# Resident Manual

## Department of Ophthalmology

## 2009-2010

UPDATED 6/11/09

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| DR. HUANG | 815-4284 |
| DR. MUNGAN | 984-5024 |
| DR. NORTHCUTT | 383-7626 |
| DR. PALMER (VA) | 319-1944 |
| DR. PARKER | 984-5500 |
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| DR. SHERWOOD (VA) | 319-1827 |
| DR. SMITH | 984-4183 |
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| EDUCATION ADMINISTRATOR (FAY) | 984-5023 |
| OPERATIONS MANAGER (SHIRLEY MCLEOD) | 815-3931 |
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| MCBRYDE CLINIC | 984-4565 |
| VA EYE CLINIC | 319-5815 |
| FLUORESCEIN LAB | 984-5026 |
| ELECTROPHYSIOLOGY | 984-6497 |
| CONTACT LENS | 984-5037 |
| RESEARCH ASSISTANT | 815-3093 |
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2008-2009

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| | DAVID LETBETTER | 414 OAK BEND<br>BRANDON,MS 39047 | 843-425-2411 |
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| | KEVIN KOSEK | 1521 ST. ANN<br>JACKSON, MS 39202 | 601-949-2714 |
| | KYLE LEWIS | 416 WESTPORT WAY<br>FLOWOOD, MS 39232 | 601-291-8767 |
| PGY-IV | FARRAH NEWMAN | 625 BERRIDGE DR .<br>RIDGELAND, MS 39157 | 601-707-7722 |
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## OPHTHALMOLOGY CLINICAL FACULTY
## 2008-2009

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RESIDENT CALL SCHEDULE

The Chief Resident is responsible for the residents call schedule for the four-month period in which he/she is Chief Resident with approval of the Program Director. The resident call schedule is usually made out several months in advance with final approval made at the monthly staff meeting. Every attempt is made to make it equitable. A cumulative list of days on call in the appropriate category shall be kept to try and make call equitable for the academic year.
The advance call schedule will be left in each resident's mailbox in room B314. Everyone should review this schedule and if changes are necessary, one should notify the Chief Resident.

Prior to the final typing of each month's call schedule and its distribution (the day after staff meeting) each resident may freely switch with another resident. After the final schedule has been made the chief resident must approve any changes. If this permission is granted, it is the responsibility of the residents involved to **POST** these changes with the adult and pediatric emergency room, UMC and VA hospital operators, the Ophthalmology master schedule (which is kept in the administrative assistant's office), floor receptionist desk, and staff and technician on call. The resident who is on call should make sure the correct pager number is listed for who will be taking the call. It is much easier to just switch pagers for the call period.

DUTIES OF ON CALL RESIDENTS

ANY RESIDENT ON CALL MUST COME IN TO EXAMINE THE PATIENT. YOU CANNOT PROVIDE PROPER DIAGNOSIS ON THE PHONE.

IF A FACULTY DOCTOR IS CONTACTED WHEN THEY ARE NOT ON CALL, THE FACULTY HAS THE OPTION OF WHETHER THEY WOULD LIKE TO SEE THE PATIENT OR ALLOW ANOTHER DOCTOR TO SEE THEM. THE PHYSICIAN MUST MAKE THE REFERRING PHYSICIAN AWARE OF THEIR DECISION.

1st Call Resident (Call begins at 4:00 p.m. and ends at 8:00 a.m.)

1. Answer all calls coming from within the University and VA hospitals.
2. Initial immediate evaluation of emergency room consults and direct referrals to eye service. Include history, exam, diagnosis, treatment, and follow-up.
3. Initial evaluation of in-house ophthalmology consults on weekdays and weekends. Please note that all consults are to be seen within 24 hours of being posted.
4. Post patients for surgery with surgery (4-2440), and the ophthalmology scrub tech if necessary. Out of courtesy, please let the techs know ahead of time if a case is pending since they are outside the hospital and will have to travel in. At VAMC, inform the nursing supervisor of a pending case.

5. Review pre-operative lab, CXR, EKG.
6. Assist in surgery.
7. Admit patients.
8. Obtain list of patients to be rounded on from each service on weekends.
9. Turn in record of patients seen on call and phone calls answered (see section VII).
10. A copy of the evaluation should be given to the service that will follow the patient by 8:30 a.m. the next day. If the patient needs to be seen that day, resident should verbally inform the staff or resident covering the service.
11. When a PGY-2 is the 1st call resident, all patients seen on call must be examined by the 2nd call resident through the end of December. Thereafter, the 1st call resident may use their clinical discretion and call their 2nd call resident as needed.

2nd Call Resident

1. Answer all calls from outside the University and VA hospitals.
2. Evaluation of emergency room consults and direct referrals to eye service with 1st call resident when appropriate.
3. Perform surgery and scrub on all staff surgery at the staff's discretion.
4. Present patients to staff when indicated. Remember: all admissions, all surgery, and all serious cases require staff approval.
5. Answer calls from outside the hospital.
6. Turn in record of patients seen and all phone calls answered (see section VII).
7. Accept patients referred from outside UMC system when indicated. (After staff approval.) The 2nd call resident must also instruct the referring M. D. to contact the E. R. to arrange transfer of care as there may be other co-existing medical problems (especially in trauma cases).
8. Round with 1st call resident on weekends.
9. The 2nd call resident must examine all patients seen during call hours when the 1st call resident is at the PGY-2 level of training through December 31st. Thereafter, the 2nd call resident must respond to all other requests for assistance by the 1st call resident.
10. Any communication to the attending doctor on call needs to be made by the 2nd call resident.
11. If more than 3 E.R./A.O. patients are waiting to be seen, the 2nd call resident is to come in to assist with the 1st call resident.
12. If the 1st call resident is scrubbed in surgery or still out of town at a satellite clinic, the 2nd call resident is to take care of E.R/A. O. patients until the 1st call is available.

Addendum to Resident Call Policy as of 5/2/07

1. If a first call resident has been seeing consults, operating, etc. in house on call for 30 consecutive hours without a break, then the second call resident must take over first call duties and give the first call resident a reasonable rest period.
2. If both residents are scrubbed in surgery and the first call receives 3 or more new consults the following policy should be followed:
    a. the first call scrubs out of surgery to go see consults or,
    b. if it is not possible for the first call to scrub out, then, both residents finish the surgery and then the 2 residents split the work of seeing the new consults.

However, if an urgent consult comes in (i.e. an open globe), then the first call should scrub out to evaluate the urgent consult.

Administrative duties of the Chief Resident

1. Responsible for taking roll call at every conference making sure that all information requested on the form is filled out. If unable to attend conference and take roll call, delegate to another resident. PLEASE PRINT THE TOPIC OF EACH LECTURE ON THE ROLL CALL SHEET. PLEASE DISCLOSE TO THE AUDIENCE IF YOU HAVE A POTENTIAL CONFLICT OF INTEREST OF WHAT IS BEING DISCUSSED AND ALSO IF THE PRESENTATION WILL OR WILL NOT INCLUDE A DISCUSSION OF AN UNLABELED OR INVESTIGATIONAL USE OF A PRODUCT.
2. Take minutes at Journal Club once a month. Type up minutes then turn in minutes to Fay. She will then send a copy by FAX to Performance Improvement and the VA. The minutes have to be in before Dr. Chen attends the Executive Committee meeting the first Tuesday of the month.
3. Set up video equipment for all conferences. Return video equipment back to our conference room if moved to another location for a conference.
4. Turn call schedule in to Sherlene by the 15th of the current month for the following month if at all possible to present at Staff Meeting the first Wednesday of each month.
5. Attend Monthly Staff meetings, if unable to attend, must delegate another resident to attend.

