed to refine the resident’s slit lamp examination skills, enhance their fund of knowledge, and help residents achieve an appropriate level of clinical performance in the area of cornea/ anterior segment and refractive surgery. On this service, residents are strongly encouraged to read the book chapter on “The Eye Examination” that is provided in the below suggested readings for this rotation. This chapter offers a philosophy about the common-sense approach toward proper patient history taking and evaluation in the area of cornea, anterior segment and refractive surgery patients.

The resident on this rotation is expected to work ahead of the attending physician on as many patients as they are comfortable evaluating. The individual responsibilities during the examination such as refraction, gonioscopy, tonometry, and application of the fluorescein staining will be determined by the attending physician at the beginning of the rotation based on the resident’s level of performance. Individual expectations will be discussed with the resident throughout the rotation. In general, residents are encouraged to work up as many patients as possible in a complete and systematic fashion. It is encouraged for residents to ask the attending in the clinic as many questions as possible. Throughout this rotation, residents will have the advantage of seeing not only an indigent patient population, but also, patients in a private practice setting. Refractive surgical observation time has also been allotted.

It is the desire of the faculty to create an educational and clinical environment that fosters passion, excitement and interest in the area of cornea, anterior segment, and refractive surgical patients. Below is a list of basic goals and objectives that should be obtained throughout the resident’s time on this rotation.

**Overall Objectives**:  
The resident is expected to:

- Describe the basic anatomy, embryology, and physiology of the cornea, sclera, conjunctiva, and eyelid margin.

- Explain the pathogenesis of common congenital and acquired disorders affecting the cornea, sclera, conjunctiva, and eyelid margin, including distinctive signs of specific diseases.

- Learn the appropriate steps in an ocular examination for corneal or external eye disease and choose appropriate laboratory and/or other diagnostic tests.

- Identify topographic changes of the cornea and describe the risks and benefits of corrective measures.

- Understand the indications and techniques of surgical procedures for managing corneal disease, trauma, and refractive error.

- Describe the various types of lasers and devices used in refractive surgery, techniques, patient selection, refractive outcomes, and complications.
Competency Based Goals and Objectives

MEDICAL KNOWLEDGE**:
Goals During PGY-2

1. **Cognitive Skills**
   a. Describe basic congenital abnormalities of the cornea
   b. Describe common conjunctival degenerations (e.g., pterygium, pinguecula)
   c. Describe common corneal disorders and differentiate degenerations from dystrophies (keratoconus vs. map-dot-fingerprint dystrophy)
   d. Understand the fundamentals of ocular microbiology and recognize corneal infections and inflammations (e.g., herpetic eye disease, peripheral ulcerative keratitis)
   e. Identify and manage various manifestations of ocular allergy (e.g., vernal, atopic, allergic, or giant papillary conjunctivitis, phlyctenules)
   f. Recognize and treat lid margin disease (e.g., Staphylococcal blepharitis, meibomian gland dysfunction)
   g. Describe ocular manifestations of Vitamin A deficiency and neurotrophic corneal disorders
   h. Identify and treat acute and chronic conjunctivitis
   i. Provide differential diagnosis of “red eye”: episcleritis, scleritis, angle-closure glaucoma, conjunctivitis (infectious, allergic, toxic), uveitis, cellulitis, carotid-cavernous fistula
   j. Describe mechanisms of traumatic and toxic injury to anterior segment (e.g., chemical burn, lid laceration, orbital floor fracture)
   k. Understand basic principles of ocular pharmacology including indications and contraindications for topical steroid use, non-steroidal anti-inflammatory drugs, antibiotic agents, other immunomodulating agents
   l. Diagnose perforating and non-perforating corneal lacerations
   m. Manage corneal and conjunctival foreign bodies
   n. Identify pterygia which require surgical excision and describe various techniques employed
   o. Diagnose and treat corneal exposure using non-surgical interventions (lubricants, moisture chamber, lid taping)
   p. Describe epidemiology, classification, pathology, management, and prognosis of common benign and malignant conjunctival and eyelid lesions (e.g., nevus, melanoma, squamous cell carcinoma, basal cell carcinoma, seborrheic keratoses)
q. Understand relationship between eyelid malposition and secondary diseases of cornea or conjunctiva (exposure keratopathy)

r. Recognize and manage chemical burns

s. Recognize and manage hyphema and microhyphema

t. Describe and manage superficial punctate keratopathy (e.g., Thygeson’s, dry eye, contact lens-related)

u. Describe findings, special tests, and management of exposure keratopathy (Schirmer test)

v. Recognize corneal manifestations of systemic disease (e.g., Wilson’s disease, vortex keratopathy)

w. Understand pathophysiology and management of pyogenic granuloma

x. Describe developmental anterior segment abnormalities (e.g., aniridia, anterior segment dysgenesis syndrome) and give differential diagnosis

2. **Technical Skills**

   a. Perform external and slit lamp biomicroscopy, and document findings via drawings

   b. Administer topical anesthesia and topical stains (fluorescein and rose bengal)

   c. Describe and perform various types of tonometry (e.g., Goldmann applanation, Schiotz, Perkins, tonopen)

   d. Perform tests for dry eye (e.g., Schirmer I and II, tear break-up time)

   e. Perform temporary or permanent punctual occlusion using plugs and cautery

   f. Perform corneal scraping and culture for infections

   g. Perform and interpret stains of the cornea and conjunctiva (e.g., Gram stain, Giemsa, calcofluor white, acid fast)

   h. Test corneal sensitivity

   i. Manage corneal epithelial defects (e.g., pressure patching, bandage contact lens)

   j. Perform removal of corneal or conjunctival foreign body or rust ring via diamond burr

   k. Perform epilation

   l. Perform irrigation of chemical burn to eye

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**Goals During PGY-3**

1. **Cognitive Skills**

   a. Describe more complex pathology of cornea, sclera, globe, conjunctiva, eyelids, lacrimal gland

   b. Identify and treat peripheral corneal thinning
c. Become more proficient at diagnosis and management of less common and more complex infectious, inflammatory, degenerative, and dystrophic disorders of the cornea, conjunctiva, sclera, eyelid, and lacrimal system
d. Describe, diagnose, and manage more complex cases of “red eye” (e.g., chronic conjunctivitis), interstitial keratitis, traumatic (e.g., corneal lacerations, hyphema) and toxic injury
e. Understand ocular microbiology and pharmacology at higher level
f. Diagnose and manage ocular cicatricial pemphigoid
g. Recognize, evaluate, and treat ocular complications of systemic disease (e.g., Steven’s Johnson syndrome, chronic exposure keratopathy, contact dermatitis)
h. Describe and manage more advanced peripheral corneal thinning or ulceration

2. **Technical Skills**
   a. Treat corneal epithelial defects with bandage contact lenses
   b. Treat band keratopathy with chelation and scraping
   c. Perform stromal micropuncture
   d. Perform application of corneal glue

**Goals During PGY-4**

1. **Cognitive Skills**
   a. Achieve the highest level of understanding with respect to disorders of the congenital and acquired cornea and ocular adnexa
   b. Understand more complex corneal optics and refraction
   c. Describe the manifestations of less common infections of the cornea and conjunctiva (e.g., amoebiasis, ochocerciasis, trachoma) and understand their management
   d. Understand ocular surface transplantation including: conjunctival autograft/flap, amniotic membrane transplant, limbal stem cell transplantation
   e. Understand the surgical indications for corneal transplant (e.g., pseudophakic bullous keratopathy, Fuch’s endothelial dystrophy, herpetic disease), perform pre-operative evaluation of these patients, and understand the surgical techniques employed in penetrating keratoplasty
   f. Understand and perform pre-operative evaluation of donor corneal buttons, including selecting age-appropriate tissue and sufficient endothelial cell count
g. Diagnose and manage types of post-keratoplasty immunologically-mediated rejection

h. Understand the pre-operative assessment, patients selection, surgical management, and post-operative care of refractive surgical techniques, including keratotomy (e.g., radial, astigmatic), photoablation (e.g., photorefractive, phototherapeutic, LASIK, LASEK), corneal wedge resection, thermokeratoplasty, intracorneal stromal rings, phakic intraocular lens, and clear lens extraction

2. **Technical Skills**
   a. Perform and interpret the most advanced corneal diagnostic techniques (e.g., pachymetry, endothelial microscopy, computerized corneal topography)
   b. Understand and perform complicated CL fitting (i.e. post-keratoplasty)
   c. Manage and treat more complex neoplasms of the conjunctiva (i.e. carcinoma, melanoma)

**SURGICAL SKILLS:**

*Goals During PGY-2:*

1. Perform incision and drainage of chalazion
2. Perform simple incisional or excisional biopsy of lid lesion
3. Perform uncomplicated lid laceration repair (not involving canalicular system)

*Goals During PGY-3:*

1. Perform pterygium excision via various methods (bare sclera, mitomycin C, conjunctival autograft, amniotic membrane)
2. Repair simple lacerations of the lacrimal drainage system (e.g., primary closure and intubations)

*Goals During PGY-4:*

1. Assist in and/or perform conjunctival surgeries (e.g., Gunderson flap, biopsy of suspicious lesion)
2. Assist in and/or perform more advanced corneal surgery (e.g., penetrating or lamellar penetrating keratoplasty, limbal stem cell transplant, amniotic membrane, phototherapeutic keratectomy)
3. Perform basic non-laser refractive surgery techniques (i.e. relaxing keratotomy)
4. Participate in refractive surgery certification course
5. Observe, assist in, and/or perform refractive surgery
PATIENT CARE:

- The residents are exposed to a variety of corneal pathology during the sub-specialty cornea clinic one and a half-day per week as well as in general clinic at VCUHS and VAMC.
- Learn to differentiate between acute and chronic corneal disorders and recognize vision-threatening condition requiring immediate intervention
- Appropriate hand-washing technique
- Formulate an appropriate management plan for infectious corneal disorders including:
  - preparing fortified antibiotics
  - using appropriate culture and staining techniques
  - assuring patient understanding of medication regimen and delivery of eyedrops

PRACTICE-BASED LEARNING AND IMPROVEMENT:

- Upon completion of an external and slit lamp examination, residents present cases to the supervising attending, which then cross checks and verifies their findings. Any discrepancies are then reviewed and explained.

INTER-PERSONAL AND COMMUNICATION SKILLS:

- Obtain a good history to determine patient’s specific visual complaints and needs
- Effectively educate the patient regarding the use of medications prescribed and verify compliance with regimen
- Given the ethnic and cultural diversity of our patient population in the Richmond area, residents frequently make use of the hospital’s official language line (translation service) if and when appropriate.

PROFESSIONALISM:

- Residents must be aware of their limitations with respect to accuracy of clinical skills and know when to ask and be comfortable asking for guidance or supervision, whether in the clinic or in the operating room
- Residents are taught to be aware of lifestyle factors which may be related to a patient’s corneal or external disease pathology (e.g., inability to work because of recurrent corneal erosions, appropriate contact lens wear, hygienic factors contributing to spread of infectious conjunctivitis)
- Counseling patients objectively and appropriately regarding refractive surgery
SYSTEM-BASED PRACTICE:

- Residents should be aware of cost-effective diagnostic work-up and therapeutic options
- Identify patients visual impairment from corneal disorders who would benefit from low vision services and/or counseling and refer appropriately
- Residents should employ the aid of Social Services in cases of:
  - Non-compliance with therapy
  - Need to apply for emergency financial assistance (Medicaid)

Teaching Faculty:

William H. Benson, MD, Professor and Department Chair, Program Director
Muneera Mahmood, MD, Associate Professor/Chief of Ophthalmology, VAMC
Dennis Pratt, MD, Assistant Professor, VAMC
Garth Stevens, Jr., MD, Associate Clinical Professor

Teaching Methods:

1. One-on-one teaching/demonstration of examination by faculty

2. Didactics: Scheduled departmental lectures and extramural coursework in cornea, external disease, and refractive surgery

3. Required reading:
   i. AAO BCSC: External Disease and Cornea section.
   ii. AAO BCSC: Refractive Surgery section.

4. Wet-Lab: Corneal, scleral, and conjunctival suturing techniques

Assessment Methods: End of rotation evaluation, OKAP exam, ABO written and oral examinations, surgical skills assessment evaluation, surgical outcomes review, surgical case log, wet-lab, Journal Club tool, and 360-degree evaluation.

*Adapted from Objectives in AAO BCSC: External Disease and Cornea and Refractive Surgery sections.

SUBSPECIALTY SERVICES:

**Glaucoma**

Glaucoma is a complex and potentially blinding disease of unknown etiology. The purpose of the Glaucoma Service is to provide and participate in comprehensive eye care to those individuals suffering from one of the many forms of this disease and associated disorders. As such, training emphasis is placed on appropriate detailed history taking, examination, decision-making and treatment.

**Resident Responsibilities**

The residents rotating through the Service are expected to become proficient in patient evaluation and management. Specifically, residents are to master the essential aspects of slit lamp examination, gonioscopy, optic nerve head and nerve fiber evaluation, visual field interpretation, tonometry and surgical aspects regarding glaucoma.

**Overall Objectives***

The resident is expected to:

- Understand the basic and advanced principles of glaucoma evaluation and management, including how to perform a comprehensive examination with particular attention to the evaluation of the optic nerve head, estimation of cupping, measurement of intraocular pressure, and gonioscopic findings.
- Learn interpretation of ancillary testing such as automated visual fields and optic nerve head imaging modalities.
- Recognize, differentiate, evaluate, and manage various categories of glaucoma (e.g., open angle vs. angle-closure, primary vs. secondary)

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**Competency Based Goals and Objectives**

**MEDICAL KNOWLEDGE**: *

*Goals during PGY-2*

1. Cognitive Skills:
   a. Describe the epidemiology and genetics of primary open-angle glaucoma (POAG), chronic angle-closure glaucoma (CACG), and secondary glaucoma
   b. Describe the mechanics of aqueous humor dynamics and anatomy of the anterior chamber, the angle, and the ciliary body
   c. Describe basic tonometry
   d. Describe optic nerve and retinal nerve fiber layer anatomy in glaucoma
   e. Describe the fundamental principles of static and kinetic perimetry and understand the benefits and shortcomings of various testing strategies
f. Describe the basic principles, indications, and techniques of gonioscopy and be able to identify both normal and abnormal findings

g. Perform a complete clinical evaluation of a glaucoma-suspect and glaucoma patient

h. Describe the features of and recognize primary vs. secondary open angle and angle-closure glaucoma

i. Describe the principles of medical management of primary and secondary open-angle and angle-closure glaucoma (e.g., indications for treatment, choice of topical and systemic medications, laser therapy, surgical options, side effects, frequency of follow-up)

j. Describe and manage normal-tension glaucoma

k. List clinically relevant outcomes of major glaucoma trials (Glaucoma Laser Trial, Normal Tension Glaucoma Study, Advanced Glaucoma Intervention Study, Ocular Hypertension Treatment Study, Collaborative Initial Glaucoma Treatment Study)

2. Technical Skills
   a. Become proficient in glaucoma evaluation skills: tonometry, gonioscopy, stereo examination of optic nerve, corneal pachymetry
   b. Interpret visual field results in glaucoma-suspect and routine glaucoma patients
   c. Interpret results from optic nerve head imaging modalities.

