

The Ophthalmology Resident's Survival Guide - Department Orientation

This section will provide you with some of the guidelines, which create a smooth working residency. Some of the information contained herein may seem obvious, but is spelled out to assure that everyone has the same understanding. Much of this section was created and further elaborated by the residents who preceded you.

Access in the Department

You need your ID to gain access into the department after hours or on weekends. If you forget your ID, you will need to call Security to unlock the clinic for you.

Gipner Library

Located in the Eye Department for ready reference for all residents, faculty and staff.

Materials on the open shelves are not to be removed from the department and new acquisitions are in the glass cabinets and can be signed out.

Photocopying

There is a small copier in the clinic area and a larger capacity copier in the digital room. If you need to have something copied at the Copy Center, you can sign out for the copy card from the Program Coordinator.

Equipment

There is limited equipment. Please keep the equipment and rooms in order. CLEAN UP AFTER YOURSELF. If equipment is malfunctioning or breaks, please inform a technician who is responsible for seeing that it is repaired or replaced.

Clinic

- Scheduled clinic hours are 8:00 a.m. to 5:00 p.m., Monday through Friday. There is usually one late day per week when SMH residents must remain until the patients are done, usually no later than 6:00 p.m.
- See the patients as scheduled,
- Practice as a group. **HELP EACH OTHER.** See the next patient located in the outpatient box unless you know a patient is there for follow-up by a specific resident. If a patient is waiting or taken out of turn, as a courtesy, let other patients know why.
- See patients from the ED as needed during clinic as time permits. Be sure to send patients back to ED when finished for discharge.

Problem patients

- Should be presented to the clinic preceptor or to an upper level resident or to any available attending if needed (waiting for an attending is the norm).

Problem in the clinic

- Inform the senior resident or the clinic nurse manager who is responsible for clinic operations and problem solving.

Routine Tests

- Requisitions for visual fields, blood, x-rays, ICG's and fluorescein angiograms need to be properly completed in order for the test to be done.
- Fluorescein angiograms and ICG's need to be cleared with the senior resident or an attending familiar with their use such as Dr. Grover.

Rounds

- A second year resident assigned to SMH is responsible for performing consult under the direction of the consult attending. The consult attending physicians are assigned on a rotational basis. Currently Dr. Brigatti oversees the consult service generally.
- First year residents should try to round on inpatients when possible to help the other residents and to learn.
- Rounds should be performed in the a.m. before the start of clinic as done on other services in order to create a daily plan for patient care.
- Sign-off or discharge patients as indicated.
- Sign out patients or problems to the resident on call.
- The weekend on-call resident rounds on all necessary inpatients.

Preoperative Work-Ups

- All adult work-ups are now performed by a nurse practitioner,
- Patients who miss their pre-op appointment are worked up by the first year resident,
- Pediatric cases are worked-up by the first year resident.

Preoperative Admissions & Work-Ups

Orders

- Admit – Attending
- Diagnosis
- Condition

- Vitals
- Activity
- Allergies
- Eye tray at bedside with a small bottle of Normal Saline
- Diet
- Medicines (medical)
- Medicines (preop)
- Void OCTOR
- IV morning of surgery for diabetics
- Diabetics - Order ½ of usual NPH Insulin requirement for day of surgery, no regular insulin, begin IV D5LR on a.m. of surgery.
- Orders - Per individual attending,
- All patients greater than 50 years of age need EKG, CSR, CBC,
- All patients on diuretics need K+ and electrolytes.
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Medications

- Dilating medications (per surgeon preference),
- Current list kept by nurse practitioner.

Paperwork

- Front sheet filled out on admission,
- Consent form filled out during work-up – forms preprinted for specific surgeries are in the Eye Clinic,
- Surgical discharge summary with chief complaint and HPI.

History and Physical

- Do not need a 8-page work-up,
- Surgical pre-op evaluation - fit for surgery,
- Any medical problems which might delay surgery or post-op recovery require obtaining proper consults,
- No PAP, pelvic, breast, or rectal needed, but document reason not performed on chart.