WORK-UP OF EMERGENCY ROOM PATIENTS

1st call resident should respond to all requests by Emergency Room Staff to see any patient concerning an ocular problem. The responsibilities include the initial interview, exam, diagnosis, and treatment suggestions. All emergency room work-ups of patients with ocular problems are to contain a history, exam, diagnosis, treatment rendered and what means of follow-up will be provided if it is needed. Admissions to the ophthalmology service require a <u>full</u> history and physical exam, not just an ophthalmology consult.
In situations where the 2nd call resident is unable to be immediately present in the emergency room (*e.g.* scrubbed in surgery, rounding with staff), the 1st call resident will then inform the patient that there will be a delay before the 2nd call resident is available. Should the patient desire to leave without seeing the 2nd call resident, the **STAFF** should be notified and disposition discussed prior to releasing the patient.

Once this write-up is completed, a copy should be given to the physician, who will be providing follow-up care, by 8:30 a.m. the next weekday. The original should be placed in the hospital chart.

Please note – **All** patients seen on an emergency basis after hours or on the weekend **must** be checked in through the ER. This is the only way patients can get hospital numbers that are needed for billing and patient tracking. It is also the only way labs or medications can be ordered for a patient, since these must be placed through the computer system.

OPHTHALMOLOGY CONSULTS/EMERGENCIES/WALK-IN's

The ophthalmology staff who is on private consults will be responsible for all in-patient consults, new out-patient consults, new patient emergency room consults, new patient emergency call-in's, and new walk-in patients received prior to 4:00 p.m. It is the prerogative of the ophthalmologists on the consults to ask another division to see the patient based on the patient's diagnosis. Established patients will be seen in the clinic in which they are being followed unless the ophthalmologist is not on campus or arrangements have been made with another ophthalmologist to evaluate the patient.

The ophthalmologist who is on call will be responsible for seeing all in-patient consults, out-patient consults, emergency room consults, emergency call-in's and walk-in patients received after 4:00 p.m. in conjunction with the residents on call.

- ONE EXCEPTION: If the patient is for the McBryde Clinic and is not an established patient of the clinic, then they must first go to the emergency room and be referred to Ophthalmology.

Definitions:

- Outpatient consult-Department is consulted by another physician, department, or facility to see a patient.
- Inpatient consult-Department is consulted by another physician or department to see a patient that is in the University Hospital.
- Emergency Department consult- Ophthalmology is consulted by the UMHC Emergency Room to see a patient who has come through their department.
- Emergency call in's: Patients who call in with visual complaints and who are deemed by the ophthalmologist, resident, or technician that they should be seen that day.
- Walk-in patients: Patients who show up in the department without an appointment.

OPHTHALMOLOGY PATIENTS SCHEDULED TO BE SEEN AFTER HOURS

Patients that return for follow-up after hours cannot be seen in the Emergency Department unless they are checked in thru ED.

Patients who are checked in thru the Emergency Department must be discharged thru the Emergency Department before going home and their chart returned to ED.

OUTSIDE PHONE CALLS

During call periods **All** incoming outside telephone calls from the UMC and VA switchboards are to be directed to the 2nd call resident on call.

WEEKEND FOLLOW-UP OF PATIENTS SEEN THE PRIOR WEEK

If a patient is brought back to the emergency room for follow-up during the weekend, the resident or staff that is bringing the patient back for follow-up **MUST** provide the designated resident with a copy of the patient's last office visit. It is **MANDATORY** that everyone communicates with the resident on call concerning the **TIME** the patient is to return for follow-up care. This will enable the resident on call to better plan and anticipate the weekend responsibilities.

When the resident on call providing the follow-up care has completed the exam, that resident should make a copy of the write-up and give this copy to the physician providing the primary care the following Monday morning.

## EMERGENCY/WEEKEND PHOTOGRAPHY

Sometimes the photography service is needed on an emergency basis (*e.g.* shaken baby syndrome). In case of an emergency, the on-call resident must assess the prognosis of the patient and determine whether or not photographs can be delayed until the next business day. If the patient is in critical condition and the resident believes the patient will succumb to his injuries, one of the photographers can be contacted. In the event that several attempts have been made and the photographers are not available, photographs will be done the next business day. As the photography staff is not held to an on-call schedule, every effort will be made to expedite the resident's request. <u>In any case, staff should be notified on all such cases due to medical-legal issues.</u>

## CALL RECORD

All residents on call will maintain a written record of all patient contacts, (*e.g.* emergency room patients, telephone calls, hospital consults). The patient's name, hospital number, diagnosis, date and time of contact, doctor on call and the appropriate follow-up will be documented on each patient. At the end of the call period, the card is to be signed, dated and returned to the file box in room B314. The Administrative Office is responsible for picking them up.

This record is filed by date. **This record is extremely important**. If a person or patient's name does not appear on the log cards for the time in question, then it will be understood that the person or party did not contact us. This record is a necessary tool to answer to other services, physicians and patients. It provides legal documentation of communications during emergency on-call hours.

## WEEKEND ROUNDING AND CARE OF HOSPITAL INPATIENTS AND SURGERY PATIENTS

The resident on each service is responsible for contacting the 1st call resident concerning any patients that need to be seen during the weekend. All patients are to be seen both Saturday and Sunday unless otherwise instructed. Most patients can be examined in their rooms on the weekend. However, those who need Slit Lamp exams must be brought to Lane 15/16 or the VA Eye Clinic. Other offices and their equipment should **not** be used unless prior staff approval has been granted.

The 1st call resident is to respond when contacted concerning any problems or orders dealing with an inpatient (*e.g.* medications, IV orders, labs, or other problems). The 2nd call resident should respond when contacted by the 1st call resident concerning any problem he/she is unable to handle.

The residents may agree among themselves to divide rounding responsibilities. If the resident on a particular service is rounding on a particular patient(s), then the two on call residents need not do so. However, it is the responsibility of the 1st call resident to make sure that every patient is seen every weekend day and holiday for both hospitals. Please note that sometimes one hospital will have a holiday when the other does not. Holiday call is **only** scheduled for official **UMC** holidays. Therefore, if the VA has a holiday and not UMC, the VA service is responsible for rounding on their own patients that day. When patients are to be seen at both hospitals, these responsibilities are usually divided with the $1^{st}$ call resident rounding at UMC and the $2^{nd}$ call resident rounding at VA.

The $1^{st}$ and $2^{nd}$ call residents are responsible for scrubbing with staff for all night and weekend surgeries unless the staff specifically requests otherwise.

The 1st call resident is responsible for making all arrangements with the operating room, anesthesia, and scrub technicians for emergency surgery.

The 1st call resident should never hesitate to call the 2nd call resident about any problem that is encountered. If there is still a question, staff should be consulted.

## PATIENT CARE

One resident team (with their attending) is responsible for their patients. Thus, any suggestion by another physician for a change in therapy or new diagnostic procedures must be made to the responsible resident (or attending) before these are initiated.