Goals during PGY-3

1. Cognitive Skills
   a. Describe, diagnose, and manage more complicated cases of secondary open-angle and angle closure glaucoma (e.g., angle recession, pigment dispersion, steroid-induced, lens-induced, plateau iris, pseudoexfoliative, iridocorneal endothelial syndromes, aqueous misdirection, neovascular glaucoma)
   b. Describe and interpret more advanced tonometric results (e.g., diurnal curve) and complicated visual field results
   c. Describe more advanced optic nerve head and retinal nerve fiber layer changes related to glaucoma (e.g., atypical cupping, rim pallor)
   d. Apply to clinical practice the conclusions of major glaucoma trials as listed above
   e. Describe features of pediatric glaucomas (primary infantile and juvenile)
   f. Diagnose ocular hypotony and its clinical presentation and understand differential diagnosis and management options
g. Describe the principles behind use of lasers in glaucoma management: indications, techniques, and potential complications

h. Describe the surgical treatment of glaucoma (e.g., timing, choice of procedure, trabeculectomy, implants, use of anti-metabolites, cyclodestructive procedures, combined triple procedure: trabeculectomy with cataract extraction and intraocular lens implant)

2. Technical Skills
   a. Refine diagnostic techniques learned previously: tonometry, gonioscopy

**Goals during PGY-4**

1. Cognitive Skills
   a. Describe, identify, and manage the most complex cases of primary and secondary glaucomas in both the adult and pediatric population with the highest level of understanding of diagnostic testing, interpretation of tests, treatment options in the context of published literature
   
b. Recognize and treat complications of glaucoma surgery
   
c. Understand indications for use of anti-metabolites in glaucoma surgery and manage associated complications
   
d. Understand surgical management of pediatric glaucomas (goniotomy, trabeculotomy)

2. Technical Skills:
   a. Manage complicated cases of a flat anterior chamber
   
b. Perform techniques for revision of a filtering bleb (failing or leaking)

**SURGICAL SKILLS:**

**Goals during PGY-3**

1. Perform lasers for various types of glaucoma including:
   a. YAG or argon laser peripheral iridotomy
   
   b. argon laser trabeculoplasty
   
   c. selective laser trabeculoplasty
   
   d. argon laser iridoplasty
   
   e. pan-retinal photocoagulation

**Goals during PGY-4**

1. Achieve highest level of proficiency in laser therapy for glaucoma as noted above

2. Perform YAG or argon laser in more complex cases (suture lysis, monocular patient, repeat laser, vitreous lysis)
3. Assist in and perform trabeculectomy with or without anti-metabolites, glaucoma implant surgery, combined procedures
4. Assist in and/or perform cyclodestructive procedures

PATIENT CARE:

- During the PGY-2 and PGY-3 years, residents participate in glaucoma sub-specialty clinic at VCUHS one full day per week supervised by two glaucoma attending. In the PGY-3 year, there is ample opportunity to become proficient in glaucoma laser therapy. During the PGY-4 year, residents spend time in the operating room at the Stony Point Surgery Center with glaucoma attending, assisting as well as performing glaucoma filtering surgeries.

- Patients with glaucoma are often followed closely long-term, providing residents the opportunity to observe any progression of disease as well as outcomes of medical or surgical intervention

- Identify patients who may be at risk for glaucoma (e.g., family members) and encourage them to undergo a screening examination

PRACTICE-BASED LEARNING AND IMPROVEMENT

- Evaluate surgical outcomes
- Surgical review conferences with faculty
- Journal Club; case presentation

INTER-PERSONAL AND COMMUNICATION SKILLS:

- Residents teach patients effective techniques for drop instillation
- Residents explain to patients the importance of compliance with their glaucoma medication regimen and assist in implementation of compliance via written instructions or charts

PROFESSIONALISM:

- Residents must be aware of their limitations with respect to accuracy of clinical skills and know when to ask and be comfortable asking for guidance or supervision, whether in the clinic or in the operating room.

- Compassion and respect for the patient’s wishes based on visual function

- Residents must be aware of their limitations with respect to language skills and know when to use the language line (translation service provided through the institution).
SYSTEM-BASED PRACTICE:

- Incorporate cost-awareness of various glaucoma medications into therapeutic plan
- Residents should employ the aid of Social Services in difficult cases of:
  - Non-compliance with therapy
- Residents should know when and where to refer a patient for visual rehabilitation if their visual impairment from glaucoma interferes with daily living

TEACHING FACULTY:
Daniel J. McGrath, MD, Associate Clinical Professor

TEACHING METHODS:
1. One-on-one teaching by faculty in clinic and in the operating room
2. Didactics: Scheduled departmental lectures and extramural coursework in glaucoma
4. Recommended Reading:
   - Glaucoma, Chandler and Grant
5. Wet-Lab: Handling Conjunctiva and Sclera; Suturing Techniques
6. Journal Club: selected recent articles from major ophthalmic journals

ASSESSMENT METHODS:
OKAP exam, ABO written and oral examinations, surgical skills assessment evaluation, surgical outcomes review, surgical case log, wet-lab, Journal Club tool, 360-degree evaluation, end of rotation evaluation.

*Adapted from Objectives in AAO BCSC: Glaucoma section.

**Optics, Refraction, Contact Lens, and Low Vision**

**Overall Objectives**:  
The resident is expected to:

- Understand the principles, concepts, instruments, and methods of optics and refraction and be able to apply them in clinical practice. The principles and skills learned during this rotation will provide the foundation for an ophthalmologic evaluation and are incorporated into daily practice during general as well as all sub-specialty clinics throughout all levels of training.

- Learn contact lens (CL) prescribing as well as fitting, building on the skills of refraction and retinoscopy learned previously.

- Understand the principles of low vision rehabilitation including: the optics of the devices and techniques employed, determining the needs of a low vision patient, the local regulations regarding disability status and licensure for driving, and appropriateness of referrals to a low vision center.

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**Competency Based Goals and Objectives:**

**Medical Knowledge**:  

**Goals During PGY-2:**

1. Understand basic optical principles  
   a. physical optics: wave vs. photon-particle theory, diffraction, interference, coherence, lasers, optical media, refractive index  
   b. geometric optics: laws of refraction and reflection, prisms, spherical lenses, astigmatic lenses, Maddox rod, vergence, lens aberrations

2. Understand clinical optics  
   a. optics of the eye  
   b. measuring visual acuity, use of pinhole  
   c. describe emmetropia, various types of ametropia and their correction (e.g. spectacle lenses, contact lenses, intraocular lenses, refractive surgery)  
   d. accommodation and presbyopia, vertex distance  
   e. retinoscopy  
   f. lens power, spectacle magnification  
   g. Low vision aids (e.g. telescopes, magnifying lenses)

3. Practice Clinical Refraction  
   a. Retinoscopy, manifest refraction, cycloplegic refraction  
   b. Determining accommodative power  
   c. Prescribing multifocal lenses

4. Become familiar with use of ophthalmic instruments and tests and understand their results  
   a. Use of direct and indirect ophthalmoscope, retinoscope, lensometer, automated refractor, potential acuity meter  
   b. Use of phoropter and trial lenses
c. Slit lamp biomicroscopy, applanation tonometer, gonioscope, keratometer, corneal topography, corneal pachymeter, specular microscope
d. Lenses used for fundoscopy: Goldmann, Hruby, 90 diopter, 20 diopter
e. Fundus camera and non- mydriatic camera
f. Color vision tests
g. Operating microscope
5. Evaluate and manage CL patients
   a. Perform the basic examination: refraction, retinoscopy, and over-refraction
   b. Describe the optics of contact lenses: soft and hard CLs, base curve, diameter, optical zone, toric lenses
   c. Be able to convert a spectacle prescription to a CL prescription taking into account change in vertex distance, or plus to minus cylinder
d. Describe indications and contraindications for CL use (refractive and therapeutic)
e. Counsel patient regarding insertion, removal, daily care, and length of wear of CL
f. Select candidates for non-complex CL wear
g. Evaluate CL fit at slit lamp biomicroscope, tear film, use of fluorescein staining
h. Identify and manage complications of CL wear: staining of cornea, pannus, giant papillary conjunctivitis, corneal ulcers
6. Evaluate and manage low vision patients
   a. Describe low vision assessment techniques (e.g. Early Treatment of Diabetic Retinopathy Study charts, Sloane chart)
b. Understand definition of legal blindness and evaluate patient’s functional vision
c. Describe significant co-morbidities which impact low vision rehabilitation
d. Describe various low vision aids and their optics
e. Describe simple but appropriate rehabilitative therapies and optical devices to improve quality of life in low vision patients (e.g. magnification, illumination)
f. Describe functional implications of various visual system pathologies and diseases
g. Describe visual field enhancing techniques for hemianopic visual field loss
h. Understand differences between visual acuity testing at distance and near and contrast sensitivity testing
i. Describe the evaluation of and rationale for licensing automobile drivers who are visually impaired
j. Describe evaluation of visual acuity and fields for determination of disability
7. Understand options for ocular prostheses (e.g., scleral shell, implants, conformers) and make appropriate referrals
8. Meet the Optical Proficiency Requirement

Goals During PGY-3:
1. Improve proficiency in ophthalmic examination skills learned during PGY-2
2. Evaluate and manage complex refractive cases (e.g. irregular astigmatism)
3. Refine CL history, examination, and fitting skills in more complex cases (e.g. keratoconus, keratoglobus, post-keratoplasty, aphakic children)
4. Identify candidates for CL wear with more complex ophthalmic disorders
5. Use corneal topography to fit more difficult CL cases
6. Counsel these patients and family members regarding CL use (e.g. parents of child with congenital cataract, now aphakic)
7. Recognize significant co-morbidities that impact low vision rehabilitation
8. Recognize and describe clinical applications, indications, and limitations of various low vision aids (e.g. closed-circuit television, magnification, Braille, large print, computers with artificial speech)
9. Describe the more advanced optics of low vision devices
10. Describe more complex visual rehabilitative therapies and optical devices to help patients meet their goals
11. Understand the optics of visual field enhancing techniques for hemianopic visual field loss
12. Perform evaluation of vision assessment in licensing drivers who are visually impaired
13. Evaluate visual acuity and field for determination of disability (for legal and insurance purposes)
14. Demonstrate low vision devices and educate low vision patients on the uses and limitations of these devices

Goals During PGY-4:
1. Apply optical principles to clinical practice at the highest level of understanding in: complex refraction and prescribing spectacles and contact lenses, cataract surgery and choice of intraocular lenses, post-cataract and post-keratoplasty refractive needs, pre and post-refractive surgery and outcomes, use of prisms for diplopia, low vision aids
2. Demonstrate the highest level of understanding and proficiency in the history, examination, and fitting of CL patients, both non-complex and complex (e.g. keratoconus, keratoglobus, post-corneal transplant or corneal laceration repair)
3. Modify CL choice if necessary based on material, length of wear, fit, and comfort
4. Treat significant co-morbidities that impact low vision rehabilitation
5. Describe indications for the most complex low vision aids
6. Apply more complex principles of optics of low vision devices
7. Prescribe the most complex rehabilitative therapies and optical devices to help the patient meet his or her functional vision needs
8. Understand and apply the most complex visual field enhancing techniques for hemianopic visual field loss

Patient care:
- Residents see adult and pediatric patients for refraction throughout all levels during training, not only during the general clinic at VCUHS, but also during other sub-specialty clinics as well.
- Provide individualized attention directed at patient’s functional needs (e.g. level of vision required for activities of daily living, occupational requirements, monocular status, aniseikonia, aphakia)
- Identify the needs of low vision patients and make appropriate referrals

Practice-Based Learning and Improvement:
- Work with the patient to refine a previous prescription and understand any mistakes made
- Compare manifest refraction or retinoscopy with results from automated refractor

Inter-Personal and Communication Skills:
- Obtain a good history to determine patient’s specific refractive complaints and needs
- Communicate to patient instructions for wear of corrective lenses
- Discuss with pre-operative cataract surgery patients options for intraocular lens choice and power
• Explain to patient local licensing regulations, level of vision required, and any limitations patient may have

Professionalism:
• Patience in refining refraction for patient throughout multiple visits
• Be sensitive to psychological and emotional aspects of visual impairment, and describe challenges encountered by patients with low vision
• Develop professional, collegial relations with optometrists, under whose direct supervision residents refract and prescribe spectacles and contact lenses
• Understand local licensing regulations and provide accurate and timely records to the Department of Motor Vehicles for patients

Systems-Based Practice:
• Incorporate cost-awareness of various spectacle, contact lens, or intraocular lens choices for our clinic patient population which tends to be of a low socioeconomic status
• Identify visually impaired patients and make appropriate referrals to various local agencies
• Identify patients who may benefit from ocular prostheses and make appropriate referrals
• Identify low vision patients who do not meet the definition for legal blindness and practice patient advocacy by contacting the social security department and testifying as to the patient’s functional visual impairment and the need for low vision benefits.

Teaching Faculty:
Evan J. Kaufman, O.D., Amy Miller, O.D., Jodi Rentz, O.D., Shradha Sanghvi, O.D.

Teaching Methods:
1. One-on-one teaching and demonstration of techniques and instruments in clinic by faculty
2. Didactics: Scheduled departmental lectures and extramural coursework in Optics, Refraction, Contact Lens, and Low Vision
3. Required reading: AAO BCSC: Optics and Refraction section.
4. Recommended Reading:
   d. Contact Lenses Manual by the Contact Lenses Society of America

Assessment Methods: Global Assessment Evaluation, OKAP exam, 360-degree evaluation (optometrists), end of rotation evaluation.

*Adapted from Objectives in AAO BCSC: Optics and Refraction section.
Adapted from: “Principles and Guidelines of a Curriculum for Education of the Ophthalmic Specialist”

Optical Proficiency Requirement

General Optic
1) Be able to convert between Minus and Plus cylinder prescription
2) Understand and be able to map out a “power cross”
3) Understand the differences between a Bifocal, Trifocal, and Progressive glasses
4) Accurately describe to a patient “Myopia, Hyperopia, Astigmatism, Presbyopia”

Retinoscopy
1) Accurately perform a retinoscopy
   a. Standards
      i. Within 20 degree of the true axis
      ii. Within 0.50 diopters of the true power
      iii. Within 0.75 diopters of the true cylinder

Refraction
1) Accurately perform a Subjective Refraction using a phoropter
   b. Standards
      i. Within 10 degree of the true axis
      ii. Within 0.25 diopters of the true power
      iii. Within 0.50 diopters of the true cylinder
2) Understand how to prescribe prism
3) Understand how to do a Balanced refraction
4) Understand how to prescribe a “Add power”

Lensometry
1) Accurately measure a glasses prescription using a manual lensometry
   a. Standard
      i. Within 5 degree of the true axis
      ii. Within 0.25 diopters of the true power
      iii. Within 0.25 diopters of the true cylinder
   b. Be able to descript the differences between a Single vision, bifocal, trifocal, and progressive lens.