Emergency Surgery

- Call operating room to book (at Strong surgeries are termed a “white sheet” if needed in 24 hours, “blue sheet” within 3 hours),
- Call admitting to inform them so a bed can be made available,
- If necessary perform H & P, obtain consent, and any necessary labs.

Children

- SMH Floor 4-1600,
- Worked up by PEDS house staff if less than 2 years of age,

- Consent and eye orders provided by Ophthalmology.

Ophthalmology Call

How to Handle Call

- Identify yourself,
- Before the history is obtained, ask if the patient has their own ophthalmologist; if so, ED should notify their ophthalmologist first and determine if they would like to see the patient or have us see the patient for them. Typically we see the patient and then inform the attending physician of the patient's problem.
- Obtain a history and do an appropriate physical exam,
- Always include a visual acuity.
- **If you are asked to see the patient, GO.** You can never be faulted for seeing a patient.
- If warranted, eye drops can be ordered over the phone.

If a ruptured globe or hyphema is suspected

- Hard eye shield (no patch) with head elevated > 30 degrees,
- Obtain labs, start an IV and antibiotics over the phone if warranted,
- At hospital, see patients in the respective eye clinic.

Back up call

Every resident on first call has at least one, generally several, back-up call residents available by phone and/or by beeper to answer questions and to assist in the evaluation and care of patients and to take the patient to the operating room if needed.

If there is uncertainty or issues regarding the proper care of a patient, a more senior resident or even the on-call attending should be consulted to assure the best possible management.

Second call switches are made at 12:01 a.m. on the relevant day unless other arrangements are made and the first call person is notified. The person coming onto a rotation would be assuming post-op care for any cases that went to the OR between midnight and morning. For example, the chief resident coming onto the RGH rotation in November would start call at midnight, even though the regular day at RGH might not start until 8:00 a.m. **No first year resident may take second call.**

First call resident - regular weekdays

Call begins at 5:00 p.m. and goes until 8:00 a.m. the following morning. However, if there is a 7:00 a.m. conference the next morning and an emergency

arises between 7:00 and 8:00 a.m., the resident(s) scheduled for the day at the hospital in question should take care of it as a courtesy to the resident on call.

For example, if an emergency arises at 7:00 a.m. at RGH, it would be reasonable for the RGH resident to go to RGH and handle the problem. However, the resident on call *should not simply assume* that the RGH resident will handle all early morning emergencies at RGH. Keep in mind that frequently there is no RGH Eye Clinic in the morning as the resident is usually in the OR. Communication is the important key here to make the on-call schedule run smoothly.

Call officially begins at 5:00 p.m. However, if the on-call resident is still tied up with patient care responsibilities, and is called to a different hospital, it is reasonable to expect one of the residents at the hospital where the patient is located to handle the problem, particularly if it is an urgent problem. Since residents frequently perform courtesies for each other, residents are asked to leave their pagers on when still in the hospital, even though they are not on call.

Clinic numbers not put on the answering service at 5:00 p.m.

- SMH 275-3251
- RGH 922-3815

Since the front desk phone numbers are put on the answering service after hours, **do not page someone to these numbers as you will be unable to receive the call!**

Consults and emergencies during the day are handled at each hospital by the residents stationed at or responsible for that hospital. However, the on-call resident for that evening should wear his/her beeper during the day and triage the consults to the proper resident or eye clinic.

Resident assigned to first call covers

- Strong Memorial Hospital,
- Rochester General Hospital,
- Emergency patients sent to SMH Clinic and SMH ED,
- Monroe Community Hospital,

*NOTE – as of July 1, 2003, we no longer cover St. Mary's or Park Ridge Hospital.

Other hospital and facilities are not covered so do not give an opinion over the phone (i.e. Sodus Hospital had a habit of calling). Have the patient sent to SMH ED. We cannot accept a transfer directly. The patient must be transferred to Surgery or Medicine. Occasionally optometrists and ophthalmologists not associated with the program call. If so, the patient should also be sent to SMH ED. At RGH, please inquire if the patient is a Wilson Health Center patient. If this is the case, then Dr. Reed's office should be called as we do not cover their patients.

