Residency Manual 2014-2015

Introduction

The department of ophthalmology serves three basic functions which are the reason for its existence: 1) the training of medical students and ophthalmology professionals, 2) the provision of high quality tertiary services and 3) the expansion of scientific knowledge by means of clinical and basic investigation and publications.
The residency program in ophthalmology offered by the Department is approved by the Accreditation Council for Graduate Medical Education (ACGME), the American College of Surgeons and has been accredited since June 11,1963.
Within these fundamental functions, the following general objectives are pursued:
A. To guarantee the provision of postgraduate education programs of the highest value that meet the requirements for endorsement by the pertinent accreditation bodies and that will lead to the professional growth and development of the house staff (interns, residents and fellows), the faculty and the allied health personnel.
The department is heavily focused on residency training, being the only source for Ophthalmology specialists in Puerto Rico. To that end, the greatest resources are provided to the development of the competent professional that the community expects. That is one who displays habitually and judiciously the integrated use of knowledge, skills, clinical reasoning, and moral values. As well as reflection and communication, all applied to benefit the patient and his community.
B. To generate the proper climate for learning and the development of clinical skills by medical personnel.
C. To foster the proper infrastructure that will stimulate research and the birth of new scientific and medical knowledge.
D. To provide specialized health care and other resources otherwise unavailable to the community
E. To develop training programs for allied health personnel.

RESOURCES AND FACILITIES

The medical sciences campus of the University of Puerto Rico provides ample facilities to house the administrative offices of the department, as well as other space, all in the ninth floor of the building. These additional spaces include office space for the billing department, research laboratories, meeting room, classroom facilities, and library space.
The medical science campus has intramural clinics, which are localized two blocks away from the main building. The clinic space is about 46,000 sq. feet. About 3,000 of them are dedicated to Ophthalmology. There are eight examining lanes as well as space for argon and Yag lasers, ultrasound, optical coherence tomography, visual fields, fluorescein angiography and electroretinography. The medical school also provides other resources, such as a five floor medical library and, a computer center. The modern library holds 100,000 volumes, a large ophthalmology section and has electronically access to all the important ophthalmology journals.

The central building of ASEM holds a fully equipped ophthalmology operating suite, six examining lanes with ultrasound and visual field facilities, a complete emergency room that houses another eye exam room and a trauma center.
Several hospitals are integrated with the residency program. These include the University Hospital, the Pediatric Hospital, Carolina Hospital and the Municipal Hospital.
The University Hospital, Pediatric Hospital, and Carolina Hospital are part of the University of Puerto Rico health system. The University hospital provides hospitalization services for patients outside of San Juan. The University hospital has a slit lamp available for examining our inpatients. ASEM provide the clinic space and OR facilities for the University Hospital. The Pediatric Hospital provides service to our youngsters. It has operating rooms equipped with ophthalmic equipment including an operating microscope. Carolina Hospital is located in Carolina, San Juan's neighbor to the east at a less than 30- minute drive from the Medical School. Carolina hospital gives service to the eastern part of the island. In Carolina hospital there are 2 fully equipped examining lanes in addition to fundus photography, ultrasonography, Optical Coherence Tomography, visual fields, fluorescein angiography and ultrasound facilities. It also provides operating room facilities with ophthalmic equipment for general ophthalmology, pediatric and retinal surgery.
The Municipal Hospital provides service to the people of San Juan. It has one fully equipped ophthalmic operating room. Patients from San Juan are evaluated in the ophthalmology clinics of ASEM.
The Veterans Administration Hospital is affiliated to the department. The V.A.H. hospital offers similar facilities as well as 20 examining rooms with sufficient space for residents, faculty and ophthalmic technicians.