Advantages and Disadvantages

Contact lens fitting
1) Insert and remove a Soft contact lens on a patient
2) Insert and remove a Hard contact lens on a patient
3) Independently- Fit a soft spherical contact lens: successfully
4) Independently- Fit a soft toric contact lens: successfully
5) With Assistance – Fit a soft Multifocal contact lens: successfully
6) Accurately access a soft lens fit
7) With Assistance - Fit a Specialty RGP Lens.
8) Understand Flouriscene pattern in a RGP fit
9) Understand and convert Glasses prescription to a Contact lens prescription using “Vertexing”

Keratometry / topography
1) Accurately access a topography scan
2) Description and differentiate the regular and irregular astigmatism
3) Understand the Difference between With the Rule/Against the Rule/ and Oblique Astigmatism
SUBSPECIALTY SERVICES:

**Neuro-Ophthalmology**

Evaluation and treatment disorders of the sensory and motor visual system. It is understood that acquiring an ability to diagnose disorders of the visual system requires a thorough history and examination of each patient as well as independent reading of pertinent textbooks and literature.

Neuro-Ophthalmology is a sub-specialty. The most important aspect of resident and student education is that of learning the science and art of the care, diagnosis, and treatment of patients with neuro-ophthalmologic disorders. Residents rotating on the Neuro-Ophthalmology Service have the privilege to see patients with one-on-one supervision by the experienced Neuro-Ophthalmology faculty. The most intense learning experience comes in this setting where the resident’s history, examination, differential diagnosis and plan are reviewed on each patient seen. This is supplemented by texts, the medical literature and electronic media.

**Resident Responsibilities**

While rotating on Neuro-Ophthalmology service, residents are expected to give primary responsibility to that service. Neurology residents are to attend their scheduled daily noon conferences and continuity clinics. Ophthalmology residents attend their daily morning conferences and Ophthalmology Grand Rounds. All other absences from the Neuro-Ophthalmology service are to be cleared well in advance by the Neuro-Ophthalmology attending faculty.

**Overall Objectives***:

The resident is expected to:

- Describe a symptom/sign-driven approach to patients with common neuro-ophthalmic conditions in order to formulate an appropriate differential diagnosis
- Localize lesions producing neuro-ophthalmic signs and symptoms by identifying relevant anatomic structures (e.g., brain, orbit, spinal cord)
- Evaluate both the visual afferent and efferent systems using a thorough neuro-ophthalmic examination
- Describe and identify the effects of systemic disorders on visual and oculomotor pathways
- Select the most appropriate tests and imaging studies to diagnose specific neuro-ophthalmic disorders in a cost-effective manner
Competency-Based Goals and Objectives

MEDICAL KNOWLEDGE**:  
*Goals during PGY-2*

1. **Cognitive Skills**
   d. Describe the neuro-anatomy of the afferent and efferent visual pathways, including the optic nerve, chiasm, and retro-chiasmal radiations, the pupillary and accommodative pathways, and related cranial nerves
   e. Describe, diagnose, and manage common optic neuropathies: ischemic, inflammatory, toxic, nutritional, compressive, hereditary, traumatic demyelinating
   f. Describe the typical features of, evaluate, and manage common ocular motor neuropathies
   g. Understand differential diagnosis for anisocoria and various testing strategies
   h. Understand visual field testing and correlate patterns of visual field loss with neuro-ophthalmic disorders
   i. Describe common features of: nystagmus, common pupillary abnormalities, ocular myasthenia gravis, carotid-cavernous fistula, congenital and acquired optic nerve abnormalities

2. **Technical Skills:**
   a. Perform and interpret basic pupillary examination (e.g., describe and identify a relative afferent pupillary defect, use pharmacologic testing for Horner’s, Holmes’ Adie’s tonic pupil, identify light-near dissociation, list differential diagnosis)
   b. Describe indications for visual field testing including choice of test, perform confrontational, kinetic (e.g., tangent screen, Goldmann) and static visual field testing and interpret results
   c. Perform ocular motility examination including measurements of ocular alignment to identify phorias and tropias (e.g., Hirschberg, Krimsky, cover-uncover testing, alternate cover testing, simultaneous prism-cover testing, Maddox rod)
   d. Understand use of prisms for diagnosis and management of diplopia
   e. Perform and understand results of forced duction and forced generation testing
   f. Test saccades and pursuits using optokinetic drum
   g. Perform measurements of eyelid position
   h. Perform direct, indirect, and magnified slit lamp ophthalmoscopic examination of optic disc differentiating optic disc swelling, atrophy, and neuroretinitis
Goals during PGY-3

1. Cognitive Skills
   a. Describe and identify typical and atypical features of various optic neuropathies, visual field defects, nystagmus, and pupillary abnormalities
   b. Describe supranuclear and internuclear motility disorders and learn to localize pathology based on clinical findings
   c. Describe findings in and differentiate between cavernous sinus, superior orbital fissure, and orbital syndromes
   d. Describe neuro-ophthalmic manifestations of common systemic diseases (e.g., hypertension, diabetes, systemic lupus erythematosus, sarcoidosis, thyroid disorders, myasthenia gravis, multiple sclerosis, giant cell arteritis)
   e. Identify and manage neuro-ophthalmic findings in trauma (e.g., traumatic optic neuropathy)
   f. Understand management of papilledema secondary to intracranial mass lesions vs. pseudotumor cerebri syndrome
   g. Understand pathophysiology of migraine and its neuro-ophthalmic manifestations
   h. Identify patients with blepharospasm or hemifacial spasm and describe options for treatment

2. Technical Skills
   a. Describe anatomy and indications for neuroimaging, demonstrating ability to communicate information to radiologists to maximize choice of proper imaging modality and accuracy of interpretation
   b. Describe indications for and administration of pharmacologic testing for myasthenia gravis with edrophonium or neostigmine, along with interpretation of results
   c. Perform detailed cranial nerve examination
   d. Interpret optic nerve head and retinal nerve fiber layer imaging (e.g., optical coherence tomography, Heidelberg retinal tomography) and correlate results with other clinical findings
   e. Describe indications for and interpret basic orbital echography
   f. Describe methods to rule out functional (non-organic) visual loss (e.g., red-green glasses, stereopsis, toothpaste refraction, mirror test)
g. Describe indications for temporal artery biopsy, be aware of complications, and interpret results in light of clinical findings and other laboratory tests

**Goals during PGY-4**

1. **Cognitive Skills**
   a. Describe, diagnose, and manage most complex neuro-ophthalmic disorders including optic neuropathies, papilledema, diplopia, cranial nerve palsies, nystagmus, pupillary abnormalities, visual field defects, neuro-ophtalmic manifestations of systemic disease, trauma, hereditary neuro-ophtalmic disorders and genetic counseling
   b. Recognize and manage monocular and binocular transient visual loss
   c. Achieve highest level of understanding of various neuroimaging modalities employed making in neuro-ophtalmologic diagnoses and be comfortable with interpretation of results

2. **Technical Skills:**
   a. Become proficient in all technical skills listed above
   b. Assist in/and or perform botulinum toxin injections for blepharospasm or hemifacial spasm

**SURGICAL SKILLS:**

**Goals During PGY-3**

1. Assist in and/or perform temporal artery biopsy

**Goals During PGY-3**

1. Assist in and/or perform strabismus surgery in adult patients with esotropia, exotropia, hypertropia, hypotropia, thyroid eye disease, or myasthenia gravis
2. Assist in and/or perform optic nerve sheath fenestration

**PATIENT CARE:**

- Residents are exposed to a variety of neuro-ophthalmic conditions during the PGY-2 sub-specialty rotation as well as during general clinic at VCUHS.

- While on call, residents in all levels of training perform consultations on in-house neurology and neurosurgery patients.

- Residents learn to differentiate between acute and chronic cranial nerve disorders and recognize vision or life-threatening conditions requiring immediate intervention

- Because of the chronic nature of various neuro-ophthalmic entities, long-term follow-up is necessary, thereby allowing residents to engage in continuity of care.
• Residents learn to select ancillary testing (e.g., neuro-imaging) appropriate to each particular patient

PRACTICE-BASED LEARNING AND IMPROVEMENT:

• Residents perform a complete history, neuro-ophthalmic examination, and differential diagnosis, after which they present the case to the neuro-ophthalmology attending supervising the clinic. Any discrepancies in examination findings are then shown to the resident before an assessment and plan are discussed with the patient.

INTER-PERSONAL AND COMMUNICATION SKILLS:

• Obtain a good history (e.g., past medical, surgical, ophthalmic, ophthalmic surgical, family, social, travel, and exposure histories) to determine patient’s specific neuro-ophthalmic issues

• Effectively educate the patient regarding the use of medications prescribed, the side effects and interactions of medications, and verify compliance with regimen

• Communicate neuro-ophthalmic findings and management plan with other health care providers (e.g., internist, neurologist, endocrinologist, radiologist) who may be co-managing the patient

• Given the ethnic and cultural diversity of our patient population in the Richmond area, residents frequently make use of the hospital’s official language line (translation service) if and when appropriate

PROFESSIONALISM:

• Residents must be aware of their limitations with respect to accuracy of clinical skills and know when to ask, and be comfortable asking, for guidance or supervision

• Since most neuro-ophthalmic disease processes require a multi-disciplinary approach, residents are taught respectful interaction with other medical services involved in a specific patient’s care

• Residents are taught the importance of follow-up care in oftentimes complicated, long-term neuro-ophthalmic disease processes

• Residents are taught the basics of proper coding, billing, and documentation, particularly in the case of a complex, neuro-ophthalmic new patient visit, which may reach a Level V.

• Residents are encouraged to evaluate patients in a holistic manner, taking into account both systemic and neurologic co-morbidities, and to be sensitive to the impact of the patient’s illness on various aspects of his/her daily life
SYSTEMS-BASED PRACTICE:

- Residents should be aware of cost-effective diagnostic work-up and therapeutic options
- Identify patients who have problems with daily living related to their neuro-ophthalmic disorder who would benefit from other services such as social service intervention and/or counseling and refer appropriately
- Residents should employ the aid of Social Services in cases of:
  - Non-compliance with therapy
  - Need to apply for emergency financial assistance (Medicaid)

Teaching Faculty:
Warren L. Felton, III, MD, Department Chairman, Neuro-Ophthalmology
Scott Haines, MD

Teaching Methods:
1. One-on-one teaching in clinic and in operating room
2. Didactics: Scheduled departmental lectures and extramural coursework in neuro-ophthalmology
4. Recommended Reading:
   b. Selected photocopied articles

Assessment Methods: OKAP exam, ABO written and oral examinations, surgical skills assessment evaluation, surgical outcomes review, surgical case log, wet-lab, Journal Club tool, 360-degree evaluation, end of rotation evaluation.

*Adapted from Objectives in AAO BCSC: Neuro-Ophthalmology section.

SUBSPECIALTY SERVICE:

**Ocular Pathology Service**

**Overall Objectives***:
The resident is expected to:

- properly identify the normal anatomy and histopathology of the eye and ocular adnexae
- understand the pathophysiology and clinicopathologic correlation of major ocular conditions including their clinical presentations, behaviors and responses to therapy
- properly handle surgical specimens for ophthalmic pathologic study including: obtaining appropriate tissue specimen, marking tissue for margin control when necessary, proper choice of fixative, and effective communication with the ophthalmic pathologist regarding relevant clinical data and tissue orientation.
- understand the ophthalmic pathology report and to properly correlate the clinical and pathological findings
- be familiar with the basic principles and special procedures used in ophthalmic pathology, including immunohistochemistry, flow cytometry, molecular pathology, and diagnostic electron microscopy
- identify those ophthalmic lesions that indicate systemic disease and/or are potentially life-threatening
- summarize current information about the most common primary tumors of the eye
- understand the basic genetics, evaluation, and management of retinoblastoma

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**Competency-Based Goals and Objectives**

**Medical Knowledge****:**

**Goals during PGY-2**

1. Cognitive Skills
   a. Describe basic ocular anatomy and identify histology of major structures of the eye (e.g., conjunctiva, sclera, anterior chamber angle, iris, ciliary body, lens, vitreous, retina, retinal pigment epithelium, choroid, optic nerve)

   b. Describe basic pathophysiology of common disease processes of the eye and identify major histologic findings of each (e.g., infection, inflammation, neoplasm)

   c. Identify the histology of important intraocular and adnexal diseases (e.g., endophthalmitis, retinoblastoma, choroidal melanoma, microbial keratitis)
d. Describe specific information necessary for communication with the pathologist regarding special handling of specimens for special stains or studies

e. Describe indications for frozen sections in ocular pathology

f. Describe the basic categorization of common extraocular and intraocular tumors

g. Recognize an ocular tumor and refer appropriately

h. Describe the major diagnostic features of major intraocular tumor types (e.g., retinoblastoma, choroidal melanoma, metastatic lesions) and the differentiating features of similar lesions

2. Technical Skills
   a. Describe steps in basic handling and processing of gross specimens in the ocular pathology laboratory

   b. Perform cutting and gross examination of whole globes

   c. Under supervision, participate in the microscopic evaluation of ophthalmic specimens from active cases

   d. Perform slit lamp, ophthalmoscopic, and ocular transillumination examination of patients with intraocular tumors (e.g., choroidal melanoma)

**Goals during PGY-3**

1. Cognitive Skills
   a. Describe more advanced ocular anatomy and identify histology from major and minor structures of the eye (e.g., conjunctival glands, normal pigment, common variants)

   b. Describe more advanced pathophysiology of disease processes of the eye and identify major histologic findings (e.g., fungal keratitis, skin and adnexal neoplasms, less common intraocular tumors)

   c. Identify histology of less common but potentially vision or life-threatening intraocular or adnexal diseases (e.g., temporal arteritis, fungal endophthalmitis, extraocular spread of intraocular tumor, metastatic disease to the eye)

   d. Describe more advanced techniques in ocular histopathology (e.g., electron microscopy, cytology, immunohistochemistry, flow cytometry, tumor-free margins)

   e. Describe the histopathology, evaluation, and management options for different intraocular tumors

   f. Describe the findings of the Collaborative Ocular Melanoma Study (COMS)

   g. Describe the classification of retinoblastoma and its treatment options
h. List the differential diagnoses for tumors of the: iris, ciliary body, choroid, retina, and optic disc (e.g., melanoma, retinoblastoma, hemangioma, melanocytoma)

i. Describe diagnostic techniques for common intraocular tumors (e.g., physical examination, imaging, laboratory studies, oncology referral, fine-needle aspiration, excisional biopsy, incisional biopsy)

j. Describe the prognostic significance of different types of ocular tumors and be able to guide systemic work-up for metastasis

k. Describe specific indications for special handling and communicate to the pathologist the necessity for special stains or studies

l. Describe indications for destruction or excision, transpupillary thermal therapy, and laser photocoagulation of conjunctival, corneal, and intraocular tumors

m. Understand treatment options for intraocular tumors (e.g., radioactive plaque localization, external beam radiotherapy, iridectomy or iridocyclectomy, resection of conjunctival tumors) and their complications

2. Technical Skills
   a. Perform more advanced handling and special processing of gross specimens
   b. Perform and prepare a biopsy specimen for frozen section
   c. Prepare a basic histologic specimen for review by the pathologist
   d. Participate as an observer during microscopic examination of active cases and perform microscopic examination with and without supervision
   e. Participate in examination under anesthesia for pediatric intraocular tumors
   f. Discuss various treatment options with the patient, family member, and/or caregiver in a detailed, ethical, and compassionate manner

Goals during PGY-4:
1. Cognitive Skills
   a. Describe the most advanced ocular anatomy and identify histology of major and minor structures of the eye and their less common variants (e.g., cobblestone degeneration, iris heterochromia, pars plana cysts)
   b. Describe the most advanced, less common, or more complex pathophysiology of the disease processes of the eye and identify major histologic findings of each (e.g., lymphoma, inflammatory pseudotumor, tissue processing artifacts)
   c. Identify the histology of the least common but potentially vision or life-threatening intraocular and adnexal diseases (e.g., healed giant cell arteritis, uncommon benign and malignant neoplasms, mimics and masqueraders of inflammation)
d. Describe management options for unusual intraocular tumors (i.e. choroidal metastasis, choroidal osteoma)

e. Apply the findings of the Collaborative Ocular Melanoma Study (COMS)

f. Recognize, evaluate, and manage most forms of extraocular and intraocular tumors

2. Technical Skills
   a. Perform pre-, intra-, and post-operative consultation with the ocular pathologist regarding specific indications for special stains or processing (e.g., orientation of specimen, special handling)

b. Interpret pathologic reports of frozen sections

c. Perform microscopic examination of a specimen with and without direct supervision and provide a relevant differential diagnosis

d. Perform indirect ophthalmoscopy for the diagnosis and localization of intraocular tumors prior to treatment

e. Describe indications for and perform an examination under anesthesia for pediatric intraocular tumors (e.g., retinoblastoma)

f. Interpret fluorescein angiography, A-scan and B-scan echography of intraocular mass lesions

g. Describe indications for and perform excision, photocoagulation, or other treatment of conjunctival, corneal, and intraocular tumors

h. Describe indications for treatment options for intraocular tumors (e.g., plaque radiotherapy, external beam radiotherapy, iridectomy, iridocyclectomy, resection or cryotherapy of conjunctival tumors, or use of antimetabolite eyedrops, transpupillary thermal therapy) and refer appropriately.