Chain of Command

If unable to see all patients while on call, the first call resident notifies the chief resident at the respective hospital during the week or the chief resident on call for that night or for the weekend if needed. One may also call colleagues of your year for assistance. If you encounter a difficult problem, or you are unsure of the diagnosis, etc. call the chief resident at the respective hospital for help.

You cannot be faulted for getting help.

Attendings are ultimately responsible. They need to be called about all difficult ED and inpatient problems.

Weekday call with teaching sessions or special conferences

If there are teaching afternoons (such as afternoon conferences or lectures) night call begins at 1:00 p.m. The resident on call handles true emergencies and urgent consults, but should not skip lectures for a consult that is not urgent (see "Consults" pg. 25) **√The same courtesies mentioned above regarding residents handling problems before they leave the hospital apply also to teaching days after 1:00 p.m. For example, if an emergency arises at RGH at 1:02 p.m. as the RGH resident is about to leave, the RGH resident as a courtesy to the on-call resident should handle the problem.

On weekdays with daylong conferences, the on-call resident will handle the emergencies and urgent consults for that day. Non-urgent consults at each hospital can be seen by the team at that hospital later the same day or the next day. Rounds on in-patients at each hospital are handled by each team before the teaching conference begins so as not to be tardy for the conference.

Attendings may cover for the residents for the out-of-town conferences, i.e. Syracuse, Buffalo, OKAPS. The senior resident will arrange this coverage and remind the attending of this responsibility. During the summer, the senior resident on call rounds Saturday and Sunday with the first year resident on call.

Weekend first call

NYS Resident Work Hour Limitation Rule: Residents are entitled to at least one 24 hr. period of nonworking time per 7 days (including no beeper call) – Weekend call must be arranged to honor this.

Weekend first call begins at 5:00 p.m. on Friday and lasts until 8:00 a.m. on Monday. Residents who do not like to take first call in such large stretches are free to trade call nights so as to reduce the length of continuous call (e.g. trade a Friday night for a weekday call night, so as to reduce call to 48 hours from Saturday 8:00 a.m.) Obviously, if this is done the residents involved need to have an understanding about who will handle Saturday morning follow-up for the

problems arising during the night Friday. **All changes for Call Schedules must be approved by the Program Director. If the request is approved, the resident requesting the change is responsible for notifying the page office and all appropriate parties (Program Coordinator will provide a fax list).** (See changes in your schedule pg. 9)**√

If first call on the weekend is too long, the back-up resident on call must see that appropriate relief is available with an 8-hour rest period.

Besides handling the emergent problems during the weekend, the first call resident has the following responsibilities on weekends:

Weekend follow-up to outpatient problems

The resident must see patients that need to be checked during the weekend. For example, corneal abrasions seen at RGH, or Strong on Friday are followed up by the *weekend on-call person* each day until the abrasion is healed, and likewise any other out-patient problem generated from any of the eye clinics is followed Saturday and/or Sunday as appropriate. Usually, the person on call will arrange to see these patients at the Strong Eye Clinic at 9:00 a.m. Saturday, but the exact time is set by the person on call.

The residents at other facilities (and at Strong) need to notify the weekend on-call resident about the name of the patient and the nature of the problem, and ask him or her what time the patient is to be seen. (likewise, follow ups generated from the Emergency Rooms during Friday and Saturday nights can be seen Saturday and Sunday mornings). If the patient to be seen is from the Strong Eye Clinic, the patient chart should be put in the box where the rounding board is kept so that the resident seeing the patient will have access to the chart.

If there are other outpatient issues that need to be checked over the weekend (e.g., culture results for an outpatient corneal ulcer), these also need to be signed out to the resident who will be on call.

Weekend rounding on SMH in-patients

The SMH team signs out to the resident who is on-call for the weekend to round on SMH in-patients. Usually as a courtesy to the on-call resident, as many loose ends as possible and which in-patients must be seen over the weekend are finished before the weekend, so that on-call rounding is minimized. Any special instructions are left on the rounding board.

Post-op rounding should not be routinely delegated to the on-call resident, but should be performed by the resident who was involved with the surgery; or that resident should make special arrangements for this rounding to be done.