## SUPERVISORY AUTHORITY FOR RESIDENTS AND PATIENT CARE

### Resident Supervision Policy

In UMC private clinics, residents are responsible for initial evaluation (including history and examination) of selected clinic patients (at the discretion of the attending) and of consults. The resident then presents the case to the attending, who then examines the patient. A discussion of treatment plans then occurs. On these rotations, the resident works directly one-on-one with his/her assigned attending. The resident is also responsible for performing pre-operative work-ups.
On the UMC McBryde rotation, the senior resident is given more latitude. The resident examines every patient. He/she must sign out all patients who potentially need surgery or admission, as well as all in-house consultations. However, the management of other patients is at the discretion of the senior resident. An attending is always immediately available during the clinic and ultimately responsible for the patient’s care. The attending assigned for the day frequently does chart reviews for patients not seen.

A similar arrangement is in place for the VA clinics. The residents perform initial histories and examinations. The PGY-II is required to sign out all cases to be examined by an attending. The PGY-III and PGY-IV are not required to have an attending examine every patient; however, every chart is signed off by an attending. All patients who are potential surgical candidates, potential admissions or in-house consultations must be examined by an attending.

On call, the first call resident performs the initial examination and evaluation. If the first call resident is a PGY-II, the second call resident (PGY-III or IV) must come in and examine the patient with the first call July through December. After December, it is at the discretion of the first call resident to request assistance from the second call, however it is encouraged they have a low threshold for calling their back-up resident. An attending is always on call and readily available for any cases that are beyond the comfort of the upper level, second call resident. There is always an attending on call at each hospital as well as a retina specialist on call. The attending is required to come in for any surgical case and be present in the operating room during the key portions of the procedure, and be present on campus for the entire procedure. The attending must be notified of any admission, and must examine the patient within 24 hours. Other in-house non-emergent consultations must be signed off by the attending within 72 hours. At the VA, the attending must be notified of all consultations immediately.

## DISCHARGE ORDERS

All medications and treatments are to be continued (unless specifically discontinued by the attending physician) until the time that the patient leaves the premises.

## FLUORESCEIN INJECTIONS

It is mandatory that a physician be present on the floor both to assist with injections if necessary and in case there is a medical emergency. The resident on the service that sends a patient for fluorescein studies is responsible for staying until the procedure is completed. If the resident is not available (*e.g.* in surgery), the 1st call resident may be notified after 4 P.M. If the 1st call resident is on a VA rotation and the 2nd call resident is at UMC, they may agree between themselves that the 2nd call resident will cover fluorescein.

## PROCEDURE FOR SCHEDULING EMERGENCY SURGERY

The case should be designated as elective, urgent or emergent:

1. Urgent – cases that need to be performed within the next 24 hours.
2. Emergent – cases that need to be performed in the next available operating room due to one of the following:
    a. Level 1 – Life/sight/limb threatened – case must go immediately into the

first available room.
    b. Level 2 – disease or trauma conditions that require surgery within 6 hours.
3. An elective or urgent add-on case (e.g., not emergent case) cannot be submitted unless the patient is fully ready for surgery, including a completed history and physical examination record, appropriate test results and signed consent.
4. Process for posting add-on procedures:
    a. ISC:
       Level I, II cases – Call the ISC Control Desk at 601-984-2440.
    b. Urgent cases – Call the Scheduling Office at 601-984-5924
    c. WSC – Regular business days between 0730 and 1500 via the WSC Control Desk.
    d. BSC: - Regular business days between 0730 and 1700 via the BSC Control Desk.
    e. All other times via the ISC Control Desk

For complete explanation of Perioperative Services, please see Perioperative Services Policy and Procedure Manual on the Intranet.

The procedure for scheduling surgery at the VAH differs. They supply their own scrub technicians and their own instruments. Once you have notified the operating room of an impending case, they will make arrangements for preparing the instruments and providing a scrub technician for the case. You must call the Nursing Supervisor at the VA and notify he/she of the impending case. He/She will help you locate the anesthetist who is on call.

## STAFF IDENTIFICATION OF PATIENTS

Every patient seen in the McBryde Clinic should have attending physician identification. Once a patient is admitted to the McBryde Clinic, the resident is responsible for making sure that the attending of record is clearly identified with each visit. Patients are to be changed to a different attending only by that patient's attending. Not only does this ensure case continuity; it also identifies practice liability. It is therefore very important for all concerned. For whatever reason, residents are not to "shop around" among the staff with a given patient. In general, the attending for a night/weekend admission will be the attending physician on at that time. If a patient needs to be followed and the staff is not available, it is the responsibility of that staff member to transfer the care to the staff on consult for that day. Quite often the staff relationship will be changed the next morning, but it is at the discretion of the attending staff.

## REFERRALS FROM OUTSIDE PHYSICIANS

1. All potential patient transfers from outside physicians will be discussed with staff **before** acceptance or denial of transfer. Acceptable criteria for referral are based on such things as:

    a) Lack of availability of the required service at the referring hospital. If this is the reason for the referral, the referring physician/hospital must send a note that includes, "This service is not

available at _________", along with the patient. This will go to Hospital Administration, and is of importance with later certificates of need, etc.

b) The existing relationship between the referring physician and the staff at UMC.

c) Uniqueness of case for teaching purposes. Most of the referral cases will not be of this category, but the staff does have some special ways to get persons who truly meet this criterion into the hospital.

2. If the transfer is for a potential admission, the Patient Placement Center must be notifield at 4-DOCS(4-3627). The Placement Center Policy (effective 4/28/08) is:
UMHC physicians requesting a bed assignment should call the Patient Placement Center. Pertinent patient information will be obtained. If the patient does not meet medical necessity for admission, the patient will not be admitted.

   External Physicians requesting admission or transfer of a patient will call the Ambulatory Access Center (866-UMC.DOCS) for connection to the appropriate attending physician. Once the attending physician has agreed to treat the patient, Placement Center nurse will collect pertinent patient information. If the patient does not meet medical necessity for admission or require a higher level of care, the patient will not be admitted or accepted for transfer. Should you have any questions, please contact Yolanda Bennett, RN at 4-3627 or via email at ybennett@nursing.umsmed.edu.

3. Ask the referring physician to tell the patient to stay NPO until they have been seen.

4. Ask the physician to find out about what time the patient is expected to arrive at the UMC ER..

5. Ask him to send a brief note with the patient saying that the resident on call is expecting the case, (*i.e*., “Please call Dr._______ upon arrival, he/she is expecting the case”.) Also notify ER triage nurse (4-4000) that the patient is expected and instructed them to page the 1st call resident on patient’s arrival. This will hopefully ensure that you are called upon their arrival, and keep them from sitting a long time in the ER and being seen by an ER physician before you are called. This can turn a 6:00 p.m. case into a midnight one.

6. When the patient arrives, if the referring doctor described a probable surgical situation, the ER Charge Nurse should be called and asked to go ahead with the routine admit lab, x- rays, etc., while you are on your way to the ER.

ADMITTING PROCEDURES

All patients have a staff physician of record, always to be noted in the chart, and so identified on each visit. Unless the patient being admitted already "belongs" to one of the staff and that staff member has agreed to admit the patient otherwise, that patient is admitted to the staff person on call that weekend. The next morning, if staff of record feels a different staff person is more appropriate, the staff person involved must agree to the staff transfer before it is effected.