Faculty

The faculty has expressed and confirmed a commitment to one or more spheres of academic medicine; teaching, research and system-based health care provision.
Twenty-nine of the thirty-six faculty members are assigned to the parent facility (UDH, Pediatric, Carolina and Municipal) and ASEM. Only four of the thirty-six are full-time, the rest are part time.
The faculty participates in the scheduled weekly didactic program and in grand rounds.
Every ophthalmic sub-specialty is represented in the faculty and great care is devoted to maintain faculty in each field or discipline, replacing those that retire and also to duplicate members of each sub-specialty whenever possible. In addition, every effort is made to attract young new sub-specialists to the department and residency program. New teaching faculty members are asked to commit either to a half time or full time appointment and be Board certified. If they are not board certified they should obtain board certification during the next three years.

Chairman and Program Director

Luis A. Serrano, M.D.

Comprehensive Ophthalmology
Ian Piovanetti, M.D.
Giselle Martin, M.D.
Yanesa Perez, M.D.
Manuel Garraton,M.D.

Cornea Service
Lilia Rivera, M.D.
Carmen Santos, M.D.
Vanessa Lopez,M.D.

Glaucoma Service
Marino Blasini, M.D.
Jorge Fernandez, M.D.
Juan Nevarez, M.D.

Neuro-Ophthalmology Service
Julio Rodríguez, M.D.
Luis Serrano, M.D.

Oculo Plastics Service
Joseph Campbell, M.D.
Jose R. Montes, M.D.
Julio Rodríguez, M.D.

Oncology Service
Noel Perez Soto, M.D.

Ophthalmic Pathology Service
Guillermo Velazquez, M.D.

Pediatric Ophthalmology and Strabismus
Ricardo Rodríguez, M.D.
Magda E. De Pool,M.D.
Luis Oms,M.D.
Rene Vazquez Botet,M.D.

Refractive Surgery
Jose Matos, M.D.

Research and Basic Sciences
Sixto Garcia, PhD

Retina Service
Jaime Bravo, M.D.
Vanesa Cruz, M.D.
Armando Oliver, M.D.
Raúl Pérez, M.D.
Andres Emanuelli,M.D.

Uveitis Service
Carmen Santos, M.D.
Armando Oliver, M.D.

Carolina Hospital Staff

Director
Ana Mejias, M.D.

Retina Service
Vanesa Cruz, M.D.

Glaucoma Service
Arnold Cortes,M.D.

Pediatric Ophthalmology and Strabismus
Ricardo Rodríguez, M.D.

Veterans Administration Hospital Staff

Director
Carmen Henn, M.D.

Retina Service
Luis Hernandez Rios, M.D.

Glaucoma Service
Arnold Cortes, M.D.

Pediatric Ophthalmology and Strabismus
Diana Martinez, M.D.

Comprehensive Ophthalmology
Orlando Pérez, M.D.
Orlando González, M.D.

Elsie Ortiz, M.D.
Nilda Pérez, M.D.

Neuro- ophthalmology
Julio Rodríguez, M.D.

Oculoplastic Service
Julio Rodríguez, M.D.

Service Faculty
Rafael Gallardo, M.D.

UPR- SCHOOL OF MEDICINE
DEPARTMENT OF OPHTHALMOLOGY
INTERNS & RESIDENTS

2014 - 2015
RESIDENTS (PGY-4)
Dr. Eduardo González
Dr. Ricardo Cumba
Dr. Allison Toledo
Dr. Juan C. Jiménez

RESIDENTS (PGY-3)
Dr. Alma Más
Dr. Vanessa Ortiz
Dr. Stephanie Llop
Dr. Carlos Fernández

Residents (PGY-2)
Dr. Stephanie Vale
Dr. Yousef Cruz
Dr. Kathleen Guerrero
Dr. José Echegaray

Interns (PGY-1)

Dr. Itza Acevedo
Dr. Pedro Dávila
Dr. Leilani Joy
Dr. Astrid González

EDUCATIONAL EXPERIENCE

An ophthalmologist is a doctor of medicine who specializes in the eye and visual system. As a licensed medical doctor, the ophthalmologist's ethical and legal responsibilities include the care of individuals and populations suffering from diseases of the eye and visual system. Such care requires not only core competencies for an ophthalmic physician, but also a set of specialized cognitive capabilities and an array of technical skills. Specialist training is designed to provide a structured program of learning that facilitates the acquisition of knowledge, understanding, skills and attitudes appropriate for an ophthalmic specialist who has been fully prepared to begin his/her career as an independent consultant in ophthalmology.