Surgical Skills:

Goals During PGY-3:
   1. Assist in and/or perform an enucleation

   2. Assist in and/or perform an evisceration

Goals During PGY-4:
   1. Assist in and/or perform a complicated enucleation or exenteration (e.g., complicated by hemorrhaging, small orbit, or scar tissue)
Patient care:

- Residents have their rotation in pathology at the beginning of their PGY-2 year. They spend one half-day a week for three consecutive months in the pathology laboratory at the VCU Medical Center under the oversight of our ocular pathologist. During this time, they learn to prepare ocular pathology specimens and perform microscopic examination under close supervision, after which clinicopathologic correlation is made.

- During the PGY-3 and PGY-4 years, residents learn how to properly perform surgical biopsies (e.g., technique, anatomic site selection, proper handling of tissue for ophthalmic pathology), interpret the pathology report, and implement appropriate clinical follow-up care.

- Residents learn how to effectively communicate to the patient the reason for the biopsy, what to expect intra- and post-operatively, the histopathologic diagnosis, future management and prognosis.

Practice-Based Learning and Improvement:

- The resident spends one-half day a week during the rotation in self-study, reviewing glass slide teaching collections. The resident is asked to examine the slide with light microscopy, to list the observed histopathologic features and histopathologic diagnosis, and then to review the pathology report on that particular case for skill self-assessment.

- A clinicopathologic case is presented to the residents monthly in the form of a “Clinical Challenge” with several questions relevant to both the clinical and histopathologic aspects of the case.

- Residents are taught the importance of reviewing the pathology with the ophthalmic pathologist in the laboratory in cases of pathologic diagnosis discordant with the clinical suspicion or serious pathologic entities to arrive at the correct diagnosis.

Inter-Personal and Communication Skills:

- Residents are taught to effectively communicate with the patient regarding all aspects of the nature of their clinical problem requiring pathologic diagnosis. Residents are to timely communicate with the patient the pathologic diagnosis so as to avoid unnecessary prolonged patient anxiety.

- Given the cultural and ethnic diversity of our patient population in the Richmond area, interpreters are frequently employed in these communications as necessary for language barriers.

- Residents are expected to effectively communicate with the ophthalmic pathologist the clinical history, pre-operative clinical diagnosis, orienting markings on the tissue specimen for proper margin control, and pertinent intra-operative findings. Conference with the ophthalmic pathologist prior to surgical biopsy may be necessary in selected cases to review the results of diagnostic tests, to assure proper handling of tissue by the resident for optimum pathologic study, and to assist the resident/pathologist in ordering the appropriate pathologic diagnostic tests.
Professionalism:

- Residents must understand that the ophthalmic pathologist and the ophthalmic surgeon work as a team for the benefit of the patient. Inadequate information provided to the pathologist by the surgeon limits the ability of the pathologist to provide the clinician with the information desired.

- Residents learn to identify or include ocular and adnexal tumors in their clinical evaluations and to expeditiously consult a clinical specialist and ancillary subspecialists for a team-approach to patient care.

- Residents must be sensitive to patient concerns when faced with the potential diagnosis of a tumor. They are taught to listen carefully to patient concerns, to be supportive and offer full, honest explanations and appropriate referrals.

Systems-Based Practice:

- Residents learn when, where, and how to make appropriate referrals to an ocular oncologist for the management of complex intraocular tumors.

- Residents learn to appropriately consult healthcare providers from other services as indicated clinically for the further evaluation and management of ophthalmic oncology patients (e.g. radiology, neurosurgery, otolaryngology, oncology, radiation oncology, psychiatry, social services)

Teaching Faculty:
Deepak Edward, M.D., Andrew P. Ferry, M.D.

Teaching Methods:
1. One-on-one teaching/demonstration of pathologic studies by faculty
2. Didactics: Scheduled departmental lectures and extramural coursework in pediatric ophthalmology
3. Required reading: AAO BCSC: Ophthalmic Pathology and Intraocular Tumors section.
4. Recommended Reading:
   a. Selected articles and chapters

Assessment Methods: OKAP exam, ABO written and oral examinations, Journal Club tool, 360-degree evaluation, end of rotation evaluation.

*Adapted from Objectives in AAO BCSC: Ophthalmic Pathology and Intraocular Tumors section.

**SUBSPECIALTY SERVICES:**

**Pediatric Ophthalmology and Strabismus**

**Resident Responsibilities**

Monday – Friday, 8:00 am – 5:00 p.m.: consults, the second year resident assigned to Pediatrics is responsible for all consults under 18 years of age. Pediatric consults are to be done on the day they are requested but under no circumstances longer than 24 hours from the request.

**Overall Objectives***:
The resident is expected to:

- Become confident in the ophthalmic examination of the pediatric patient – neonate, infant, toddler, child, and adolescent. The foundation skills include assessment of visual acuity in these patients using age-appropriate methods, cycloplegic and non-cycloplegic refraction, and retinoscopy.

- Identify, measure, and categorize various types of ocular misalignment including: horizontal, vertical, comitant, incomitant, paralytic, and restrictive strabismus. The resident gains a thorough understanding of the medical treatment of amblyopia and strabismus mainly in the PGY-2 and PGY-3 years, graduating to the surgical treatment of strabismus, mainly during the PGY-4 year.

- Identify and manage various other types of congenital and acquired pediatric ophthalmic disorders including: cataract, glaucoma, nasolacrimal system obstruction, ptosis, retinal dystrophies, and intraocular inflammation. Residents should understand common congenital ocular anomalies and their systemic associations, as well as their genetics.

- Become comfortable with the evaluation of premature infants for retinopathy of prematurity in the neonatal intensive care setting under the supervision of an attending.

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**Competency Based Goals and Objectives**

**MEDICAL KNOWLEDGE******:  
*Goals during PGY-2*

1. **Cognitive Skills**
   a. Describe basic examination techniques for strabismus (e.g., ductions and versions, cover-uncover, alternate cover, cardinal fields, Hirschberg, Krimsky)

   b. Describe basic timeline for visual development and visual acuity assessment of the pediatric ophthalmology patient (e.g., central, steady, maintained, Allen pictures, HOTV, Teller cards)

   c. Describe basic anatomy and physiology of strabismus (e.g., innervation of extraocular muscles, primary, secondary, and tertiary actions, comitant and incomitant deviations, overaction and underaction)
d. Describe basic sensory adaptation for binocular vision (normal and anomalous retinal correspondence, suppression, horopter, fusion, stereopsis, convergence amplitudes)

e. Describe, evaluate, and manage pseudostrabismus

f. Describe types and etiologies of: esotropia, exotropia, strabismus patterns (A and V-patterns), vertical strabismus, childhood nystagmus

g. Describe non-surgical indications and treatment for strabismus

h. Describe symptomatology and findings of convergence insufficiency

i. Describe etiology, clinical features, and management of: pediatric cataract, retinoblastoma, and retinopathy of prematurity

j. Describe and recognize ophthalmic findings in child abuse (e.g., retinal hemorrhages) and know when to refer to child protective services or other authorities

k. Describe common congenital or hereditary ocular motility or lid disorders (e.g., Duane’s retraction syndrome, Brown’s syndrome)

l. Describe basic features of dyslexia

m. Describe basic evaluation of decreased vision in infants and children (e.g., sub-groups of amblyopia, retinopathy of prematurity, hereditary retinal disorders, congenital glaucoma, vitamin A deficiency)

n. Describe congenital ocular abnormalities (e.g., persistent pupillary membrane, microphthalmia)

o. Describe ocular findings in inherited metabolic conditions (e.g., mucopolysaccharidoses, aminoacidurias)

p. Describe common ocular findings in chromosomal disorders

2. Technical Skills

a. Perform an extraocular muscle examination based on knowledge of anatomy and physiology of ocular motility (ductions, versions, ocular alignment measurements, saccades, pursuits)

b. Apply Hering’s and Sherrington’s laws

c. Perform basic ocular alignment measurements (including Park-Bielchowsky three-step test, Lancaster red-green test, Maddox rod)

d. Perform assessment of vision in the neonate, infant, and child
Recognize and apply the following skills in the ocular motility examination: stereoacuity testing, accomodative convergence/accommodation ratio, tests of binocularity and retinal correspondence, cycloplegic refraction using retinoscopy, anterior and posterior segment examination, strabismus measurements using various methods, assessment of vision using age-appropriate methods (e.g., Teller acuity cards, fixation preference test, standard subjective acuity tests).

Measure convergence amplitudes in cases of suspected convergence insufficiency.

Goals during PGY-3

1. Cognitive Skills
   a. Describe basic and more advanced strabismus measurement techniques (combined vertical and horizontal measurements, double Maddox rod testing)
   
   b. Describe basic and more advanced methods to assess visual acuity in the pediatric patient (blink to light or threat, fixation and following behavior, objective measures)
   
   c. Describe more advanced anatomy and physiology of strabismus (torsion, tertiary actions, consecutive deviations), sensory adaptations (anomalous head position)
   
   d. Describe basics of binocular sensory testing (Titmus stereo, Randot stereo, Worth four-dot, Bagolini lenses)
   
   e. Describe, diagnose, and manage various etiologies of: amblyopia, esotropia, exotropia. A- and V-patterns, vertical strabismus, childhood nystagmus (sensory, motor, acquired, congenital), retinopathy of prematurity, pediatric cataract, hereditary or malformative ocular anomalies and syndromes, retinoblastoma (including genetics)
   
   f. Describe, know indications for, and utilize non-surgical treatment of strabismus and amblyopia (e.g., patching, atropine penalization, ground-in prism, and Fresnel prisms)
   
   g. Describe the main features of dyslexia and its relationship to vision
   
   h. Describe basic evaluation of limited visual acuity in neonates, infants, and children (e.g., retinal and optic nerve abnormalities, amblyopia)
   
   i. Describe recognizable causes of blindness in infants (e.g., albinism, optic nerve hypoplasia, achromatopsia, Leber’s congenital amaurosis)
   
   j. Describe etiology, evaluation, and management of congenital infections (e.g., toxoplasmosis, rubella, cytomegalovirus, syphilis, herpes)
   
   k. Describe the common causes of uveitis in the pediatric population
2. **Technical Skills**
   a. Perform more advanced extraocular muscle examination and assessment of ocular motility problems (e.g., bilateral or multiple cranial nerve palsies, thyroid eye disease, myasthenia gravis)
   
   b. Apply Hering’s and Sherrington’s laws to more complex cases (e.g., pseudoparesis of contralateral antagonist)
   
   c. Perform assessment of vision in more difficult strabismus cases (e.g., autistic child, uncooperative patients, nonverbal or preverbal patients)

**Goals during PGY-4**

1. **Cognitive Skills**
   a. Describe and perform advanced strabismus examination techniques (e.g., nystagmus, dissociated vertical deviation)
   
   b. Describe assessment of visual development in complicated or non-cooperative pediatric patients (e.g., electrophysiologic testing)
   
   c. Describe the most advanced knowledge of strabismus anatomy and physiology (e.g., spiral of Tillaux, tertiary actions) and sensory adaptations (e.g., anomalous head positions)

   d. Identify and manage complicated cases of amblyopia, esotropia, exotropia, less common strabismus patterns (e.g., aberrant regeneration, thyroid eye disease, myasthenia gravis, vertical strabismus), non-surgical treatment of amblyopia, childhood nystagmus, complex retinopathy of prematurity, uncommon etiologies of pediatric cataract, complex hereditary ocular syndromes (e.g., bilateral Duane’s syndrome, Moebius syndrome), complex retinoblastoma, congenital ocular anomalies (genetic)

   e. Apply the most advanced principles of binocular vision and amblyopia (e.g., diplopia, confusion, suppression)

   f. Describe, diagnose, and understand the management of pediatric retinal diseases, glaucoma, cataract, anterior segment abnormalities, eyelid disorders, orbital disorders (e.g., rhabdomyosarcoma, orbital floor fractures)

2. **Technical Skills**
   a. Understand and be able to manage complications of strabismus surgery (e.g., slipped muscle, anterior segment ischemia)

   b. Describe indications and contraindications for more complex strabismus surgery (e.g., reoperations, thyroid eye disease, Duane’s syndrome, slipped muscle); perform pre- and post-operative assessment, describe intraoperative techniques, and post-operative complications

   c. Describe and manage more complex complications of strabismus surgery (e.g., globe perforation, endophthalmitis)
SURGICAL SKILLS:

Goals During PGY-3
1. Assist primary surgeon in recession and resection procedures
2. Observe and participate in examinations under anesthesia of pediatric patients (e.g. cases of retinoblastoma, pediatric glaucoma, etc.)

Goals During PGY-4
1. Understand and perform basic extraocular muscle surgery, including pre-operative assessment, intraoperative techniques, and post-operative management
2. Perform recession and resection procedures
3. Describe indications for, assist in, and/or perform tenotomies and tucks, transposition, adjustable sutures
4. Perform more complex strabismus surgery (e.g., reoperations)

PATIENT CARE:

- During the PGY-2 and PGY-3 years, Residents spend one day per week seeing patients in the pediatrics clinic at VCUHS under the direct supervision of the pediatric attending.

- During the PGY-3 year, residents have the opportunity to evaluate premature babies for retinopathy of prematurity in the neonatal intensive care unit under the supervision of the retina attending.

- During the PGY-4 year, residents perform strabismus procedures in the OR three days per month; additionally, they see their pre-ops and post-ops under the oversight of the pediatrics attending.