## Call Policy

The weekend call schedule begins at 4:00 p.m. on Friday and ends at 8:00 a.m. on Monday morning. Weekday call begins at 4:00 p.m. and ends at 8:00 a.m. the following morning. On a holiday, the resident on call is responsible for hospital rounds. During call rotations, residents must be available by pager or phone. They must be able to respond in a timely fashion.

### UMC On Call Room for Ophthalmology

Ophthalmology residents have an assigned call room for rest and sleep for use when it is impractical or inadvisable to leave the hospital. The room is H650 on 6 East.

## PGY-1 Internship Year

Each PGY-1 Ophthalmology resident during their internship year will report to the Administrative Assistant in Ophthalmology if there is any change in their schedule from the original rotation. On the calendars that are sent out to other departments, PGY-1's are listed as Ophthalmology residents even though they are doing rotations through Medicine or other departments. Because of this, Ophthalmology is the first department called when someone is trying to locate a PGY-1 resident. The administrative office needs to know every resident's exact rotation each month while in Medicine to complete the Medicare Audit report for Graduate Medical Education each year.

When away at the Basic Clinical Science Courses, stay in close contact with the administrative office as to your whereabouts during the course. Be sure the administrative office has a "day" and "evening" phone number, as well as both your permanent and temporary residence addresses.

Anytime a PGY-1 resident is on vacation, he/she is to let the Ophthalmology Administrative Assistant know in advance that he or she will be on vacation. A leave slip has to be filled out and given to the administrative office prior to **any** time you plan an absence from work.

## Travel Requests for meetings

Any time you are doing any travel on UMC business even if totally at your own expense be sure a travel request is submitted at least 15 days prior to travel. This has a number of functions not the least of which is to legitimatize your presence away from the University. International travel requests must be submitted 60 days in advance.

The department will only pay up to $2,000 for any travel to meetings. Anything over this will be paid by the resident.

The department of ophthalmology may support the attendance of each resident for one national meeting per year after the successful completion of the PGY-2 year. PGY-3 residents will attend the Armed Forces Institute of Pathology meeting in Washington, D.C. PGY-4 residents may attend the AAO annual meeting. Travel and lodging up to a specified amount will be reimbursed by the department. Attendance at other **national** meetings will require academic justification, such as delivering a scientific presentation. All requests to attend additional meetings must be made to the Program Director. A committee of the faculty convened for the purpose will study the travel proposal and make their recommendations to the Program Director and Chairman on a case by case basis. Duplicate submissions to different meetings of the same material for presentation will not be entertained for the purposes of travel. Housestaff attendance at international meetings will not be supported by the department. Residents planning to attend international meetings must request the time as personal leave (vacation) and bear the expense of travel and attendance from their personal funds.

## CONFERENCES

Conference attendance is mandatory. The only exceptions are seeing a patient in the ER, being away at satellite clinic or being in surgery. Residents are expected to leave clinic to attend noon and afternoon conferences and each staff member is aware of this. Roll call is taken at every conference by the Chief Resident and turned in to the administrative office. Each resident must sign or initial their name on the attendance sheet at every conference. A brief "excuse" must be noted by your name if you missed a conference.

A monthly calendar is furnished the last week of each month for the coming month. Conferences are scheduled for the most part in a routine manner to allow you to plan other activities. However, there are occasions when holidays, speakers or other activities may cause variation in the schedule. You will be contacted by a text page or memo in your mailbox (B314) or by the Chief Resident of any schedule changes once the calendar has been sent out for the month.

Resident Day Conference will be held in June each year. Each resident is required to make one paper presentation (see Program Goals and Objectives Manual). All clinics will be closed on this day so that the Faculty can be present for these presentations.

## PAGERS AND BATTERIES

The department of ophthalmology supplies the residents' pagers. Batteries are available in the administrative office and also from Central Supply 24 hours a day. All pagers are with Teletouch. Their phone number is 933-4631. If there are any problems with the pagers, call Teletouch to arrange for a replacement.

## MAILBOXES

Residents have a mailbox located at the UMC Post Office. You need to check this box regularly and pick up your mail.

Residents also have a mailbox in room B314 of the Ophthalmology department. You need to check this box **daily** for important memos and respond to them within the time frame given.
Also, do not let these boxes fill up. They do not hold very much mail, so throw away what you have taken care of or do not need.

## MEDICAL RECORDS

The Chief Resident is responsible for signing incomplete records (e.g.. verbal orders) on a weekly basis. This does not include delinquent dictations or notes which should be completed by the appropriate resident. Operative reports and discharge summaries are now electronically signed. Operative reports and discharge summaries must be dictated the same day or they will automatically be delinquent. H&P's must be completed within 24 hours of admission. All discharges require a final progress note. The Chief Resident will notify each resident of any medical record deficiencies and these should be taken care of immediately.

PGY-1's and new PGY-2's are still responsible for completing their records from other services.

## OPERATIVE REPORTS

You will each be responsible for keeping accurate and complete operative procedure lists throughout your residency. This requirement affects both your eligibility for certification and the accreditation of this ophthalmology program. The operative log needs to be updated regularly and will be formally reviewed by the faculty at staff meeting every other month. This should includes all surgical procedures in which you are involved including those done in clinic and office operating areas. This is mandatory for completion of this program. All residents are required to post their surgery cases on the ACGME web site quarterly.

## RESIDENT AND PROGRAM EVALUATION

Residents are evaluated during their rotations and at the end of each rotation by the attending in charge of the rotation. The attending must discuss the evaluations with the residents.
Some evaluations are completed thru E-Value (i.e., global evals, 360) and others are done on paper (i.e, OCEX, OCAT surgery evals).

Annual evaluations of the Ophthalmology program and faculty are to be submitted on E-Value in April of each year by **every** resident. This information is a helpful planning tool and is required by the Accreditation Committee.

RESIDENT DUTY HOURS

The duty hours policy [this refers to the verbatim ACGME statement on duty hours included in the resident handbook] conforms to the current requirements set forth by the ACGME. Please read carefully the UMMC Institutional Duty Hours Policy, which may be obtained from the GME office or from the program coordinator. The Department of Ophthalmology has developed this supplement to provide guidance on the department's implementation of the ACGME and UMC policies. Residents will be notified as modifications to the departmental policy are made to meet anticipated future changes.
In order to meet these new requirements each resident must understand the definitions and intent of the policy, self-monitor the duty hours served, and report any anticipated approaches to the duty hours limit. The department will review the monthly call schedule and resident self reporting of hours worked for policy compliance, but all call day swaps, changes in diabetic screening coverage, or unusual periods of onsite (in hospital) time on call must be reported as soon as possible to the administrative chief resident and program coordinator.

Weekend call periods offer the greatest potential to exceed the continuous on site duty period allowed by the ACGME (paragraph 3.b). As currently organized by the department of ophthalmology, normal weekend call periods consist of 80 hours when the two resident call teams may be performing duty (based on 8 am Friday normal workday until 5pm on Monday) on call from home. By departmental policy, during the calendar period from July through December of each year, consultations must be seen by the first and second call residents together. It is during this period that call teams members are most likely for both resident members to approach their duty limits simultaneously. Residents should carefully document their call records, monitor their continuous duty amounts, and notify the attending physician on weekend call if the limit is met. The attending is responsible for assuring service coverage during mandated periods of rest (10 hours) if this occurs. However, splitting the weekend call duties between two residents teams makes this possibility an extremely remote one.