The educational experience of the Residency Program in Ophthalmology consists of 36 calendar months, including appropriately spaced and pre-scheduled vacation periods that do not exceed one month. Additional discretionary leave is conceded to the resident staff for symposia, professional meetings and for fellowship interviews as long as the educational goals are not affected.

Internship (PGY-1)

Prior to appointment in the program, all residents must have successfully completed a post-graduate clinical year (PGY-1) in an ACGME-accredited program, or in a program located in Canada and accredited by the Royal College of Physicians and Surgeons of Canada.

The PGY-1 must be in one of the following specialties: emergency medicine, family medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, surgery, or transitional year.

After a satisfactory completion of his internship the candidate starts his first year of residency (PGY-2)

FIRST YEAR RESIDENCY IN OPHTHALMOLOGY (PGY- 2)

The first year resident (PGY-2) is assigned to rotations in the University Hospital, the Municipal Hospital, Pediatric Hospital and the Veterans Administration Hospital. In this rotations he will examine patients in the general clinics, develop skills with the use of diagnostic equipment, including visual fields, fluorescein angiography and ultrasonography. He will also be exposed to retina, uveitis, pediatric clinics and low vision. The first year resident will assist to wet lab sessions so that he will learn the essentials of patient care in the operating room as well to start developing his surgical skills. During this year he performs minor surgery. The resident has time protected for research activities also. The first year resident accompanies the second year resident to the ER every third or fourth day after 4:00 PM for a maximum of four hours to become abreast with regular ER on call duties. During his/her stay at the ER, the first year resident is always under close supervision by the second year resident who has the back up of the senior resident and the faculty on-call.

During the months of January through March the PGY 2 resident assists at the Guillermo

Pico Santiago Basic Science Course. The course, now in its 46th year is a didactic introduction to Ophthalmology fundamentals and clinical not only for our residents but also to many Latin American countries. It is a full time course, running 8 hrs. daily for 8 weeks. The course is taught by visiting and as well as local professors.

GOALS AND OBJECTIVES

Upon completion of the first year of residency in ophthalmology, the resident should have attained the following competencies:

Medical Knowledge

a) To describe the basic principles of optics and refraction.
b) To list the indications for and to prescribe the most common low vision aids.
c) To identify the key examination techniques and management of basic and most common medical problems in the subspecialty areas of glaucoma (e.g., primary open angle glaucoma), cornea (e.g., dry eye, microbial keratitis), orbit and oculoplastics (e.g., common lid lesions, ptosis), retina (e.g., macular disorders, retinal detachment, diabetic retinopathy), and neuro- ophthalmology (e.g., optic neuropathy, ocular motor neuropathy, pupillary abnormalities, visual field defects).
d) To describe indications for, performance of, and complications of common anterior segment surgery, (e.g., cataract extraction, trabeculectomy, peripheral iridectomy), and to assist at surgery.
e) To describe the common but serious genetic ocular disorders (e.g., retinal and macular dystrophies).
f) To recognize the most common ophthalmic histopathology findings and to recognize basic histopathology of common ocular lesions (e.g., retinal detachment, pterygium, corneal button removed at keratoplasty).