Rounding on in-patients at other facilities is not a routine function of the on call resident; these patients should be followed over the weekend by the team that is

stationed at that facility during the week. If there are reasons why that team cannot follow them (e.g. vacation schedules or NYS work rules), then special arrangements can be made.

Weekend in-patient consults

New in-patients consults at SMH, and RGH are done by the resident on call, unless they are so clearly non-emergent that they can be postponed until after the weekend. If they remain to be done by the regular team at that hospital then obviously they have to be signed out to that team. All consults done over the weekends by beginning first years should be reviewed with the chief resident at that hospital by phone the day they are done or with the senior on call resident. All consults need to be presented to an attending for sign off.

Weekend follow-up arrangements

ED patients seen over the weekend, who need follow-up after the weekend and who have the type of insurance seen by our clinics, should be told to call the eye clinic at the hospital where they were seen on Monday morning after 9:00 am. Do not tell them to just appear at the clinics.

If you know that the clinic at that hospital will be closed Monday morning and they need follow-up, then refer them to one of the other clinics. Arrange follow-up for in-patient consults, if they need it by entering them on the rounding board at Strong or by leaving notes for or calling the residents at other hospitals. Notify any fulltime faculty or community attending whose patient you saw both as a courtesy and as good patient management.

Where Calls Come From

Clinic Patients

Our affiliated clinics [SMH, RGH, MCH, and possibly the VA], may page you for a clinic patient problem. If the problem is truly not urgent, recommend follow-up at the clinic where they have been followed. If the problem needs evaluation, have the patient come to the Strong Eye Clinic and evaluate them there, without having them go through the ED.

There are times, though, when you should have them come through the ED rather than meeting them directly at the eye clinic. These include among others possible angle closure glaucoma, major eye trauma, and chemicals splashed into the eye. The eye clinic is not an emergency center and you do not want to be irrigating an eye for hours in the eye clinic. There are facilities for that in the ED. Likewise, major trauma such as possible ruptured globes, etc. should come through the ED since other injuries will need to be ruled out and appropriate imaging studies, lab studies, IV labs, etc., can best be obtained through the ED.

In-Patients

As mentioned above, non-routine consults on in-patients will be taken care of by the residents on call the day they are called in. Also, you will often be called by the nursing staff and other hospital personnel regarding details of ophthalmology pre and post-op patients. Some of these patients you will never have heard of, since they will be at hospitals other than the one you are at during the day. Usually the nurses can give enough details about the patient and what surgical procedure they had, or what eye problem they are being followed for, to help you answer the question. Some of these are non-ophthalmologic questions (e.g. abnormal blood pressure).

If it is a question you cannot answer, call the back-up eye resident for that hospital or, if purely a medical or pediatric non-ophthalmic problem, calling for advice from medicine or pediatrics can be warranted.

We cover patient services at:

- Strong Memorial Hospital
- Rochester General Hospital
- Monroe Community Hospital

ED

We are consultative to the Emergency Rooms at SMH and RGH. This means that the primary evaluation is performed by the emergency room doctors at those hospitals and that they will call about eye problems they do not know how to handle. They should know how to handle basic problems such as conjunctivitis, corneal abrasions, and also how to give initial treatment for chemical injuries. It is our responsibility to be responsive, helpful, and timely. If they do not know how to treat problems that you think general emergency doctors should be able to treat (such as corneal abrasions), teach them. It is reasonable to expect that the ED doctors will give you a basic exam such as vision, pupils, etc. If they do not know how to do this, teach them so that next time they will be able to give better information.

You are always right to go see the patient; you are often wrong thinking you do not need to see the patient. Whenever you are asked to see the patient – see the patient!

If the patient is followed by a private ophthalmologist, sometimes the ED staff can call that ophthalmologist and they will see the patient. However, do not count on it. If they are unable to reach that doctor or that if ophthalmologist requests that you see the patient, you should see the patient.

At RGH, always ask if the patient is from Wilson Health Center. If they are, then Reed's group should see them unless Dr. Reed personally calls you to request you see them.