The UMC department of ophthalmology intends to uphold the spirit of the ACGME policy, which is intended to protect the patient and resident alike from the effects of excessive fatigue and wakefulness on physicians. The department recognizes that residents have private lives that make demands on time and add stress to that already present in the daily work environment. Lack of sleep, disturbed sleep, and physical and emotional fatigue may be features of outside responsibilities that are additive to those imposed by the demands of residency training. The department cannot monitor these external situations. Therefore, it is incumbent on each resident to take the responsibility to notify the program director and appropriate faculty of situations that "preclude rest and reasonable personal time" or " excessive fatigue" cited in the ACGME policy.

All residents are to post their duty hours worked each month on the E-Value system. You must keep a copy of this in your competency portfolio also. If you work over 80 hours in one week, you must provide an explanation and discuss with the program director.

All residents are to have an average 1 in 7 days free from duties (4 days in 28 day period). If the service you are rotating on is not abiding by this policy, the resident must notify the attending physician and program director immediately to work out a schedule.

One of the provisions regarding the ACGME Duty Hours is that 10 hours must be provided between daily duty periods. To ensure our training program is not in violation of this rule we are implementing the following policy:

1. During regular work days, a resident is to leave the hospital/clinics by 9:00 p.m. on days when he/she will be required to return at 7:00 a.m. on the next morning, at 10:00 p.m. when he/she will be required to return at 8:00 a.m. the next morning, etc; so that he/she has a 10-hour duty free period
2. It is the resident's responsibility to abide by this rule and to inform his/her staff and the appropriate on-call person when his/her necessary hour of departure is approaching
3. Any remaining surgical responsibilities are to be signed out to the 2nd call resident. Other work is to be signed out to the first call resident.

The Program Director monitors the duty hours regularly. They must be entered into E-Value in a timely fashion by each resident.

## MEDICAL LICENSES

Medical license expires each year in June. Be sure to renew and pay fees before June 30 of each year.

## STEP III

It is a department policy that our ophthalmology residents must take and pass Step III before becoming a PGY-III resident in our department. You will not be promoted to a PGY-III resident until you have taken Step III. The department does not cover any expenses to take this test.

## LAB COATS

Each new PGY-1 resident will be given three lab coats at orientation. The Department of Ophthalmology will pay to have these coats monogrammed which is arranged through the administrative office. The department also will pay to have the coats laundered. Soiled coats should be left in the clothes hamper in room B314.

## ACLS COURSE (ADVANCED CARDIAC LIFE SUPPORT COURSE)

All residents must maintain a current certificate in ACLS during their full 4 years of training. A copy of the certification is to be filed with the administrative office. Courses are offered throughout the year at both UMC and VA for those residents whose certification has expired. Details are available from the administrative office.

## MOONLIGHTING

Residents are not required to engage in moonlighting. The University of Mississippi Medical Center discourages moonlighting or professional activity by residents or fellows apart from full-time UMMC sponsored or ACGME-sanctioned postgraduate educational programs because these activities tend to interfere with the educational process and health of the physician-in-training. The program director must acknowledge in writing that a resident or fellow is moonlighting and the information made a part of the resident's folder. Any resident with approval to moonlight must fill out "Outside Employment Form" and have approved with the program director/chairman. The effects of moonlighting on performance in the residency program will be monitored and adverse effects may lead to withdrawal of permission to engage in moonlighting activities.

The University of Mississippi Medical Center professional liability program for residents only applies to those professional activities within the course and scope of their employment while at UMMC and/or on

official rotation at other hospitals or clinics. It does not apply to outside professional activities such as moonlighting.

The UMMC institutional DEA number must not be used while moonlighting.

## VA DIABETIC SCREENING CLINIC

A Saturday morning clinic provides screening eye exams for the detection of diabetic retinopathy for veterans with diabetes. Participation in the clinic is voluntary and the residents are paid as individual subcontractors for the number of patients examined. Prerequisites are USMLE step 3 passage, credentialing and privileging at the VA for this purpose, completion of the retina rotation, and/or instruction by the retina service on retinopathy recognition and risk stratification.

## CHECKOUT LIST FOR GRADUATING SENIORS LEAVING UMC

The following is a list of things to do and places to go in order to process out for the graduating seniors.

1. Must visit and be cleared from the following departments:
   a) Benefits Office
   b) Physical Facilities to turn in Medco keys
2. Go to the Benefit's Office (N146) for an exit interview and to discuss insurance, retirement and final pay. Need to see Mamie Henderson.
3. Turn in all keys to Ophthalmology department to the Ophthalmology administrative office. Medco keys to the front door of Addie McBryde must be turned in to Physical Facilities.
4. Clear out your mailbox at the Post Office and leave a forwarding address. Also, clear out your mailbox in room B314 and leave a forwarding address with the administrative office.
5. Go to the VA and report to Sandra Finney in the Surgical Service Office located on the 2nd floor, Room B214 to pick up clearance form with directions to start the clearance process. Residents are required to return your name badge, parking decal and any VA keys issued to you. A copy of your clearance form should be returned to Surgical Service after you clear all areas. You may call 601-364-1354 if you have any questions.
6. Take your white coats with you when you leave.
7. Turn in updated operative report list on all surgeries performed during last rotation to the administrative office.
8. If you have anything which should be included in the annual report for the Department such as grants you received for the last year, publications which appeared in print, exhibits and/or presentations, any IRB communications/paperwork. Please give this information to the administrative office and Suzanne Hoadley before you leave on June 30.
9. <u>All</u> paperwork (copies) involving the IRB <u>must</u> be given to Suzanne Hoadley before you graduate on June 30 for all of your research projects.

10. Before leaving on June 30 please go to photography and have Liz or to make a picture to keep in the ophthalmology alumni archives. Check with photography to arrange for photo to be taken in the department or at the UMC Medical Media department. The picture needs to be in color and size 3 ½ x 5.
11. Turn in your pagers to the Ophthalmology Administrative Office

RESIDENT LEAVE POLICY

1. The ACGME training requirement is as follows: "the length of training in ophthalmology must be at least 36 calendar months, including appropriate short periods for vacation, special assignments, or exceptional individual circumstances approved by the program director".

2. UMC and the VA use different methods of calculating accrued and used leave, and each institution has a different set of holidays. The net result is a virtually equivalent number of days that qualify as personal leave or holiday. **Nevertheless, in order to achieve the aims of the academic program, the department of ophthalmology, limits the personal leave a resident may use to 15 weekdays per year.** Residents are reimbursed for unused accrued leave upon separation from either institution. Residents are encouraged to review the specifics in the employee handbook of each institution. Official holidays shared by both UMC and VA will NOT be charged against personal leave.

3. Residents are encouraged to take vacation in 5 weekday blocks. In general, only 5 days of leave should be taken during any given rotation except in extenuating situations as approved by the Program Director. This policy may be amended for exceptional circumstances with the permission of the Program Director.

4. Additional leave of any type beyond the 9 weeks granted during the 36 month training period (excluding the PGY-1 year) will require an extension of the residency training period. This additional period of training will be performed at the completion of the regular 36 calendar months and be repaid on a day for day basis.