Patient Care

a) To perform the basic anterior segment (e.g., basic refraction, basic retinoscopy, slit lamp bio microscopy) and posterior segment examination skills (e.g., dilated fundus examination, use of magnification and lenses, Hruby lens, 90 Diopter lens, three mirror Goldman contact lens) and to understand and use basic ophthalmic instruments (e.g., tonometer, lensometer).

b) To triage and manage ocular emergencies (e.g., central retinal artery occlusion, giant cell arteritis, chemical burn, acute angle closure glaucoma, endophthalmitis, traumatically open globe).
c) To perform minor external and adnexal surgical procedures (e.g., chalazion excision, corneal foreign body removal, use of foreign body corneal drill for removal of a rust ring, conjunctival biopsy, corneal scraping, isolated entropion).

PRACTICE-BASED LEARNING AND IMPROVEMENT

a) To analyze practice experience and perform practice-based improvement activities using a systematic methodology.

b) To locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.
c) To obtain and use information about their own population of patients and the larger population from which their patients are drawn.
d) To use information technology to manage information, access on-line medical information; and support their own education.

INTERPERSONAL AND COMMUNICATION SKILLS

a) Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, patients' families, and professional associates.
b) Establishes and maintains rapport with patients, peers, faculty, nurses and ancillary personnel.
c) Shows sensitivity to patients' fears, anxieties, need for privacy.
d) Transmits to patients and relatives the management plans and status of the case in a clear way that is understandable to them.
e) Explains management plans in a way that motivates the patient's willing participation.
f) Explains plans to nurses and other members of the health team.

PROFESSIONALISM

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

a) Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and
society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development.
b) Demonstrate a commitment to ethical principles pertaining to provision or information, informed consent, and business practices.
c) Demonstrate sensitivity and responsiveness to patients' culture, age, gender.

Professional attitudes and conduct require that trainees must also have developed a style of care, which is:

§ Humane (reflecting compassion in providing bad news, if necessary; the management of the visually impaired; and recognition of the impact of visual impairment on the patient and society);
§ Reflective (including recognition of the limits of his/her knowledge, skills and understanding); ethical;
§ Integrative (including involvement in an inter-disciplinary team for the eye care of children, the handicapped, the systemically ill, and the elderly); and
§ Scientific (including critical appraisal of the scientific literature, evidence-based practice and use of information technology and statistics).

SYSTEMS-BASED PRACTICE

Residents must demonstrate an awareness of and responsiveness to the larger

context and system of health care and the ability to effectively call on system resources to provide care that are of optimal value. Residents are expected to:

a) Understand how their patient care and other professional practices affect other health care professionals, the health care organization and the larger society, and how these elements of the system affect their own practice;

b) Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.

c) Practice cost-effective health care and resource allocation that do not compromise quality of care;

d) Advocate for high quality patient care and assist patients in dealing with system complexities; and

e) Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

Second Year Residency in Ophthalmology (PGY- 3)

The second year of residency in ophthalmology is one that brings the fullest activity to the resident, as he is heavily relied upon for medical care skills development. Besides the general ophthalmology clinic during his second year of residency the resident is exposed to subspecialty clinics including Glaucoma, Cornea, contact lens, Pediatrics, Retina and Uveitis. Second year residents have time dedicated to low vision clinic, refractions and research.

Intense demands of surgical skills development are encountered in traumatic wound repairs, and in cataract and strabismus rotations.

The second year resident is on call every third to fourth day for all ER cases as well as covering for hospitalized patients. His usual schedule of work starts at 4:00 PM weekdays. During this on call time, he will expend an average of 3-4 hours answering consults at the ER or taking care of hospitalized patients, the rest of the time he/she will be at their home on-call.

On weekends, the second year on-call duties cover a 24 hour period, with an real time within the Medical Center premises of about 6-8 hours in the average, the rest of the time he/she is on-call at their home.

The second year resident has always the third year resident and a faculty assigned for consultation.

The second year resident has the responsibility of organizing our monthly case presentations and teaches the first year resident.