- Residents learn the techniques of successfully instilling mydriatic eyedrops in the pediatric patient as well as the choice of drops based on individual patient

- To successfully deliver eye care in the pediatric population, residents learn various ways to interact with:
  - an infant, toddler, school-age child, and adolescent
  - an uncooperative child
  - a neurologically impaired child
  - the parent, family member(s), and/or guardian
PRACTICE-BASED LEARNING AND IMPROVEMENT:

- Upon the completion of a pediatric exam, residents are expected to cross-check their cycloplegic retinoscopy with results from the automated refractor to make sure they are on target. If there is a significant disparity, residents must repeat the retinoscopy. The final check is the cycloplegic retinoscopy performed by the attending supervising the clinic.

- Residents analyze the results of their strabismus surgeries by comparing pre- and post-operative ocular alignment measurements

INTER-PERSONAL AND COMMUNICATION SKILLS:

- Residents learn to effectively educate the patient, parent, and/or guardian regarding:
  - the use of spectacles (single vision and bifocal)
  - medical and surgical therapy for amblyopia
  - orthoptic exercises for convergence insufficiency
  - medication use

- The skills of effective listening and communication are stressed. Residents are taught to ask the patient/parents/guardians for any questions, answer exactly what is asked, and clarify any uncertainties.

- Given the ethnic and cultural diversity of our patient population in the Richmond area, residents frequently make use of the hospital’s official language line (translation service) if and when appropriate.

PROFESSIONALISM:

- Residents must be aware of their limitations with respect to accuracy of clinical skills (e.g., measurement of refractive error, retinoscopy, or ocular alignment) and know when to ask, and be comfortable asking, for guidance or supervision

- Residents must be aware of their limitations with respect to language skills and know when to use the language line (as noted above).

- Residents are taught the importance of communicating back to the pediatrician the results of the child’s examination, regardless of whether a referral was made.

- Residents are taught to greet and address the patient, especially in the case of a school-age child or adolescent, not just the parent/guardian.
SYSTEMS-BASED PRACTICE:

- Residents should know when, how, and where to make referrals for:
  - Electrodiagnostic testing (e.g., visual evoked potential or electroretinography)
  - Geneticist or craniofacial specialist

- In the case of a child in foster care who requires strabismus surgery (which occurs in approximately 1/3 of our pediatric strabismus cases), residents must ensure that appropriate informed consent is obtained from the legal guardian, be it the birth parent or the social services agency.

- Residents should employ the aid of Social Services in difficult cases of:
  - Non-compliance with spectacle wear or amblyopia therapy
  - Suspected child abuse

TEACHING FACULTY:
Keith W. McNeer, MD, Clinical Professor
Christopher T. Leffler, MD, Assistant Professor
Mary G. Tucker, MD, Assistant Clinical Professor

TEACHING METHODS:

1. One-on-one teaching/demonstration of examination by faculty

2. Didactics: Scheduled departmental lectures and extramural coursework in pediatric ophthalmology

3. Required reading:
   AAO BCSC: Pediatric Ophthalmology and Strabismus section.

4. Recommended Reading:
   b. Articles referenced and/or photocopied with individual lectures
   c. Strabismus Handbook prepared/compiled by Wendy Fingerhut, CO

Assessment Methods: OKAP exam, ABO written and oral examinations, surgical skills assessment evaluation, surgical outcomes review, surgical case log, Journal Club tool, 360-degree evaluation, end of rotation evaluation.

*Adapted from Objectives in AAO BCSC: Pediatric Ophthalmology and Strabismus section.

SUBSPECIALTY SERVICES:

Retina

During the Retina rotation, residents will be exposed to a wide variety of diseases and surgery of the retina and vitreous at the VCU Medical Center, and the Ambulatory Surgery Center at Stony Point. Supervision will be provided by the VCU retina faculty physicians.

Resident Responsibilities
The residents are responsible for the evaluation, examination, including color-coded retina drawings where appropriate, diagnostic testing, management, and follow-up of all patients on the Retina Service. This includes written and verbal communication with primary care and consulting physicians, preoperative histories and physical exams, formulation of treatment plan, and appropriate rescheduling of no-show and missed appointment patients with Clinic staff. The residents are responsible for the completion all paperwork on patients seen on the Retina Service, including the dictation of letters to referring physicians, verification of clinic visit(s), nursing home and Department of Corrections forms, and return to work forms. All statements of temporary or permanent disability, job duty restrictions and limitations, or medicolegal opinions are the responsibility of the attending physician of record on the individual case. The resident is expected to be able to explain why tests are ordered, follow up on the results, and inform the patient of the test results. The residents are expected to be familiar with the pre- and post-operative medications and regimens of the individual retinal physicians and surgeons. All variations or atypical situations should be discussed with the attending physician.

The residents are responsible for seeing any Retina Service patients who come to the Ophthalmology Clinic on an emergency or walk-in basis prior to discussing or presenting the patient to the retina attending physician. The Retina residents are responsible for evaluating all questions or issues regarding the retina evaluation from other clinic residents or attending staff prior to presenting the patient to the retina attending physician. A complete history and examination, initial assessment, differential diagnoses, and management plan are expected. Emergency or urgent cases from the General Eye Clinic or from outside VCU must be scheduled into an available time slot on the Retina Service. Double books or overbooks must be approved in advance by either the Retina Service lead technician and/or the Retina faculty physician.

The Retina residents are expected to review all Retina Service patient fundus photographs, fluorescein angiograms (IVFA), diagnostic ultrasound studies, and Ocular Coherence Tomography (OCT) scans and write a preliminary interpretation in the patient’s chart. The photos, angiogram, OCTs, and interpretation will be reviewed with the attending, time permitting.

Retina evaluations should include scleral depression with a color-coded retina drawing, contact lens evaluation, and gonioscopy when appropriate. The Retina resident should become proficient in the use of the +20 and +28 diopter indirect lenses, Zeiss 4-mirror lens, Goldmann 3-mirror lens, +78 and +90-diopter examination lenses, and the various laser treatment lenses. He/she should be proficient in the use of B-scan ultrasonography for diagnosis. He/she should also become proficient in the evaluation of post-operative patients with intraocular gas or silicone oil. Some of the assessment of proficiency in retina is based upon the Retina resident’s history, examination findings including color-coded retinal sketches and drawings, interpretation of diagnostic studies, diagnoses, and treatment plan as documented in the patient’s medical record. The resident will be expected to be familiar with the American Academy of Ophthalmology’s (AAO) Preferred Practice Patterns, including those for age-related macular degeneration, diabetic retinopathy, PVDs, retinal tears and detachment, and lattice retinal degeneration, and visual rehabilitation in the adult, and for
following those guidelines. The proper disposition, coding of diagnoses and procedures performed, and timing of any follow-up care and/or treatment is to be noted by the attending physician before the patient leaves the clinic.

The Retina resident is responsible for collecting and preparing cases and examples for presentation at the monthly Retinal Imaging Conference. These cases should be reviewed with the Retina faculty physician responsible for that month’s conference ahead of time. During the initial part of the rotation, the attending physician will be expected to help with the clinic “flow” to move patients along and may need to see patients without resident assistance at times. The Retina faculty physician is responsible in all cases of patients seen on the Retina Service for the evaluations and assessments made by the Retina residents. Any resident who sees a Retina Service patient in the absence of a faculty physician, must review the case and management with the retina attending physician at the earliest convenience. The Retina residents’ performance is judged according to the published guidelines and criteria of the ACGME. The resident is expected to be able to complete a full day of Retina Clinic evaluations, including injection procedures and laser treatments, by the end of the rotation. The Retina resident is expected to adhere to the published resident clinic schedule. If there are any problems due to illness, scheduled leave, emergency surgery, or for any other reason the resident cannot fulfill his/her scheduled Retina Clinic assignment, the resident should inform both the Retina Service Lead Technician and the Chief Resident, who will try to arrange for a substitute resident. If the Chief Resident is unable to cover the absence, he/she is to inform the Retina faculty physician whose clinic in impacted, and the Residency Program Director for expected fill-in.

The residents are expected to try to obtain IV access and perform the dye injection for the departmental photographer/angiographer for all patients requiring intravenous fluorescein angiography. They are expected to explain to the patient beforehand the reason(s) for the study, side effects, risks, and possible complications of these studies, and to be familiar with and assist in the treatment of any adverse reactions. The PGY-2 Retina resident will “first assist” on all surgical retina cases on Tuesdays at the Stony Point Surgical Center with one of the retinal surgeons from VCU.

The residents are expected to explain to each patient any procedures that are to be performed, preferably by the use of the model eye, illustrations, or other props in the clinic. The resident must be able to explain to the patient the more common and frequent complications and risks associated with any retinal procedures, such as intravitreal injections, retinal laser photocoagulation, and major retinal and vitrectomy surgery. It should be documented in the chart that the procedure, indications, alternatives, risks, and potential complications, have been explained to the patient and that they wish to proceed with the procedure. The chart should be legible and contain the appropriate signed and witnessed informed consent form(s), a procedure note, and any other VCU required documentation. All surgical procedures, including sub-Tenon’s and intravitreal injections, laser photocoagulation, diagnostic or therapeutic taps, medication injections, etc., must be approved by an attending physician prior to being performed. No retinal or vitreous procedures are to be performed by a resident without a retina faculty physician or other faculty physician willing to supervise the procedure in the clinic. Any questions should be directed to the retina faculty attending staff.
**Overall Objectives***:
The resident is expected to:

- Identify pathophysiologic processes that affect the structure and function of the retina, vitreous and choroid.
- Formulate a differential diagnosis for retinal findings
- Choose appropriate methods of examination and ancillary studies for diagnosing vitreoretinal disorders.
- Incorporate data from major prospective clinical trials in the management of selected vitreoretinal disorders.
- Become comfortable with the principles of medical and surgical treatment of vitreoretinal diseases.

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**Competency Based Goals and Objectives**

**Standard level goals based on ACGME Core Competencies:**

Goals during PGY 3 & PGY 4 *(in addition to the Basic level goals already achieved/completed at a PGY 2 level)*

**MEDICAL KNOWLEDGE******:  

1. **Cognitive Skills**
   1. Describe more advanced retinal anatomy and physiology
   2. Understand indications for and interpretation of fluorescein or indocyanine green (ICG) angiography in select cases of retinal vascular and other disorders
   3. Describe principles of retinal detachment: recognition, various types of retinal detachment (e.g., exudative, rhegmatogenous, tractional), and their evaluation, management, and repair (e.g., identify retinal break).
   4. Describe and recognize typical features of less common macular diseases (e.g., parafoveal telangiectasias, cone dystrophies, inherited macular dystrophies, fundus flavimaculatus, toxic maculopathies).
   5. Describe indications for and complications of laser photocoagulation.
   6. Describe the findings of major studies in vitreoretinal diseases, including the following:
      a. Diabetic Retinopathy Study (DRS).
      b. Early Treatment of Diabetic Retinopathy Study (ETDRS).
      c. Diabetic Vitrectomy Study (DVS).
d. Diabetes Control and Complications Trial (DCCT).
e. Macular Photocoagulation Study (MPS).
f. Branch Vein Occlusion Study (BVOS).
g. Central Vein Occlusion Study (CVOS).
h. United Kingdom Prospective Diabetes Study (UKPDS).
i. Age-Related Eye Disease Study (AREDS).
j. Verteporfin in Photodynamic Therapy Study ((VIP).
k. Treatment of Age-Related Macular Degeneration with Photodynamic Therapy Study (TAP)
l. The ANCHOR/ MARINA/ PIER, and SAILOR studies
m. The CATT Study

7. Describe, evaluate, and manage peripheral retinal diseases and vitreous pathology (e.g., vitreous hemorrhage, retinal breaks, lattice degeneration).

8. Describe, evaluate, and manage choroidal detachments and uveal effusion syndrome

9. Identify and manage retinoschisis (e.g., juvenile, senile).

10. Diagnose, manage, and recognize the complications of retinopathy of prematurity (e.g., threshold disease, tractional retinal detachment).

11. Describe, evaluate, and treat the following retinal vascular diseases:
   a. Arterial and venous obstructions.
   b. Diabetic retinopathy.
   c. Hypertensive retinopathy.
   d. Peripheral retinal vascular occlusive disease.
   e. Acquired retinal vascular occlusive disease.
   f. Ocular ischemic syndrome.
   g. Sickle cell retinopathy.

12. Describe and recognize common and uncommon macular disorders: age-related macular degeneration (ARMD), choroidal neovascularization (e.g., associated with ARMD, histoplasmosis, or high myopia), macular dystrophies, epiretinal membrane, macular holes, cystoid macular edema, central serous chorioretinopathy, optic pit and secondary serous detachment, retinal pigment epithelial detachment.

13. Describe the fundamentals of and indications for electrophysiologic testing.

14. Describe, recognize, and evaluate hereditary retinal and choroidal diseases
15. Recognize, evaluate, and understand management of retinal and choroidal toxicity (e.g., phenothiazine, hydroxychloroquine/chloroquine toxicity, tamoxifen).

16. Describe the techniques for retinal detachment repair (e.g., pneumatic retinopexy, scleral buckling, vitrectomy).

17. Describe the basics of surgical vitrectomy (e.g., indications, mechanics, instruments, and technique).

18. Describe the indications for and timing of basic laser treatment of diabetic retinopathy (e.g., panretinal photocoagulation, macular grid).

19. Describe the fundamentals of special vitreoretinal techniques:
   a. Macular hole repair
   b. Epiretinal membrane peeling.
   c. Complex vitrectomy for proliferative vitreoretinopathy.
   d. Use of heavy liquids and intraocular gases (e.g., perfluorocarbons).

20. Describe, evaluate, and manage posterior uveitis syndromes

21. Describe, evaluate, and manage endophthalmitis

22. Describe indications, techniques, and complications of pars plana vitrectomy

2. Technical Skills

   1. Perform indirect ophthalmoscopy with scleral indentation.
   2. Perform ophthalmoscopic examination with contact lenses, including panfundusscopic lenses.
   3. Interpret fluorescein and ICG angiography in complicated cases.
   4. Interpret retinal nerve fiber layer imaging (e.g., ocular coherence tomography, retinal thickness analysis).
   5. Describe the indication for and interpret basic electrophysiological tests (e.g., electroretinogram (ERG), electrooculogram (EOG), visual evoked potential (VEP), dark adaptation).
   6. Interpret basic ocular imaging techniques (e.g., B-scan echography, nerve fiber layer analysis).
   7. Perform fundus drawings of the retina, showing complex vitreoretinal relationship and findings.
   8. Perform intravitreal and subtenon’s injections of pharmacologic agents
   9. Examine a premature infant for retinopathy of prematurity in the neonatal care unit under the supervision of the retina attending
SURGICAL SKILLS:

Goals During PGY-2 & 3
1. Perform posterior segment photocoagulation
   a. Focal or grid macular laser treatment
   b. Peripheral scatter laser photocoagulation (panretinal, quadratic)
   c. Laser retinopexy for isolated retinal breaks.
2. Perform cryotherapy of retinal holes and other pathology

Goals During PGY-3 & 4
1. Become fully proficient in retinal laser procedures as listed above
2. Assist in and/or perform pars plana vitrectomy procedures under supervision
   a. With intraocular gas injection
   b. With membrane peeling
   c. With endolaser
3. Assist in and/or perform scleral buckling procedures.

PATIENT CARE:

- Throughout all levels of training, residents have the opportunity to evaluate and manage the spectrum of vitreoretinal disorders from common to complicated in a graduated fashion. All residents see retina patients one full day a week in the clinic at VCUHS under the supervision of the retina attending.