5. Individual attending physicians **DO NOT** have the authority to grant leave requests. However, the attending physician who is the resident's immediate supervisor on a given rotation must be advised in advance of the intent to take leave during the rotation. Their signature or initial on the leave request will verify that they have been informed of the planned leave. The Program Director is available to mediate disagreements about leave when attending faculty raise objections.

6. The Program Director is the authorizing agent for all leave requests, and leave documents are invalid without his/her signature. All leave request documents must be delivered to the administrative office before the leave is actually taken. In addition, residents who are paid by the VA must have a VA leave request signed by the VA attending supervisor or the VA Chief of Surgery on file with the VA Surgery office before taking leave. The UMC program coordinator and Chief Resident must verify that the leave reservation is valid and the individual resident's leave allowance has not been exceeded before any signature will be given.

7. No routine use of personal leave will be permitted during the last or first two weeks of the academic year (June and July) to allow the orderly entrance of new residents and the graduation of seniors.

8. Leave to conduct interviews for employment, or practice is personal leave. The department will not grant a leave deficit, nor administrative leave to accommodate these activities.
The following information is the revised policy regarding resident vacations. Please read and follow instructions listed below. The new policy was effective July 1, 2005.

Resident Vacation Schedule for Academic Year and beyond

-Residents (PGY-2 through PGY-4 beginning July of each year) submit vacation preference dates for the entire academic year in writing to Dr. Crowder by second Monday of May.
-Dr. Crowder will assign tentative dates (preference given by seniority) and then submit these vacation dates (including the resident rotation schedule) to the entire staff at staff meeting in June.
-The entire staff will approve/disapprove of the resident vacation schedule at the June staff meeting.
-Permanent vacation dates will be given to the residents by June 15 of each year.

Guidelines
-15 days of personal leave/vacation total per academic year
-May only take 1 week total per 4 month rotation
-Only 1 resident on vacation at any one time
-No vacation given when other residents are scheduled to be away at academic conferences, including but not limited to; Academy meeting, AFIP, ARVO, San Antonio course, Houston Basic Science course
-No vacation first 2 weeks of July or last 2 weeks of June
-Neuro-ophthalmology intern is not subject to the above criteria, but must have approval from Dr. Corbett and Dr. Crowder before planning leave.

-If proper leave request forms are not signed and turned in to proper administrative personnel prior to leave being taken, then 1 personal day will be docked from allowed leave time.

Exceptions
-3 days given for paternity leave at the time of the birth of a child (see resident manual)
-Maternity leave – see resident manual
-Days will be given for death/illness of a family member (# at the discretion of Chair and Program Director) as well as the staff member with whom the resident is currently rotating)
-Administrative/training time – see resident manual
-Residents will be allowed to re-arrange dates for interviews with approval from Chairman and Program Director as well as the staff member with whom the resident is rotating.

Changes
Any requests for changes to the vacation schedule after it has been published in June must be made in writing and submitted to Program Director at least 60 days prior to proposed change. The proposed change will be reviewed at the following staff meeting. There is no guarantee that proposed changes will be granted.

Maternity Leave

1. It is the Department of Ophthalmology's policy that a resident's total leave and vacation may not exceed four (4) weeks in any one academic year. Maternity leave is a family and medical leave qualifying condition under the Family and Medical Leave Act of 1993. Any employee who has been employed for at least one year, working a minimum of 1250 hours during that year is eligible to take up to twelve (12) calendar weeks away from work for the birth or adoption of a child. This eligibility includes fathers as well as mothers. If both father and mother are employees of the Medical Center, the eligible weeks are a combined 12 rather than 12 weeks each.

   While it may be necessary to limit a resident's total leave and vacation because of the nature of the residency program, according to federal regulations an employee can not be denied time off for certain family and medical circumstances for up to a period of 12 weeks per calendar year. An additional requirement lengthening the residency program may be required as a result of a resident's absence for a qualifying family and medical event, but the request may not be denied to an eligible employee.

   Full-time permanent female employees who have been employed less than one year are eligible for temporary disability leave for the birth of a child. There is also a leave option available when family and medical leave or temporary disability leave are not feasible, such as in the case of a full-time permanent male employee who has been employed by the Medical Center for less than one year. The State leave policy provides than an employee may use major medical leave for the illness or

injury of the employee or member of the employee's immediate family. When an employee is absent for more than four days and less than two weeks, only a medical certification is required by the employee's department.

2. Pregnancy must be announced to the faculty and Director of Residency Training in a timely fashion.

3. The Department of Ophthalmology reserves the right to change the resident's rotation schedule based on the needs of the department.

4. Please refer to the UMC Employee Handbook regarding Temporary Disability Leave and Family and Medical Leave.

a) Employees are required to substitute accrued paid leave for the entire leave if sufficient leave is accrued.

b) The first 8 hours must be personal leave, then major medical leave must be used, followed by personal leave.

c) Holiday pay is not available during family and medical leave.

d) Leave taken in addition to the total 3 months allowed during the 36 months of training will require an extension of the training period by an equal amount.

5. A signed release from the attending physician is required upon return to work.

Paternity

1. Three days of paternity leave may be granted. The first 8 hours will be charged as personal leave and the remaining time charged to major medical leave.

2. Please refer to paragraph 4 under maternity leave.

Administrative

Limited administrative leave is granted at the discretion of the Director of Residency Training. Reasons for administrative leave include those recognized under the Administrative Leave section of this manual and those which arise as a direct result of the nature and needs of the residency program.
Training leave time will be granted per year per resident for meetings such as the AFIP and AAO. Any additional meetings will be at the Chairman's discretion.

We attempt to sponsor the PGY-4's to go to the Academy and PGY-3's to attend AFIP each year. Sponsorship is limited to the per diem of up to $2,000 as approved by Dr. Chen.. AAO - $2,000.00 plus the laser course if you are taking that. ARVO is $1,500.00 for expenses. Any residents who is first

author on an  abstract accepted by the American Academy of Ophthalmology or ARVO will be sponsored to attend these meetings.  Residents attending ARVO to present paper/poster will be given a maximum of 3 days off to attend meeting, 2 days to travel and 1 day to present paper.  Residents must stick to the list from the Academy concerning hotels and room rates.    It is recommended by the faculty that all residents apply for membership to the Academy.

Any other administrative leave regardless of the PGY year shall be granted provided there is coverage on the call schedule and the various rotations and that the resident has submitted a Travel Request form which has been approved by UMC.

Fellowship Interviews

A. Each resident who has applied for a fellowship and received interview invitation(s) will be granted 3-5 days of administrative leave to attend said interviews at discretion of the Chairman and Program Director.  These days may ONLY be used for attendance of fellowship interviews and proof of attendance must be presented upon request by the department.  Any additional days needed to complete interviews will be charged as personal leave and count toward the total 15 days of personal leave given to each resident each year.  It is the resident's responsibility to make sure all call, clinical duties, etc. are covered before he/she leaves.

B. Any senior resident who has been accepted at a fellowship program to begin July 1st immediately following completion of his/her residency, will be given the opportunity to reserve 3 of the 15 days of his/her personal leave to be used the last 3 week days of June.  This is in order to accommodate the resident to have time to move and attend whatever functions the fellowship program deems necessary prior to the July 1st start date.  These 3 days must be requested in writing and submitted  to the Chairman and/or program director at least 60 days prior to the leave to be approved in staff meeting (as per the resident leave policy 2005 for changes to leave time).