GOALS AND OBJECTIVES

By the end of his second year of residency the resident should be able:

MEDICAL KNOWLEDGE

a) To describe the more advanced principles of optics and refraction.
b) To list the indications for and uses of more advanced low vision aids.
c) To describe the more advanced principles of optics and refraction.
d) To identify the key examination techniques and management of the less common surgical problems in the subspecialty areas of glaucoma (e.g., secondary open angle and closed angle glaucoma), cornea (e.g., fungal and other less common microbial keratitis, corneal transplantation), ophthalmic plastic surgery (e.g., extensive benign and common lid lesions, ptosis), retina (e.g., primary retinal detachment, mild to moderate proliferative and non- proliferative diabetic retinopathy and laser treatments), and neuro-ophthalmology (e.g., less common optic neuropathy, supranuclear palsies, myasthenia gravis, more complex visual field defects).
e) To recognize, and refer if indicated, some major genetic ocular disorders (e.g., Neurofibromatosis II, tuberous sclerosis, Von Hippel-Lindau syndrome, retinoblastoma, retinitis pigmentosa, macular dystrophy and I).
f) To recognize more complex and difficult ophthalmic histopathology findings.

PATIENT CARE

a) To perform more advanced anterior segment (e.g., more complex refractions, including contact lens and post-operative refractions, intermediate retinoscopy, including moderate astigmatism, examination of young children, intermediate techniques of slit lamp biomicroscopy) and posterior segment examination skills (e.g., more advanced techniques of dilated fundus examination, including scleral depression, use of magnification and lenses to diagram and describe retinal lesions).

b) To recognize and treat ocular emergencies (e.g., central retinal artery occlusion, giant cell arteritis, chemical burn, acute angle closure glaucoma, endophthalmitis, traumatically open globe), as well as the short and long term complications of these disorders.

c) To perform more advanced external and adnexal surgical procedures (e.g., isolated ectropion and isolated entropion repair, removal of small, localized, and benign lid lesions, pterygium excision).

d) To perform common anterior segment surgery (e.g., cataract extraction, trabeculectomy, peripheral iridectomy) and strabismus surgery.

PRACTICE-BASED LEARNING AND DEVELOPMENT

a) To use information about self-error and improve them
b) To show gradual but prompt and definite improvement in surgical technique and judgment.
c) To demonstrate recovery from knowledge and attitudinal deficiencies.
d) To demonstrate that patient care now reflects learning from previous experiences.
e) To apply evidence from literature to the specific patient.

f) To apply knowledge of studies and statistical methods to evaluate studies.
g) To understand ways of keeping up to date medical information.
h) To show improvement on case presentations and conferences

INTERPERSONAL AND COMMUNICATIONS SKILLS

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, patients' families, and professional associates.
Residents are expected to:
a) Create and sustain a therapeutic and ethically sound relationship with patients.

b) Use effective listening skills and elicits and provides information using effective nonverbal, explanatory, questioning, and writing skills.

c) Work effectively with others as a member or leader of a health care team or other professional group.

PROFESIONALISM

At the end of his second year of residency, the resident should demonstrate the progressive
attainment of the knowledge, skills and attitudes required to provide legal, ethical and culturally
sensitive medical care to children and adults and
a) Demonstrate respect, compassion and integrity.
b) Demonstrate a commitment to ethics, confidentiality and informed consent.
c) Demonstrate sensitivity and responsiveness to patient's age, culture, gender and disabilities and willingness to provide needed care, with the same standards of quality for all patients, regardless of type of reimbursement or ability to pay.
d) Maintains attitude of awareness, inquisitiveness and "can do".