- During the formal retina rotation in the PGY-3 year, residents perform laser photocoagulation for vitreoretinal disorders. The PGY-3 also spends one day a week in the operating room assisting in and performing vitreoretinal procedures. The residents also have the opportunity to screen premature infants for retinopathy of prematurity and assist in their treatment in the neonatal intensive care units at VCUHS.

- Residents learn various ways to interact with:
  o the patient and other family member(s) when appropriate
  o an uncooperative patient
  o a non-English speaking patient
  o an immuno-compromised patient

- Residents are taught to be sensitive to various cultural, psychological, and socioeconomic factors which may impact the delivery of effective and timely patient care.
PRACTICE-BASED LEARNING AND IMPROVEMENT:

- Upon the completion of a dilated exam, residents are expected to document their findings in an intelligible fashion that can be understood by other ophthalmic practitioners. The final check is the confirmatory retinal examination performed by the attending supervising the clinic.

- During weekly fluorescein angiography/OCT rounds, residents review interesting cases and findings, as well as discuss their management with the retina attending.

- Residents are able to describe more advanced principles and features of Ocular Coherence Tomography (OCT) in retinal and vitreous diseases.

- Residents are able to describe the fundamentals of retinal electrophysiology, including a- and b-waves, oscillatory potentials, flash vs. pattern, and multifocal ERG, EOG, VEP, and dark adaptometry.

INTER-PERSONAL AND COMMUNICATION SKILLS:

- Residents learn to effectively educate the patient, family, and/or caregiver regarding:
  - The nature and severity of their ocular disease
  - The effects of glycemic control, blood pressure, cholesterol, and weight loss (when pertinent) on their overall health and ocular disease
  - The use of medication
    - instillation (methods and dosage)
    - storage
  - Medication side effects

- To describe the indications, methods and techniques (slit lamp, binocular indirect, endolaser delivery), risks, and complications of retinal laser photocoagulation.

- To describe and discuss the indications, techniques, risks, and potential complications of pars plana vitrectomy surgery.

- The skills of effective listening and communication are stressed. Residents are taught to ask the patient/family/caregiver for any questions, answer exactly what is asked, and clarify any uncertainties.

- Given the ethnic and cultural diversity of our patient population in the Richmond area, residents frequently make use of the hospital’s official language line (translation service) if and when appropriate.

- Residents are taught the importance of communicating both pertinent positive and negative findings and using understandable language with other health care providers regardless of whether a referral was made.
PROFESSIONALISM:

- Residents must be aware of their limitations with respect to accuracy of clinical skills and know when to ask, and be comfortable asking, for guidance or supervision.
- Residents must be aware of their limitations with respect to language skills and know when to use the language line (as noted above).
- Residents are taught the importance of greeting and addressing the patient, especially in cases of elderly patients or children who are accompanied by a family member or caregiver.

SYSTEMS-BASED PRACTICE:

- Residents should know when to order or where to make referrals for:
  - Fluorescein angiography
  - Ultrasonography
  - Retinal nerve fiber layer imaging (e.g., optical coherence tomography)
  - Electrophysiologic testing (e.g., pattern, flash, or multifocal electroretinography)
- Residents should know when, how, and where to make referrals for or perform:
  - Anterior chamber paracentesis
  - Vitreous biopsy
  - Chorioretinal biopsy
- Residents should employ the aid of Social Services in cases of:
  - Non-compliance with therapy
- Residents should know when and where to refer a patient for visual rehabilitation if their visual impairment from vitreoretinal disease interferes with daily living
- residents should be able to apply experiential learning from previous retinal cases to future patient care.

TEACHING FACULTY:

Juan Orellana, MD, FACS
Vikram S. Brar, MD, FACS

TEACHING METHODS:

1. One-on-one teaching by faculty in clinic and in the operating room
2. Didactics:
   - Scheduled departmental lectures and extramural coursework in vitreoretinal topics
   - Weekly fluorescein angiography and optical coherence tomography rounds
3. Required reading:
   - AAO BCSC: Retina and Vitreous section.
   - AAO BCSC: Intraocular Inflammation and Uveitis section.
   - AAO Preferred Practice Patterns (PPP) Guidelines
     - Age-Related Macular Degeneration PPP
     - Diabetic Retinopathy PPP
     - Idiopathic Macular Hole PPP
     - Posterior Vitreous Detachment, Retinal Breaks, and Lattice Degeneration PPP
     - Vision Rehabilitation for Adults PPP

4. Recommended Reading / References:
   - Gass JD. Stereoscopic Atlas of Macular Diseases: Diagnosis and Treatment.
- Singh, A.D., Damato, B.E., Peer, J., Murphee, AL, Perry, J.D., Clinical Ophthalmic Oncology, (Saunders-Elsevier, Inc., 2007)
- Color Atlas of Ocular Manifestations of AIDS
- Treatment of Retinopathy of Prematurity

5. Wet-Lab: suturing techniques and use of operating microscope
6. Journal Club: selected recent articles from major ophthalmic journals

**Assessment Methods:** OKAP exam, ABO written and oral examinations, surgical skills assessment evaluation, surgical outcomes review, surgical case log, wet-lab, Journal Club tool, 360-degree evaluation, end of rotation evaluation.

*Adapted from Objectives in AAO BCSC: Retina and Vitreous section.

SUBSPECIALTY SERVICES:

**Oculoplastic Service**

First Year – PGY-2

Goals:
By the completion of the PGY2 year the resident should be able to examine, evaluate and identify patients with abnormal lacrimal, eyelid and orbital findings.

Objectives:
The following cognitive and technical objectives should be acquired, assimilated and integrated by the completion of this year.

**Medical Knowledge:**

- Describe basic eyelid, lacrimal, and orbital anatomy and physiology (e.g., eyelid, orbicularis, orbital structures, meibomian glands, lacrimal glands, Zeiss glands, Whitnall’s ligament, Muller’s muscle, Lockwood’s ligament, canaliculi, puncta, orbital bones, orbital foramina, paranasal sinuses, annulus of Zinn, arterial and venous vascular supply, lymphatics, nerves, extraocular muscles).
- Describe basic mechanisms and indications for treatment of eyelid, orbital, and lacrimal trauma.
- Describe the differential diagnosis of lacrimal gland mass (e.g., inflammatory, neoplastic, infectious).
- Describe the differential diagnosis of proptosis in children and adults.
- Describe techniques and complications of minor operating room procedures (e.g., incision and drainage of chalazia, excision of small eyelid lesions).
- Describe typical features of orbital cellulitis.

**Patient Care:**

- Perform preoperative and postoperative assessment of patients with common oculoplastic disorders.
- Recognize simple orbital trauma (e.g., orbital foreign body, retrobulbar hemorrhage).
- Recognize and treat floppy eyelid syndrome.
- Recognize and treat localized trichiasis, blepharospasm and hemifacial spasm.
- Describe indications for and perform the basic office examination techniques for the most common oculoplastic and orbital abnormalities.
- Perform the basic assessment of the eyelids, eyebrows, and eyelashes (e.g., eversion, double eversion, margin to reflex distance, lid crease, levator function, eyelid/brow malpositions.
- Identify indications for and perform the basic lacrimal assessment (e.g., dye testing, punctal dilation, canalicular probing, lacrimal irrigation).
- Identify indications for and perform the basic assessment of the orbit (e.g., Hertel exophthalmometry, inspection, palpation, auscultation).
- Perform minor lid and conjunctival procedures (e.g., removal of benign eyelid skin lesions, chalazion curettage or excision, conjunctival and eyelid biopsy).
- Perform punctal plug insertion and removal.
- Treat complications of minor operating room procedures (e.g., incision and drainage of chalazia, excision of small eyelid lesions).
- Recognize and treat trichiasis (e.g., epilation, cryotherapy, surgical therapy).
Interpersonal and Communication Skills:

- In conjunction with radiologist be able to identify normal orbital anatomy on imaging studies (e.g., magnetic resonance imaging, computed tomography, ultrasound.

Practice Based Learning and Improvement:

- Prepare Grand Rounds and Journal Club on oculoplastics subjects under faculty advisement.

Professionalism:

- Perform a simple enucleation or evisceration under supervision. Understand psychosocial implications and co-ordinate with patient follow up with oculist.

Systems-Based Practice:

- Describe epidemiology, clinical features, evaluation, and management of fetal alcohol syndrome including method to co-ordinate with appropriate supporting agencies.

Second Year PGY-3

Goals:
At the end of the PGY3 year the resident should be able to identify, evaluate and treat most eyelids, lacrimal and orbital abnormalities.

Objectives: The PGY3 resident will acquire and assimilate the following cognitive and technical objectives.

Medical Knowledge:

- Describe the clinical features, evaluation and management of congenital orbital deformities (e.g., synophthalmia, anophthalmia, microphthalmia, cryptophthalmia, hypertelorism, hypotelorism).
- Describe more advanced eyelid, lacrimal, and orbital anatomy and physiology (e.g., lacrimal apparatus, orbital vascular anatomy).
- Describe the mechanisms and indications for treatment of more advanced eyelid, orbital, and lacrimal trauma (e.g., full thickness lid laceration, chemical burns to the face).
- Recognize less common orbital tumors (e.g., metastatic lesions).
- Describe the mechanisms and indications for treatment of more advanced eyelid, orbital, and lacrimal trauma (e.g., full thickness lid laceration, chemical burns to the face).

Patient Care:

- Treat (or refer for treatment) congenital eyelid abnormalities.
- Perform preoperative and postoperative assessment of patients with simple and more serious oculoplastic disorders (e.g., multi-disciplinary procedures).
o Describe features of, evaluate, and treat more complicated cases of nasolacrimal duct obstruction, canaliculitis, dacryocystitis, acute and chronic dacryoadenitis, preseptal cellulitis, and orbital cellulitis.
ob o Recognize, evaluate, and treat orbital inflammatory pseudotumor (e.g., symptoms and signs, orbital imaging, differential diagnosis, biopsy indications, choice of treatments).
ob o Recognize, treat, or refer blepharospasm or hemifacial spasm.
ob o Describe indications for and perform more advanced examination techniques for less common oculoplastic and orbital abnormalities (e.g., measurement of levator function, orbital ultrasound interpretation).
ob o Identify indications for and perform more advanced assessment of eyelids and eyebrows (e.g., hypoglobus, facial asymmetry, brow ptosis).
ob o Identify indications for and perform more advanced lacrimal assessment (e.g., interpretation of dye testing, canicular probing in trauma).
ob o Identify indications for and perform more advanced assessment of the orbit (e.g., enophthalmus, interpretation of orbital ultrasound in common conditions).
ob o Perform more complicated minor lid procedures (e.g., larger benign skin lesions) or surgery (e.g., recurrent or multiple chalazion).
ob o Recognize the indications and complications and perform more complex minor operating room or limited operating room procedures (e.g., incision and drainage of recurrent or larger chalazia, excision of moderate sized benign eye-lid lesions).
ob o Recognize and treat orbital trauma (e.g., intraorbital foreign body, retrobulbar hemorrhage, fracture).
ob o Describe, recognize the indications for and complications of, and perform the basic lacrimal procedures below:

  a. Lacrimal drainage testing (irrigation, dye disappearance test).
  b. Lacrimal intubation.
  c. Dacryocystorhinostomy (external).

**Practice Base Learning and Improvement:**

o Describe the genetics (where known), clinical features, evaluation, and treatment of congenital eyelid deformities (e.g., coloboma, distichiasis, epicanthus, telecanthus, blepharophimosis, ankyloblepharon, epiblepharon, euryblepharon, and Goldenhar syndrome, Treacher-Collins syndrome, Waardenburg syndromes).

**Interpersonal and Communication Skills:**

o Recognize, evaluate and treat thyroid ophthalmopathy (e.g., epidemiology, symptoms and signs, associated systemic diseases, orbital imaging, differential diagnosis, surgical, medical and radiation indications, side effects of treatment).
ob o Identify indications for and perform more advanced socket assessment (e.g., extrusion of implants, anophthalmic socket complications). Co-ordinate care with ocularist and identify sources for aid in obtaining prosthesis.
ob o Treat common presentations of preseptal or orbital cellulitis. Coordinate care with other specialties.

**Professionalism:**

o Communicate extent of ocular involvement in cases of facial trauma and facilitate multidisciplinary treatment.
**System Based Practice:**

- Describe the genetics, clinical features, evaluation, and team management of common craniosynostoses and other congenital malformations (e.g., Crouzon and Apert syndromes).
- Identify common orbital pathology (e.g., orbital fractures, orbital tumors) on imaging studies (e.g., magnetic resonance imaging, computed tomography, ultrasound).

**Third Year PGY4**

**Goals:**
At the end of third year the resident should demonstrate the ability to assess, evaluate, and treat more complex lid, lacrimal and orbital problems.

**Objectives:**
The resident must integrate and assimilate the following cognitive and technical objectives.

**Medical Knowledge:**

- Describe the most advanced eyelid, lacrimal, and orbital anatomy and physiology.
- Describe the etiology, evaluation, and medical and surgical treatment of the following eyelid diseases:
  - a. Complex ectropion (e.g., congenital, paralytic, involutional, cicatrical, mechanical).
  - b. Complex entropion (e.g., involutional, cicatrical, spastic, congenital).
  - c. Complex myogenic ptosis (e.g., chronic progressive external ophthalmoplegia).
  - d. Complex differential diagnosis for dermatochalasis (e.g., blepharochalasis).
  - e. Benign, pre-malignant, or malignant eyelid tumors (e.g., papilloma, keratoacanthoma, seborrheic keratosis, epidermal inclusion cyst, molluscum contagiosum, verruca vulgaris, actinic keratosis, basal cell carcinoma, squamous cell carcinoma, sebaceous cell carcinoma, melanoma).
  - f. Single or recurrent inflammatory lesions (e.g., recurrent chalazion or its mimics).
  - g. Facial dystonia (e.g., blepharospasm, hemifacial spasm).
  - h. Facial nerve palsy with exposure keratopathy (e.g., tarsorrhaphy, gold weights).
  - i. Complex lid and orbital trauma cases.

**Patient Care:**

- Evaluate and treat simple and more advanced eyelid, orbital, and lacrimal trauma (e.g., full thickness lid laceration, chemical burns to the face).
- Describe the indications for and perform more complicated and advanced “in office” examination techniques for less common but important oculoplastic and orbital abnormalities.
- Perform preoperative and intraoperative assessment of the eyelids and eyebrows (e.g., intraoperative adjustments).
Recognize and treat more complex or difficult socket-related problems and complications (e.g., extrusion of implants, anophthalmic socket complications).

Perform more complicated lid procedures (e.g., larger benign, recurrent, or multiple skin lesions, eyelid reconstruction).

Perform more advanced lacrimal assessment (e.g., intraoperative and postoperative testing, more complex trauma to lacrimal system).

Describe management of and treat lacrimal system abnormalities, including:
   a. More complex congenital disorders (e.g., canalicular stenosis).
   b. More complex acquired disorders and their treatment (e.g., conjunctivodacryocystorhinostomy with Jones tube).
   c. Complex moderate trauma (e.g., requiring lacrimal intubation).