C. If the senior resident who has been accepted to a fellowship program chooses not to reserve 3 of his/her personal days to be used the last 3 days of June, he/she will be expected to be present in the department to complete his/her duties through June 30th at 4 p.m.

D. With the exception of #2 above only, the resident's manual will continue to read NO personal leave is to be taken the last 2 weeks of June.

E. Any senior resident who is absent any day during the last 2 weeks of June, with the exception of pre-approved leave as stated in #B will be charged with an unexcused absence and will be required to appear in person (at his/her own expense) before the department staff to explain his/her leave prior to the chairman's release of the letter of recommendation for the resident to sit for the Ophthalmology Board exams.

F. All medical records must be completed prior to completion of the program. Failure to complete all medical records will result in delay of the Chairman's release of his recommendation for the resident to sit for the board exams

LASER USE

**LASER SAFETY IS EVERYONE'S CONCERN.** All physicians operating lasers, including residents, must be familiar with hospital policies and insist on compliance by all personnel in attendance. These policies are clearly enunciated in the *UMMC Laser Safety Manual***,** available from the Department Secretary or the UMMC laser safety web site (www.umc.edu).

Residents are considered employees who are still in training and cannot meet the requisite training requirements for formal approval or credentials to use laser devices unsupervised at UMMC. Therefore, each resident who may use a laser must agree to:

1. Work under the supervision of an attending physician with laser privileges approved by the Credentials Committee

2. Ensure that they are fully compliant with the departmental criteria for laser use as established by the Departmental Chairperson and their immediate supervisor. (These are listed below).

3. Maintain a use log, which documents the number and type of procedures performed, type of laser and wavelength used and the supervising Clinician. Each resident should consult with their supervising clinician regarding accuracy of the information. Note that it will be necessary for the supervising clinician to verify completed training of each resident.

4. Document receipt of the UMMC Laser Safety Manual

5. Provide the Chairman and the Laser Safety Officer with all appropriate documentation upon request for laser privileges at the end of the residency program/training (see **Attachment G - Application for authorization to use laser systems** in the *UMMC Laser Safety Manual*).

Before using any laser or being present at any laser procedure, the resident must attend a laser safety course, which will be given in the Department of Ophthalmology at the beginning of each academic year at a time that will be announced to all residents. If the resident cannot attend this course, then he/she must attest to having reviewed the following laser safety training resources: a copy of the *UMMC Laser Safety Manual* (available from the UMMC Laser Safety Officer or on the website at UMMC Laser Safety Web Site, *www.umc.edu* ) and *Laser Safety Comes To Light*, a 45-minute videotape produced by the Coherent Laser Company. This tape is on reserve at the reference desk of the library.

After attending the course, the resident must obtain an appropriate **UMMC Statement of Laser Use** (**Attachment F in the** *UMMC Laser Safety Manual* ) from the Department Secretary or the UMMC laser safety web site (*www.umc.edu*). Complete and sign the appropriate forms and obtain the signature of the department chairman on **Attachment F** and submit back to the Department Secretary.

In addition, all users of lasers must complete a Medical Survey (**Attachment E – Medical Survey for Potential Eye and Skin Laser Exposure** in the *UMMC Laser Safety Manual* ) to gather base line information. This form will be kept on file in the Laser Safety Office. This form should also be used to report an incident involving laser injury.

Residents must be aware of emergency response procedures for injuries caused by laser radiation:

a. Response During Normal Working Hours On Campus:

1) Contact UMMC Employee and Student Health Services at (601) 984-1185.

b. Response After Normal Working Hours on Campus:

1) If an incident occurs after normal work hours, call University Police at (601) 984-1360.

In addition, report all incidents involving injury (**Attachment E – Medical Survey for Potential Eye and Skin Laser Exposure** in the *UMMC Laser Safety Manual*) or a safety violation to the Laser Safety Office at 984-1078 or to Risk Management at 984-1980 as soon as reasonably possible.

## CURRENT UMC OPHTHALMIC FORMULARY

| | |
|---|---|
| HYDROCORTISONE TOPICAL | 25 mg |
| HYDROCORTISONE TOPICAL | 25 mg |
| ATROPINE | 0.05 mg/ml |
| ATROPINE | 0.1 mg/ml |
| ATROPINE | 0.4 mg/ml |
| ATROPINE OPHTHALMIC | 1% |
| ATROPINE OPHTHALMIC | 1% |
| ATROPINE OPHTHALMIC | 1% |
| ATROPINE OPHTHALMIC | 1% |
| OPHTHALMIC IRRIGATION, INTRAOCULAR | Balanced Salt Solution |
| OPHTHALMIC IRRIGATION, INTRAOCULAR | Balanced Salt Solution |
| BETAXOLOL OPHTHALMIC | 0.50% |
| BETAXOLOL OPHTHALMIC | 0.50% |
| BETAXOLOL OPHTHALMIC | 0.25% |
| BETAXOLOL OPHTHALMIC | 0.25% |

| | |
|---|---|
| BOTULINUM TOXIN TYPE A | 100 u |
| BOTULINUM TOXIN TYPE A | 100 u |
| OPHTHALMIC IRRIGATION, INTRAOCULAR | Balanced Salt Solution Plus |
| OPHTHALMIC IRRIGATION, INTRAOCULAR | Balanced Salt Solution Plus |
| TRIETHANOLAMINE POLYPEPTIDE OLEATE OTIC | 10% |
| TRIETHANOLAMINE POLYPEPTIDE OLEATE OTIC | 10% |
| CYCLOPENTOLATE OPHTHALMIC | 0.50% |
| CYCLOPENTOLATE OPHTHALMIC | 1% |
| CYCLOPENTOLATE OPHTHALMIC | 2% |
| CYCLOPENTOLATE-PHENYLEPHRINE OPHTHALMIC | 0.2%-1% |
| CARBAMIDE PEROXIDE OTIC | 6.50% |
| DEXAMETHASONE OPHTHALMIC | 0.10% |
| EPINEPHRINE OPHTHALMIC | 1% |
| EPINEPHRINE OPHTHALMIC | 1% |
| FLURBIPROFEN OPHTHALMIC | 0.03% |
| FLURBIPROFEN OPHTHALMIC | 0.03% |
| GENTAMICIN OPHTHALMIC | 0.30% |
| GENTAMICIN OPHTHALMIC | 0.30% |
| HYDROCORTISONE TOPICAL | 1% |
| HYDROCORTISONE TOPICAL | 1% |
| HYDROCORTISONE TOPICAL | 0.50% |
| HYDROCORTISONE TOPICAL | 0.50% |
| HYDROCORTISONE TOPICAL | 1% |
| HYDROCORTISONE TOPICAL | 1% |
| HYDROCORTISONE TOPICAL | 2.50% |
| HYDROCORTISONE TOPICAL | 2.50% |
| APRACLONIDINE OPHTHALMIC | 0.50% |
| APRACLONIDINE OPHTHALMIC | 1% |
| Dextrose 5% in Lactated Ringers Injection | SOLUTION |
| Dextrose 10% with 0.9% NaCl | SOLUTION |
| Dextrose 5% with 0.2% NaCl | SOLUTION |
| Dextrose 5% with 0.45% NaCl | SOLUTION |
| Dextrose 5% with 0.9% NaCl | SOLUTION |
| Dextrose 5% in Water | SOLUTION |
| Lactated Ringers Injection | SOLUTION |
| Electrolyte Solution (Plasma-Lyte) | SOLUTION |
| Sodium Chloride 0.45% | SOLUTION |
| Sodium Chloride 0.9% | SOLUTION |
| Sodium Chloride 3% | SOLUTION |
| CROMOLYN NASAL | 5.2 mg/inh |
| OLOPATADINE OPHTHALMIC | 0.10% |
| CYCLOPENTOLATE OPHTHALMIC | 1% |
| PHENYLEPHRINE OPHTHALMIC | 10% |
| PHENYLEPHRINE OPHTHALMIC | 10% |
| PHENYLEPHRINE OPHTHALMIC | 2.50% |