SYSTEMS-BASED PRACTICE

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal
value. Residents are expected to:

a) Understand how their patient care and other professional practices affect other health care professionals, the health care organization and the larger society, and how these elements of the system affect their own practice;

b) Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources;

c) Practice cost-effective health care and resource allocation that do not compromise

quality of care;

d) Advocate for high quality patient care and assist patients in dealing with system complexities; and
e) Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

THIRD YEAR RESIDENCY IN OPHTHALMOLOGY (PGY-4)

The third and final year of training is devoted to mastering the more sophisticated and complicated surgical and medical procedures. He rotates by neuro – ophthalmology clinic as well as Plastics, Glaucoma, Refractive surgery and Retina clinics. He has time dedicated for research and presents
his research projects at the local medical society meeting and he is expected to submit a paper for publication.
The third year resident is responsible for the supervision of junior residents, rotating physicians and medical students. He must be prepared to dictate conferences to other departments and medical students.
The third year resident is on second call in the emergency room roster. The senior resident is on-call for a week at a time at his/her home. Most of the work during this on call period is done during weekends when surgical emergencies are operated. The average time they stay at the Medical Center,
usually for surgical cases, is 6-8 hours for a regular weekend, with an additional 2-4 hours for longer weekends.
Weekdays surgical emergencies are rarely operated after 4:00 PM; they are usually attended the next day within the regular day schedule.
All surgical cases are done with the faculty on-call supervision.

GOALS AND OBJECTIVES

The third year resident must acquire the final knowledge and skills to be a competent professional and be able to work by himself. He should accept the fact that the practice of ophthalmology evolves and he must keep up to date for the benefit of his patients. He must be able:

MEDICAL KNOWLEDGE

a) To describe the advanced principles of optics and refraction (e.g., pre- and post-refractive surgery, higher order aberrations).
b) To list the indications for and uses of advanced low vision aids.
c) To identify the key examination techniques and management of complex but common medical and surgical problems in the subspecialty areas of glaucoma (e.g., complicated or post- operative primary and secondary open and closed angle glaucoma), cornea (e.g., unusual or rare types of microbial keratitis), ophthalmic plastic surgery (e.g., less common and more complex lid lesions, re-operation or complex or recurrent ptosis), retina (e.g., complex retinal detachment, tractional retinal detachments and severe proliferative diabetic retinopathy, proliferative vitreoretinopathy), and neuro-ophthalmology (e.g., unusual optic neuropathy, neuroimaging, supranuclear palsies, uncommon visual field

defects).

d) To recognize, evaluates, and treats, if possible, the major genetic ocular disorders (e.g., neurofibromatosis I and II, tuberous sclerosis, von Hippel-Lindau syndrome, retinoblastoma, retinitis pigmentosa, macular degenerations).

e) To recognize uncommon or rare but classic ophthalmic histopathology findings.

PATIENT CARE

By the end of the third year, the senior resident should have mastered the skills of and be able:

a) To perform the most advanced anterior segment (e.g., complex refractions, advanced retinoscopy, advanced slit lamp biomicroscopy) and posterior segment examination skills (e.g., drawings of retinal detachments and scleral depressions; interpretation of macular disorders with slit lamp biomicroscopy).

b) To manage or supervise the more junior trainees (e.g., medical students or medical residents) in the management ocular emergencies (e.g., central retinal artery occlusion, giant cell arteritis, chemical burn, angle closure glaucoma, endophthalmitis).

c) To perform more advanced external and adnexal surgical procedures (e.g., lacrimal gland procedures, complex lid laceration repair, e.g., canalicular and lacrimal apparatus involvement).

d) To perform and treat complications of common anterior segment surgery, (e.g., cataract extraction, trabeculectomy, peripheral iridectomy).

e) To perform phaco-emulsification techniques, their variations and proper application according to the case and cataract type

f) To perform various techniques for retinal detachment repair and when to use each.

g) To perform pars plana vitrectomy and panretinal photocoagulation.

Practice-based Learning and Improvement

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

a) Analyze practice experience and perform practice-based improvement activities using a systematic methodology.
b) Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.
c) Obtain and use information about their own population of patients and the larger population from which their patients are drawn.
d) Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
e) Use information technology to manage information, access on-line medical

information; and support their own education.
f) Facilitate the learning of students and other health care professionals.