Describe, recognize the indications for and complications of, and perform the eyelid procedures listed below:
   a. Basic biopsy techniques.
   b. Lateral tarsal strip.
   c. Specialized lid suture procedures (e.g., Quickert sutures).
   d. Medial spindle.
   e. Retractor reinsertion.
   f. Levator advancement.
   g. Eyelid laceration/margin repair.
   h. Tarsorrhaphy.
   i. Lateral canthoplasty (canthotomy and cantholysis).
   j. Blepharoplasty.
   k. Facial nerve palsy — gold weight placement in the lid.
   l. Simple eyelid reconstruction.
   m. Orbital approaches and incisions (e.g., Kronlein, Caldwell-Luc, transconjunctival, transnasal).

Describe, recognize the indications for and complications of, and perform basic orbital skills and procedures, including:
   a. Anterior orbitotomy for tumor biopsy/excision.
   b. Orbital floor fracture repair.

Perform botulinum toxin injections (e.g., blepharospasm).

Identify more advanced orbital pathology (e.g., complex orbital fractures, orbital tumors) on imaging studies (e.g., magnetic resonance imaging, computed tomography, ultrasound).

Interpersonal and Communication Skills:

Perform preoperative and postoperative assessment and coordination of care of patients with more advanced or complex oculoplastic disorders (e.g., systemically ill patients, multi-disciplinary procedures).

Co-ordinate the smooth function of the oculoplastic clinic at CVC and VA and even distribution of surgical cases amongst the junior residents.

Practice Base Learning and Improvement:

Oversee and present at Grand Rounds Oculoplastic entities of interest.

Select and present at Journal Club oculoplastic articles.
**Professionalism:**

- Describe the indications for and interpret CT and MRI scans (e.g., orbital trauma, orbital lesions and tumors) and co-manage with other sub-specialist.

**Systems – Based Practice:**

- Recognize typical and atypical features and describe the differential diagnosis, clinical features, and co-management of more complicated orbital diseases, including:
  a. More complex orbital infections (e.g., preseptal and orbital cellulitis, mucormycosis, aspergillosis).
  b. Congenital tumors (e.g., dermoid).
  c. Fibro-osseous disorders and tumors (e.g., fibrous dysplasia, osteoma, chondrosarcoma, osteosarcoma, Paget’s disease).
  d. Vascular tumors (e.g., capillary hemangioma, cavernous hemangioma, hemangiopencytoma, lymphangioma, Kaposi’s sarcoma).
  e. Xanthomatous tumors (e.g., xanthelasma, juvenile xanthogranuloma).
  f. Lacrimal gland tumors (e.g., benign mixed tumor, adenoid cystic carcinoma, malignant mixed tumor, lymphoma).
  g. Neural tumors (e.g., optic nerve glioma/meningioma, neurofibromatosis, neuroblastoma).
  h. Rhabdomyosarcoma.
  i. Orbital pseudotumor.
  j. Lymphoid lesions (e.g., lymphoid hyperplasia, lymphoma, leukemia).
  k. Thyroid-related orbitopathy.
  l. Metastatic tumors (e.g., from breast, lung, prostate, colon, melanoma).
  m. Trauma (e.g., orbital fractures, traumatic optic neuropathy).

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Teaching Faculty:

**William K. Blaylock, MD, Assistant Clinical Professor**

**Recommended Texts:**


**Assessment Methods:**
OKAP exam, ABO written and oral examinations, surgical skills assessment evaluation, surgical outcomes review, surgical case log, Journal Club tool, 360-degree evaluation, end of rotation evaluation.
### Attending Physicians and Optometrists at McGuire VAMC

<table>
<thead>
<tr>
<th>ACTIVE STAFF</th>
<th>COVERAGE</th>
<th>DAYS AT THE VA</th>
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<tbody>
<tr>
<td>Kimberly Anderson, MD</td>
<td>Clinic: Eye/MD 1</td>
<td>Everyday</td>
<td>4144</td>
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<tr>
<td>William Benson, MD</td>
<td>Surgery</td>
<td>Thursday (2&amp;4) all day</td>
<td>3504 (MCV beeper)</td>
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<td>Vikram Brar, MD</td>
<td>Retina Consultant</td>
<td>1&lt;sup&gt;st&lt;/sup&gt;, 3&lt;sup&gt;rd&lt;/sup&gt; Tuesday</td>
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<td>Clinic/Laser</td>
<td>Wednesday all day</td>
<td>1586 (MCV beeper) 905-1610 (direct beeper)</td>
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<tr>
<td>Richard Fenton, MD</td>
<td>Glaucoma, Clinic/Surgery</td>
<td>Mon-Thursday (surgery on Thursday)</td>
<td>4142;4055; 351-9389 (beeper)</td>
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<td>Chris Leffler, MD</td>
<td>Strabismus, Clinic/Surgery</td>
<td>1&lt;sup&gt;st&lt;/sup&gt;, 3&lt;sup&gt;rd&lt;/sup&gt; and 5&lt;sup&gt;th&lt;/sup&gt; Thursday all day</td>
<td>4142 257-1182 (beeper)</td>
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<tr>
<td>Muneera Mahmood, MD</td>
<td>Chief Cornea, Clinic/Surgery</td>
<td>Mon-Wed all day Thursday AM</td>
<td>4143; 4120 (office) 759-4162 (beeper)</td>
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<tr>
<td>Amy Sporn Miller, OD</td>
<td>Optometrist Clinic</td>
<td>Mon-Thursday all day</td>
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<td>Every other Friday all day</td>
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<tr>
<td>Dennis Pratt, MD</td>
<td>Surgery/Clinic</td>
<td>Tuesday all day</td>
<td>4142;4143 359-9959 (beeper)</td>
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<td>Jodi Rentz, OD</td>
<td>Optometrist Clinic</td>
<td>Mon-Thursday all day</td>
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<tr>
<td>Shradha Parikh, OD</td>
<td>Low Vision Optometrist/clinic</td>
<td>Mon-Friday all day</td>
<td>2971</td>
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MCV HOSPITALS & PHYSICIANS of VCU HEALTH SYSTEM
Department of Ophthalmology Faculty Contact List

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(804) 675-5541
2012-2013: CALENDAR OF EVENTS

JULY: NEW INCOMING RESIDENTS ORIENTATION
   Institutional Orientation: July 2nd
   Walk the Walk: July 3rd
   Departmental Orientation: July 5-15

AUGUST: No Events

SEPTEMBER: UVA – Annual Marion K. Humphries, Jr., MD Symposium: September 8th

OCTOBER: American Academy of Ophthalmology; Chicago
   Subspecialty Day: November 9-13th

NOVEMBER: RESIDENCY INTERVIEWS
   Session I: November 16
   Session II: November 17

DECEMBER: HOLIDAY PARTY – TBD

JANUARY: WET LAB (ALCON): Saturday, January (TBD)

FEBRUARY: BASIC SCIENCE COURSE
   The University of Texas Medical School at Houston: February 4th – March 1st

MARCH: American Society of Cataract and Refractive Surgery
   Symposium – San Diego, CA: February 14th - 18th

APRIL: OKAP Exam: April 20th
   EVMS Annual John Dickerson Lecture: April 26th & 27th

MAY: ARVO: Seattle, Washington: May 5th – 9th

JUNE: 2013 VCUHS Resident Research & Alumni Day; MCV Alumni House: June 21st
   GRADUATION DINNER; The Jefferson Hotel: June 21st
   VSO Annual Scientific Meeting; Arlington: TBD
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<th>RESIDENT</th>
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VAMC RESIDENT ROTATION SCHEDULE  
DEPARTMENT OF OPHTHALMOLOGY  
JULY 2012- JUNE 2013

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<td>3RD YEAR</td>
<td>Jack Johnson</td>
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<td>2ND YEAR</td>
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<td>Allison Pariyadath</td>
<td>Vasuki Vivek TEXAS</td>
<td>Nisha Gupta</td>
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Please refer to the schedule handout provided during orientation or at the beginning of the academic year.

_for more details contact the Program Coordinator._
EVALUATION METHODS

Of RESIDENTS:

Bi annual
- Procedural Report Card
- Resident Self-Reflection / Assess
- Chart Audit
- Rotational Eval
- Duty Hours Compliance

- Surgical Assessment
- Developmental Milestones
- Conference Attendance
- Eval based on Competency

360 Eval
- Eval by Peers
- Eval by staff (techs, office, photographer, etc.)
- Eval by patient (patient survey)

GR / JC Assessment
- By Faculty
- Self-Assessment

Rotational eval by faculty

Post OKAP Questionnaire

OCEX

Surgical Skills
- Assess by Faculty
- Self-Assessment

Exit Eval

Of FACULTY:

Eval of faculty by residents

Of PROGRAM:

Eval by Residents
Eval by Faculty
<table>
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<th>Medical Knowledge</th>
<th>Surgical Skills</th>
<th>Patient Care</th>
<th>Self-Reflection</th>
<th>Evidence Based Medicine</th>
<th>Quality Improvement</th>
<th>Teaching Skills</th>
<th>Health Care Delivery System</th>
<th>Cost Effective Practice</th>
<th>Patient Safety &amp; Advocacy/Syscom</th>
<th>Causes of Error</th>
<th>Communicating w/Patients &amp; Families</th>
<th>Communicating w/Team Members</th>
<th>Scholarly Communication</th>
<th>Professional Behavior</th>
<th>Clinical Competencies</th>
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<td><strong>Pain Evaluation</strong></td>
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<td><strong>300: Evaluation</strong></td>
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</tbody>
</table>
OVERALL COMPETENCE
(Based on average summary of evaluations through current period)

I. Patient Care
   ☐ Resident is at or above expected level of Patient Care core competency
   Average Score ___  Peer Comparison ___
   Comments: _____________________________________________

II. Medical Knowledge
    ☐ Resident is at or above expected level of Medical Knowledge core competency
    Average Score ___  Peer Comparison ___
    Comments: _____________________________________________

III. Professionalism
     ☐ Resident is at or above expected level of Professionalism core competency
     Average Score ___  Peer Comparison ___
     Comments: _____________________________________________

IV. Practice Based Learning & Improvement
    ☐ Resident is at or above expected level of Practice Based Learning & Improvement core competency
    Average Score ___  Peer Comparison ___
    Comments: _____________________________________________

NAME: ___________________ PGY: ________
V. Interpersonal & Communication Skills

☐ Resident is at or above expected level of Interpersonal & Communication Skills core competency
Average Score _____ Peer Comparison _____
Comments: ____________________________________________________________
__________________________________________________________

VI. Systems Based Practice

☐ Resident is at or above expected level of Systems Based Practice core competency
Average Score _____ Peer Comparison _____
Comments: ____________________________________________________________
__________________________________________________________

VII. SURGICAL SKILLS

☐ Resident is at or above expected level of Surgical Skills competency
☐ Faculty Surgical Assessment / Resident Self-Assessment Reviewed
☐ ACGME Case Log Reviewed
☐ Present at Surgical Case Review Conferences

Comments: ____________________________________________________________
__________________________________________________________

OTHER AREAS:

SCHOLARLY ACTIVITY / RESEARCH:
Current Topic: __________________________________________________________
Future goals for next 6 months: __________________________________________
__________________________________________________________

BOARD PREPARATION:

☐ Resident has an education plan in preparation for in-service & board exam
Future goals for next 6 months: __________________________________________
__________________________________________________________
WORK LIFE BALANCE:
Comment: 

CAREER PLANNING:
Comment: 

RESIDENT OVERALL CONCERNS and/or COMMENTS:


PROGRAM DIRECTOR COMMENTS:


The Program Director and resident have met and discussed this evaluation personally.

Program Director __________________________ Date ____________

Resident __________________________ Date ____________
The VCU Ophthalmology Training Program is committed to resident development of ongoing self-assessment and self-reflection skills. Self-evaluation is an essential lifelong professional skill. This process is meant to assist you and your mentor in completing your overall evaluation.

The Accreditation Council for Graduate Medical Education (ACGME) has defined six areas of “general competency” that are expected of residents in all specialties.

Please complete the following self-assessment form prior to your bi-annual review meeting with the Program Director. Include comments on your performance from a personal perspective, considering any problems you may be encountering, looking at your personal goals and making concrete plans for the future.

**PATIENT CARE:** Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

<table>
<thead>
<tr>
<th>How I am doing? (circle)</th>
<th>Feel Uncomfortable</th>
<th>Feel Comfortable</th>
<th>Feel Very Comfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need Improvement (circle)</td>
<td>A lot</td>
<td>Some</td>
<td>Little to none</td>
</tr>
</tbody>
</table>

Area(s) in which I feel strong:

__________________________________________________________________________________________________________________________________________

Area(s) I need to keep improving:

__________________________________________________________________________________________________________________________________________

Specific objectives for next 6 months and strategies to achieve objectives

1.________________________________________________________________________________________________________________________________________

2.________________________________________________________________________________________________________________________________________

**MEDICAL KNOWLEDGE:** Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

<table>
<thead>
<tr>
<th>How I am doing? (circle)</th>
<th>Feel Uncomfortable</th>
<th>Feel Comfortable</th>
<th>Feel Very Comfortable</th>
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</thead>
<tbody>
<tr>
<td>Need Improvement (circle)</td>
<td>A lot</td>
<td>Some</td>
<td>Little to none</td>
</tr>
</tbody>
</table>

Area(s) in which I feel strong:

__________________________________________________________________________________________________________________________________________

Area(s) I need to keep improving:

__________________________________________________________________________________________________________________________________________

Specific objectives for next 6 months and strategies to achieve objectives

1.________________________________________________________________________________________________________________________________________

2.________________________________________________________________________________________________________________________________________

(OVER)
**PRACTICE BASED LEARNING & IMPROVEMENT:** Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

<table>
<thead>
<tr>
<th>How I am doing? (circle)</th>
<th>Feel Uncomfortable</th>
<th>Feel Comfortable</th>
<th>Feel Very Comfortable</th>
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</thead>
<tbody>
<tr>
<td>Need Improvement (circle)</td>
<td>A lot</td>
<td>Some</td>
<td>Little to none</td>
</tr>
</tbody>
</table>

Area(s) in which I feel strong:

Area(s) I need to keep improving:

Specific objectives for next 6 months and strategies to achieve objectives

1. __________________________________________________________
2. __________________________________________________________

**INTERPERSONAL & COMMUNICATION SKILLS:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and professional associates.

<table>
<thead>
<tr>
<th>How I am doing? (circle)</th>
<th>Feel Uncomfortable</th>
<th>Feel Comfortable</th>
<th>Feel Very Comfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need Improvement (circle)</td>
<td>A lot</td>
<td>Some</td>
<td>Little to none</td>
</tr>
</tbody>
</table>

Area(s) in which I feel strong:

Area(s) I need to keep improving:

Specific objectives for next 6 months and strategies to achieve objectives

1. __________________________________________________________
2. __________________________________________________________

**PROFESSIONALISM:** Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

<table>
<thead>
<tr>
<th>How I am doing? (circle)</th>
<th>Feel Uncomfortable</th>
<th>Feel Comfortable</th>
<th>Feel Very Comfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need Improvement (circle)</td>
<td>A lot</td>
<td>Some</td>
<td>Little to none</td>
</tr>
</tbody>
</table>

Area(s) in which I feel strong:

Area(s) I need to keep improving:

Specific objectives for next 6 months and strategies to achieve objectives

1. __________________________________________________________
2. __________________________________________________________
SYSTEMS-BASED PRACTICE: Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

How I am doing? (circle)  Feel Uncomfortable  Feel Comfortable  Feel Very Comfortable
Need Improvement (circle)  A lot  Some  Little to none
Area(s) in which I feel strong:

____________________________________________________________________________________
____________________________________________________________________________________

Area(s) I need to keep improving:

Specific objectives for next 6 months and strategies to achieve objectives
1. ________________________________________________________________________________
2. ________________________________________________________________________________

DUTY HOURS: Maintains duty hours within ACGME prescribed limits (no more than 80 hours/week averaged over 4 weeks; should have 10 hours free of duty, and must have eight hours between scheduled duty periods; no longer than 24 hours/shift and no new patients after 24 hours).