| | |
|---|---|
| PHENYLEPHRINE OPHTHALMIC | 2.50% |
| SODIUM HYALURONATE OPHTHALMIC | 10 mg/ml |
| SALIVA SUBSTITUTES | - |
| SALIVA SUBSTITUTES | - |
| SCOPOLAMINE | 0.4 mg/ml |
| SCOPOLAMINE | 0.4 mg/ml |
| TOBRAMYCIN OPHTHALMIC | 0.30% |
| TOBRAMYCIN OPHTHALMIC | 0.30% |
| SCOPOLAMINE | 1.5 mg |
| SCOPOLAMINE | 1.5 mg |
| TROPICAMIDE OPHTHALMIC | 0.50% |
| TROPICAMIDE OPHTHALMIC | 1% |
| DICLOFENAC OPHTHALMIC | 0.10% |
| DICLOFENAC OPHTHALMIC | 0.10% |
| LATANOPROST OPHTHALMIC | 0.005% (50mcg/mL) |
| ZINC SULFATE | 1 mg/ml |
| ZINC SULFATE | 1 mg/ml |
| ZINC SULFATE | 220 mg |
| ZINC SULFATE | 220 mg |

## Resident Requirements for Promotion , Procedure for Academic Review and Policy on Termination Department of Ophthalmology

### Promotion of House Officers – Ophthalmology

I. Responsibilities/Requirements

A. The decision to re-appoint and promote a house officer to the next level of post-

graduate training shall be done annually by the Program Director upon review of the house officer's performance. Global resident evaluations are set up after completing a four month rotation. Clinical and surgical evaluations are performed at least every other month.

B. The Program Director shall consider the following factors in the decision to promote:

1. All evaluations of the house officer's performances

2. Performance on in-service examinations

3. Other criteria listed in Procedures for Academic Review.

C. The Program Director will decide by July 1 of each year whether to promote a resident to the next level. If the Program Director fails to promote a house officer by July 1, the Program Director will notify the house officer in writing of the reason for withholding the promotion.

D. Any house officer pending promotion due to academic performance will be placed on either Departmental Remediation or Institutional Probation.

E. In the event that a house officer is on departmental Remediation or Institutional Probation at the time of contract renewal, the Program Director may choose to extend the existing contract for the length of time necessary to complete the remediation process, not to exceed six months, or to promote the house officer to the next level. If the house officer's performance continues to be unsatisfactory, he/she may either be placed on the next level of discipline or terminated.

F. A house officer may request a Fair Hearing by submitting his complaint to the UMC Grievance Committee.

## Residency Requirements and Procedure for Academic Review

Housestaff are trainees and students of the Graduate Medical Education program and required to demonstrate proficiency in the areas listed below. Academic remediation or dismissal can be based on deficiencies in one or more of the following areas:

1. Incremental increases in clinical competence (including identifying and performing invasive and non-invasive medical procedures; gathering critical information and data, whether in the form of H & P's or diagnostic testing; interpreting results; and knowledge of preferred practice guidelines);

2. Fund of knowledge and willingness to teach and supervise others;

3. Clinical judgment (including synthesizing data gathered from appropriate sources and applying the information and medical knowledge to a particular patient care situation, and the ability to respond to unpredictable treatment situations);

4. Necessary skills (those technical skills necessary to perform diagnostic, medical and surgical procedures and to deliver other forms of medical treatment);

5. Humanistic skills (interacting with patients, peer residents, faculty, and medical staff; receptivity to feedback and corrective action from faculty and peers; and demonstrating concern for patients' well-being);

6. Attendance, punctuality, enthusiasm and availability; and

7. Adherence to institutional standards of conduct, rules and regulations, including program standards, and hospital and clinic rules

8. Satisfactory performance of all applicable ACGME competency areas as evaluated by the department of ophthalmology.

Reappointment and promotion to the subsequent year of training require satisfactory, cumulative evaluations by program faculty.

ACADEMIC DEFICIENCY AND REMEDIATION PERIODS (ADRM)

A remediation period is an opportunity for the resident to correct academic deficiencies and to develop and demonstrate appropriate levels of proficiency for patient care and advancement in the program. Being placed in remediation is notice to the resident of his or her failure to progress satisfactorily as reflected by evaluations and/or other assessment modalities. It is not discipline.

Forms of remediation may include: (1) repeating one or more rotations; (2) participation in a special program determined by the department chairman; (3) continuing scheduled rotations with or without special conditions; (4) supplemental reading assignments; (5) attending undergraduate or graduate courses and/or additional clinics or rounds; and (6) extending the period of training. The remediation measure(s) assigned and the period of time that such measures remain in place shall be determined by the program director or his or her designee. The form(s) of remediation assigned are left to the discretion of the department and is/are not subject to the academic review provisions of part II.

If the department chair determines a resident's deficiency to be of sufficient gravity to warrant immediate dismissal, the resident may be dismissed without first being offered an opportunity for remediation; provided, however, that the chair must consult with the Office of Graduate Medical Education prior to instituting a dismissal that is not preceded by a period of remediation. In that instance, the resident may obtain review under the UMC Evaluation Policy and Grievance Algorithm. During or following a period of remediation, any resident who fails to correct a deficiency may be dismissed.

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III. DISCIPLINARY ACTION (OTHER THAN ACADEMIC)

Residents in the University of Mississippi Graduate Medical Education Program are subject to the University's Personnel Policies and Procedures and University work rules. Copies of all applicable policies, procedures and work rules are available from your Department Chair and the University's Personnel Services Office.

I. Termination/Dismissal of Employment – Ophthalmology

I. Responsibilities/Requirements

A. Termination of a house officer's employment prior to the established expiration date of the contract may be accomplished only for good reason.

B. VOLUNTARY TERMINATION/RESIGNATION

1. If the house officer desires a termination of employment, a letter of resignation should be submitted to the Program Director stating the reason for the action.

2. An interview may be requested by the Program Director.

3. Termination my be granted with the concurrence of the Program Director/Department Chairman and the Associate Dean of Graduate Medical Education.

C. INVOLUNTARY TERMINATION

1. According to Institutional Policy, the Hospital may elect to terminate a house a house officer’s employment prior to the established contract expiration date due to:

   a) Academic or Professional (Gross) Misconduct

   b) Endangerment of the health or safety of others, including patients, employees, or other persons

   c) Unsatisfactory performance

   d) Abandonment of position/employment

   e) any disciplinary action as detailed in the UMC Employee Handbook

2. The Program Director shall notify the house officer in writing of the decision to terminate employment with a copy of the notification to the Associate Dean of Graduate Medical Education.

3. Upon notice of termination, the house officer has the right to follow the grievance procedure as outlined by the UMC GME Evaluation and Grievance Policy.