Interpersonal and Communication Skills

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, patients' families, and professional associates. Residents are expected to:

a) Create and sustain a therapeutic and ethically sound relationship with patients.

b) Use effective listening skills and elicits and provides information using effective nonverbal, explanatory, questioning, and writing skills.

c) Work effectively with others as a member or leader of a health care team or other professional group.

Professionalism

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

a) Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development.

b) Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices.

c) Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities.

SYSTEM-BASED PRACTICE

On completion of his senior year, the residents:

a) Must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

b) Understand how their patient care and other professional practices affect other health care professionals, the health care organization and the larger society, and how these elements of the system affect their own practice.

c) Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.

d) Practice cost-effective health care and resource allocation that do not compromise quality of care.

e) Advocate for high quality patient care and assist patients in dealing with system complexities.

f) Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

g) Demonstrate knowledge of the sources of financing for Puerto Rico and U. S. health care, including Medicare, Medicaid, the VAH, the Dpt. of Defense, the Puerto Rico Health Dpt. as well as Private health plans and the Puerto Rico Health Reform plan.
h) Knows how health care is delivered in Puerto Rico and U.S. in different venues such as hospitals, medical offices, and state-sponsored units
i) Demonstrate knowledge of the regulatory environment including state licensing authority, State and local Public Health rules and regulations, and regulatory agencies such as HCFA, PRO and JCAHO.
j) Demonstrate ability to work with social services and public health agencies, religious institutions, police and other community organizations as appropriate in assisting their patients.
k) Demonstrate knowledge of basic practice management principles such as budgeting, record keeping, billing systems, and the recruitment, hiring, supervision and management of staff.

ELIGIBILITY FOR RESIDENCY

The department of ophthalmology of the University of Puerto Rico School of Medicine offers a graduate education program accredited by the ACGME. Accordingly, physicians seeking to enter the program must comply with the qualifications required by the accreditation council. Those are as follows:
a) Graduates from institutions in the United States and Canada whose programs are accredited by The Liaison Committee on Medical Education (LCME).
b) Graduates from institutions in the United States accredited by the American Osteopathic Association.
c) Graduates of medical schools whose programs are not accredited by the LCME, who meet the following additional qualifications:
• Have fulfilled their educational requirements of that country, or possess unrestricted license to practice there, have passed the examination designated as acceptable by the ACGME and, have proven capability to understand both spoken and written English, and these credentials have been validated by an organization acceptable to the ACGME.
• Have a full and unrestricted license to practice medicine in the United States jurisdiction providing such license.
• Special circumstances as detailed in sections 3.1.4. And 3.1.5. Of the publication"
"Essentials of Accredited Residencies in Graduate Medical Education"

SELECTION OF RESIDENTS

Applicants must submit their complete application form by November 30, two years prior to the projected date of beginning the first year of residency. As of November 30, all applications will be reviewed by the Resident Admission Committee, which will select a number of candidates for interview, not to exceed 10, for consideration for the four available slots.

Candidates invited to interview are each interviewed by each of the four members of the Admissions Committee during the month of December. The committee then meets to select the candidates by order of rank from one to ten. The ranking list is submitted to the Ophthalmology Residency Matching Program. The actual match is announced to the program as well as to the candidate in January.

The basis for candidate selection is as follows: 75 % is allotted to credentials: this includes 10% for university grades, 35 % for medical school grades, 15% for USMLE step1 and 15% for USMLE step 2 grade. 25 % is allotted o the interview, letters of recommendations, and a compulsory rotation in our clinics. Also if the candidate is reapplying to our program consideration is given to what has he done to improve his curriculum vitae like research work or publications. A personal statement is mandatory.

The residents are ranked according to the number of points obtained, and the ranking list is submitted to the Matching program. When the match is announced in January, the first 4 matched resident candidates are accepted into the program.

RESIDENT EVALUATION AND PROMOTION

A series of assessment tools are used to evaluate the resident.