How I am doing? (circle)  Feel Uncomfortable  Feel Comfortable  Feel Very Comfortable
Need Improvement (circle)  A lot  Some  Little to none
Area(s) in which I feel strong:

____________________________________________________________________________________
____________________________________________________________________________________

Area(s) I need to keep improving:

Specific objectives for next 6 months and strategies to achieve objectives
1. ________________________________________________________________________________
2. ________________________________________________________________________________

SURGICAL SKILLS: (based on PGY level)

How I am doing? (circle)  Feel Uncomfortable  Feel Comfortable  Feel Very Comfortable
Need Improvement (circle)  A lot  Some  Little to none
Area(s) in which I feel strong:

____________________________________________________________________________________
____________________________________________________________________________________

Area(s) I need to keep improving:

Specific objectives for next 6 months and strategies to achieve objectives
1. ________________________________________________________________________________
2. ________________________________________________________________________________
SCHOLARLY ACTIVITIES / RESEARCH:

Do I have an active research project? (circle) YES NO

If yes, what is the status of your current research project? _________________________________________________________

Title:_______________________________________________________________________________________________________

If no, what is your plan in developing such project?

__________________________________________________________________________________________________________

Area(s) of research in which I’d like to be more involved:

__________________________________________________________________________________________________________

Area(s) in my research that need improvement?

___________________________________________________________________________________________________________

Specific timeline and objectives for next 6 months and strategies to achieve objectives

1.__________________________________________________________________________________________________________

2.__________________________________________________________________________________________________________

BOARD/ OKAP EXAM PREP:

How I am doing? (circle) Not Ready for OKAPs Ready for OKAPs Overprepared for OKAPs

Need to Read (circle) A lot more Some About Right

How am I preparing for in-service and board exam? Area(s) in which I feel strong:

__________________________________________________________________________________________________________

Area(s) I need to keep improving:

__________________________________________________________________________________________________________

Specific objectives for next 6 months and strategies to achieve objectives

1.__________________________________________________________________________________________________________

2.__________________________________________________________________________________________________________

WORK - LIFE BALANCE:

How I am doing? (circle) Not in Balance Balanced Not an Issue

Need Improvement (circle) A lot Some Little to none

Area(s) in which I feel strong:

__________________________________________________________________________________________________________

Area(s) I need to keep improving:

__________________________________________________________________________________________________________

What obstacles, if any, are you experiencing that impede your professional growth?

__________________________________________________________________________________________________________

Specific objectives for next 6 months and strategies to achieve objectives

1.__________________________________________________________________________________________________________

2.__________________________________________________________________________________________________________

(OVER)
**EMOTIONAL HEALTH:**

<table>
<thead>
<tr>
<th>How I am doing? (circle)</th>
<th>Feel Uncomfortable</th>
<th>Feel Comfortable</th>
<th>Feel Very Comfortable</th>
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<tbody>
<tr>
<td>Need Improvement (circle)</td>
<td>A lot</td>
<td>Some</td>
<td>Little to none</td>
</tr>
</tbody>
</table>

Area(s) in which I feel strong:

__________________________________________________________

Area(s) I need to keep improving:

__________________________________________________________

Do you have adequate time for rest and relaxation? If not, what would be helpful and what ideas do you have to improve this?

__________________________________________________________

Specific objectives for next 6 months and strategies to achieve objectives

1. ____________________________________________________________
2. ____________________________________________________________

**CAREER PLANNING:**

<table>
<thead>
<tr>
<th>Have you thought about your future in Ophthalmology? (circle)</th>
<th>Not at all</th>
<th>Somewhat</th>
<th>Yes</th>
</tr>
</thead>
</table>

Ophthalmic area(s) of interest:

______________________________________________________________________________________

Ophthalmic area(s) I am not interested in:

________________________________________________________________________________________

Specific objectives for next 6 months and strategies to achieve possible future career aspirations:

1. ____________________________________________________________
2. ____________________________________________________________

**OVERALL RESIDENT CONCERNS:**

<table>
<thead>
<tr>
<th>Overall, how I am doing at this level? (circle)</th>
<th>Below my expectations</th>
<th>At expectation</th>
<th>Exceeding expectations</th>
</tr>
</thead>
</table>

Area(s) in which I feel strong:

________________________________________________________________________________________

Area(s) I need to keep improving:

________________________________________________________________________________________

Specific objectives for next 6 months and strategies to achieve objectives

1. ____________________________________________________________
2. ____________________________________________________________

(OVER)
OVERALL PROGRAM CONCERNS: (Please address this as a reflection of how the program is preparing you as a resident at your PGY level)

Overall, how is the PROGRAM doing (based on PGY level)?  Below my expectations  At expectation  Exceeding expectations

Area(s) in which the program is strong (based on PGY level):

______________________________________________________________________________________

Area(s) in which the program needs to improve (based on PGY level):

___________________________________________________________________________________________________________

Is the residency program meeting my professional and personal needs?

___________________________________________________________________________________________________________

Specific objectives for next 6 months and strategies to achieve objectives at how the Program can improve at this level.

1.__________________________________________________________________________________________________________

2.__________________________________________________________________________________________________________

Additional Comments:

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

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Resident Signature: ___________________________  Date: ________________

____________________________________________________________________________________________________________

FORM REVIEWED BY: ___________________________  Date: ________________

Program Director
Ophthalmology CHART AUDIT FORM

RESIDENT NAME: ________________________________  Date of Review: __________________
Post Graduate Year of Training:  2  3  4  Patient MRN:   ____________   Evaluator Name:  ________________

Type of Document Reviewed:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Outpatient</th>
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<tbody>
<tr>
<td>___ History &amp; Physical Exam</td>
<td>___ History &amp; Physical Exam</td>
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<tr>
<td>___ Discharge Summary</td>
<td>___ Progress Note</td>
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<td>___ Progress Note</td>
<td>___ Consultation</td>
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<tr>
<td>___ Consultation</td>
<td>___ Procedure Note</td>
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<tr>
<td>___ Procedure Note</td>
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Please evaluate the sections that are relevant to the record you are reviewing.
Cite specific examples of resident performance and include recommendations for improvement.

<table>
<thead>
<tr>
<th>ITEMS TO BE EVALUATED</th>
<th>YES</th>
<th>NO</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>PATIENT CARE</strong></td>
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<tr>
<td>Appropriate history for presenting problem documented</td>
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<td>Appropriate examination documented</td>
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<td>Accurate assessment</td>
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<td>Developed diagnostic plan</td>
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<tr>
<td>Developed therapeutic plan</td>
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<td>Follow-up plan documented</td>
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<td>Procedures</td>
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<td>- Indications clearly documented</td>
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<td>- Written consent documented</td>
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<tr>
<td>- Procedure note present and complete</td>
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<tr>
<td><strong>MEDICAL KNOWLEDGE</strong></td>
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<tr>
<td>Differential diagnosis documented</td>
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<td>Interpretation of exam and laboratory data documented</td>
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<td>Demonstrates investigatory and analytic thinking</td>
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<td>Demonstrates knowledge appropriate to level of thinking</td>
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<td><strong>INTERPERSONAL AND COMMUNICATION</strong></td>
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<td>Legible</td>
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<td>Thorough and complete</td>
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<td>Communicates well with referral source/primary care provider</td>
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<td>Medication list current as of last visit</td>
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<tr>
<td>Problem list updated</td>
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<tr>
<td><strong>PROFESSIONALISM</strong></td>
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<tr>
<td>Timely completion of records</td>
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<tr>
<td><strong>SYSTEMS BASED PRACTICE</strong></td>
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<tr>
<td>Provides documentation to enable appropriate billing</td>
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<td>Uses appropriate ICD codes</td>
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<tr>
<td>Uses appropriate E&amp;M codes</td>
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<td>Made appropriate referral(s)</td>
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<tr>
<td>Provides cost-effective healthcare</td>
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<tr>
<td>Appropriate use of lab, x-ray, etc.</td>
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</table>

VCUHS, OPHTHALMOLOGY (Dev. 12/10)
## ROTATIONAL EVALUATION

### PERFORMANCE REVIEW SUMMARY

**RESIDENT:** ___________________________  **DATE:** ________

**KEY:**

- 1.0 – 3.9 Below Expectations
- 4.0 – 6.9 Expected Level
- 7.0 – 9.0 Exceed Expectations

### Section Average

<table>
<thead>
<tr>
<th>I. Patient Care</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Gathers information</td>
<td>________</td>
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<tr>
<td>b. Displays mastery</td>
<td>________</td>
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<tr>
<td>c. Formulates thorough diagnosis</td>
<td>________</td>
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<tr>
<td>d. Develops &amp; initiates appropriate mgmt</td>
<td>________</td>
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<tr>
<td>e. Effectively counsels and educates patients</td>
<td>________</td>
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<tr>
<td>f. Utilizes auxiliary resources</td>
<td>________</td>
</tr>
</tbody>
</table>

| II. Medical Knowledge | ![ ] |
|-----------------------|
| a. Applies knowledge of basic & clinical sciences | ________ |
| b. Demonstrates analytical thinking | ________ |

| III. Professionalism | ![ ] |
|----------------------|
| a. Behaves respectfully and compassionately | ________ |
| b. Sensitive to cultural/age/gender/disability issues | ________ |
| c. Fulfills assigned clinical & on-call responsibilities | ________ |
| d. Displays professional ethics | ________ |

| IV. Practice-Based Learning & Improvement | ![ ] |
|------------------------------------------|
| a. Uses evidence from ophthalmic literature | ________ |
| b. Utilizes information technology | ________ |
| c. Teaches students, staff, and colleagues | ________ |
| d. Continually improves practice based on past experience. | ________ |

| V. Interpersonal & Communication Skills | ![ ] |
|----------------------------------------|
| a. Establishes therapeutic relationship with patient | ________ |
| b. Interacts well with staff, faculty, and colleagues | ________ |
| c. Displays effective listening skills | ________ |
| d. Maintains timely and legible medical records | ________ |
| e. Presents patients effectively and succinctly | ________ |
Systems-Based Practice

a. Practices cost-effective care
b. Collaborates with other health care providers
c. Acts as advocate for patient within health care system

Surgical Skills

a. Exhibits logical preoperative decision-making
b. Adequately informs patients of risks, benefits, and alternatives to procedure
c. Demonstrates sound intraoperative judgment
d. Displays technical surgical competence
e. Provides appropriate postoperative care,
f. including management of complications
g. Maintains surgical log

General Comments:

Resident Comments:

I have read this document, discussed the contents with my supervisor, and acknowledge this with my signature. My signature does not necessarily indicate that I agree with my supervisor’s assessment of my performance.

Resident’s Signature ___________________________ Date ___________

Program Director’s Signature ___________________________ Date ___________
Faculty Surgical Skills Assessment Tool

Name of Resident: __________ Date: ______
Learning activity: ____________
Type of Surgery: _______ Venue: _______
Number of cases for the day: ______

SCALE (1-10): Disagree = 1  Agree = 5  Strongly Agree = 10  Rate 1-10

1. Surgical skills evaluation / Patient Care:
   a. Pre-Op:
      1. The pre-operative evaluation was adequate ______
      2. The Resident perform sufficient scrub techniques ______
   b. Intra-Op:
      1. The wound construction was well performed ______
      2. The Vital intraoperative steps (please list the critical steps of the procedure the resident performed well on and those which need assistance)
         Comments: ____________ ____________
      3. The wound closure was performed well ______
      4. The resident handles complications well ______
      5. Would you like the resident to present any particular case at the upcoming surgical case review conference?
         Comments: ____________ ____________
   c. Post-Op:
      1. The resident performed post-operative care appropriately ______

2. Professionalism:
   a. The Resident performs effectively as a leader or member of the healthcare team in the O.R. ______
   b. The Resident coordinates O.R. team members to effectively treat the patient and optimize O.R. time ______
   c. The Resident conducts themselves in a professional manner consistent with ethical principles ______

3. Medical Knowledge:
   a. The Resident displayed proficient medical knowledge throughout the surgical procedure ______

4. Practice Based Learning:
   a. The Resident displayed practice based learning and improvement during this surgical day ______
   b. The Resident displayed evidence of using skills needed to gather information technology to locate, appraise, and assimilate evidence from scientific studies and apply it to this day of surgery ______


5. Interpersonal and Communication Skills
   a. The Resident communicated the results of the surgery with the family in the waiting room
   b. The Resident communicated with the family effectively throughout the procedure
   c. During this surgical day, the resident taught skills to ancillary staff, medical students, fellow residents and staff that will enhance patient care
   d. During this surgical day, the Resident displayed the ability to effectively communicate with participants of a variety of educational backgrounds (ancillary staff, medical students, patients, multiple level residents, and faculty)

6. System-Based Practice
   a. Throughout this surgical day, the Resident altered or confirmed current practice patterns that will directly affect surgical care and serve as a quality improvement activity.
   b. On this surgical day, the resident displayed elements of system-based practice principles.
   c. Did this surgery day qualify as an experiential learning which identified system errors or corrections?

Comments: __________ ____________ __________

Additional Comments:
_________________________________________________________

Evaluator: __________ Date: __________

Resident: __________ Date: __________
VCU OPHTHALMOLOGY - OPHTHALMIC CLINICAL EVALUATION EXERCISE (OCEX)

Resident: ____________________________  Evaluator: ____________________________

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

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<th>The rating system is:</th>
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<tr>
<td>1-Does Not Meet Expectations 2-Meets Some Expectations 3-Meets All Expectations 4-Exceeds Expectations na-Not Applicable</td>
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### Interview Skills

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### Examination

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### Interpersonal Skills/ Professionalism

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### Case Presentation

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Comments: ____________________________

We have reviewed this OCEX together. Resident Initials: __________  Evaluator Initials: __________  Date __________

Dx = Diagnosis; IOP = Intraocular pressure; RAPD = relative afferent pupillary defect.

From *Ophthalmology* Volume 112, Number 10, October 2005
Each year a chief resident will be selected in part by the residents, faculty, ancillary staff, program director and chair of the department. The chief resident will be chosen based on his/ her academic record, profession demeanor, personal conduct and commitment to the residency program.

The chief resident exemplifies the standards by which the department holds all of its residents. The chief resident is expected to take a leadership role in the residency by volunteering participation at lectures, attending graduate medical education committee meetings, and voicing the concerns of the residents at appropriate sessions.

The chief resident is responsible for providing the call schedule, coordinating didactic sessions, and acting as a liaison between the residents as a whole and the program director/coordinator. The chief resident is expected to work closely with the program director, chair, and coordinator.

For these additional commitments, the chief resident will be compensated additionally as an annual stipend, be granted paid days for meetings in the PGY-4 year, and a $1500 budget toward AAO meetings.

_In the event that more than one resident is chosen as Chief Resident, the additional stipend granted will be divided amongst all chosen._