We do not cover the EDs out of town such as at Sodus Point. **If you are called by an out of town ED without ophthalmology coverage, explain that you are a resident and that your malpractice insurance does not cover you to give advice over the phone regarding patients unrelated to our hospitals.** If they are uncomfortable about the management of some eye problem, recommend that they send the patient to RGH or Strong ED and the patient will be evaluated by the ED staff there. We cannot accept patients over the phone, however, from out of town hospitals because our only function can be to advise our own ED physicians about the management of eye problems of patients in our ED's.

Beware of suggestions that you accept responsibility for the patient, since they may have other problems (e.g. head trauma or other injuries) that require the evaluation of other ED physicians. If the person calling has any problem with this protocol, be sure to get the name of the person calling.

Feel free to take patients from the ED to the eye clinic. Write the consult on ED stationery and keep a copy for the clinic. Log in the patients you see in the consult logs at the respective eye clinics so they can be properly billed as well as counted towards RRC accreditation.

If you are asked to evaluate a patient with significant trauma, be sure to ask whether it is okay for you to dilate the patient's eyes. If the patient is on neuro checks, they may want you to hold off dilating the patient. However if there is a suspicion of a ruptured globe, dilation may be necessary, but be sure to explain to the others caring for the patient why this is necessary. If the service calling has not yet done CT scans, or is about to do them, it may be appropriate to ask them to get a CT of the orbits at the same time possibly with direct coronals.

Notify the person on back-up call of any potential admissions to our service (e.g. first year residents should not independently decide whether or not to admit hyphema or corneal ulcer patients).

Coverage for private practices of full and part-time faculty

Patients who are followed in the practices of ophthalmologists that work closely with us (i.e. Metz, Searl, Ching, etc.) are evaluated by our call service as a courtesy. After an appropriate evaluation, call them. If the problem you saw the patient for is not something the attending needs to know about right away, you can call them (or leave a note) the next day. You can give them a copy of the note you wrote for their files.

Some attendings may prefer you call them all the time. Always err on the side of calling too often! And you can always call the backup emergency on call attending for that particular hospital.

Miscellaneous hints about call and consults

If you are not sure whether or not you need to see the patient, **see the patient**. At first while on call you will be seeing quite a few patients, but as your knowledge and judgment grows, you will feel more comfortable handling some problems over the phone.

If there is any possibility of a serious problem that needs early management, **see the patient**. Or, if you are asked to come and see the patient, see the patient (even if the problem is not serious), and thank the doctor who is calling.

In most cases you should examine the patient and do what you can to evaluate the problem before calling the back-up resident. But do not hesitate to call, after you have gone to the limits of what you feel comfortable with. Long intricate presentations to the back-up resident are not necessary, but organized succinct brief presentations are helpful. Start your comments by saying the name, age, race, and sex of the patient and a very brief statement of the main problem followed by a brief statement of your exam.

For example, "I am seeing a patient Judy Jones, a 36-year-old black female who comes in complaining of floaters and decreased vision in her right eye. She has a history of high myopia. Her vision is 20/200 OD and 20/20 OS. Pupil, external, motility, and slit lamp exam are normal. I think her dilated exam shows a retinal detachment in the right eye, but I am not sure because I have not learned how to use the indirect yet." That is the sort of summary we would expect to hear from a first call resident during the summer.

Consider keeping a logbook of on-call conversations and experiences.

Usually the first call resident would just communicate to the back-up call resident, not directly to the attending. An exception is where the problem concerns a patient of the attending. Sometimes it is reasonable for the first call resident to speak directly to the attending about the patient. If you are not sure about something, however, it does not hurt to run it by the second call resident first.

Call Schedule

The administrative chief resident plans the call schedule for the year. If you have requests or want to change a scheduled call, contact him or her. The request for change must be in writing. It will be submitted to the Program Director for approval. If a trade or call is made on short notice, notify all three of the eye clinics, the page operators, the SMH private office answering service and the three EDs we cover. **The Program Coordinator must be notified as we are required to keep a master log.**

If you cannot do the call you are assigned to, you have the responsibility of notifying the chief resident as soon as possible. That may seem intuitively obvious to the casual observer, but it is sometimes forgotten. All first or second call missed should be made up to the person who covered for you, and you have the responsibility of arranging that. This, too, may seem intuitively obvious to the casual observer, but it is not always done.

Always keep work hour rules in mind!