This includes a Global performance rating, 360-degree evaluation, Objective structured clinical Examination, resident portfolio and case logs.

The Global performance rating is the evaluation given at the end of the rotation. The attending physician in charge of the educational experience evaluates residents on each of the six competencies during each clinical and surgical rotation. The evaluation is discussed with and signed by both resident and faculty.

A 360degree evaluation consists of measurement tools completed by multiple people in a person sphere of influence. That is superiors, peers, subordinates, patients and families. It is used to assess interpersonal and communication skills, professional behaviors, and some aspects of patient care and system based practice.

The Objective Structured Clinical Examination provides a standardized mean to asses history taking and examination skills, breath and depth of medical knowledge, communication skills with patients and family members, ability to summarize and document findings, make a differential diagnosis, and elaborates a treatment plan.

Resident portfolio is a collection of products prepared by the resident that provides evidence of learning and achievement related to a learning plan. It contains written, documents, videos, photographs, a log of clinical procedures done, a summary of research literature, a quality improvement project plan, and presentations given by the resident.

Operative case logs are entered in the ACGME website by each resident. There are a minimum number of procedures that each resident has to have prior to finishing his

residency period. The program director will make sure that all residents obtain a balanced educational experience. The definition of a surgeon and minimum case requirements are described later in this manual.
The resident performance in journal clubs, case presentations, on call, and in the operating room is also evaluated. The evaluation is discussed with the resident.
Twice a year residents are evaluated by the Clinical Competency Committee and provided feedback of their progress. These evaluations are accessible for resident review.

As a measure of his cognitive ability the resident is also required to take annually the O.K.A.P. exam. Results of OKAPS are utilized to guide the faculty in assessing strengths and weaknesses of individual residents and program.
The Clinical Competency Committee will decide if the resident has reached the required milestones to be promoted to the next level. In the case of third year residents, they are given a summative evaluation and awarded the certificate of successful completion of the residency program.

Faculty Evaluation

There is an annual confidential evaluation of the faculty by the residents and an annual evaluation of the faculty by the program director as it relates to teaching skills, commitment to the program, clinical knowledge, professionalism, and scholarly activities.

Program Evaluation

The curriculum is evaluated annually and modifications are made depending on resident performance on OKAPs and certification exams. The faculty and residents also evaluate the program annually in a confidential manner. A written plan for remedial action is made at the end of each academic year.

Institutional Policies

Supervision

The ACGME requires that all residents be supervised during the discharge of their patient care responsibilities. To that effect, supervision is provided in outpatient clinics, operating rooms and inpatient consultations.
All clinics are under the supervision of a member of the faculty. All major surgeries require the presence of a member of the faculty. A member of the faculty must do one-eye patients requiring surgery.
While on call after hours , the PGY3 year resident evaluates the patients and consults with the PGY4 resident. There is a faculty roster for consultation if needed or if the patient has to be taken to the operating room.

Moonlighting

Moonlighting is absolutely prohibited during the residency. The resident involved in this practice will be referred to the grievance committee for appropriate action immediately.

Duty Hours

One resident at each PGY level is in charge of making the on-call duties schedule of his/her level, a second resident of the same level monitors the assignments to avoid conflicts, inequalities and to assure compliance with the ACGME Duty hour's standards .
The program is committed to promote patient safety and resident well-being. Therefore residents are not allowed to work more than 80 hrs. a week with one day of seven free of all institutional responsibilities averaged over a four-week period. Calls at night are taken at home and time spent in the emergency room evaluating patients is counted toward the 80 hrs rule. Residents are asked to sign a log of all time spent in the hospital.

Dress Code

All Ophthalmology residents and medical students rotating through the Department of Ophthalmology should maintain a professional appearance and dress appropriately whenever they are representing the department of Ophthalmology of the School of Medicine of the University of Puerto Rico in any on or off campus settings. Being neatly dressed and well groomed exemplifies a professional appearance and shows respect for patients and colleagues. Each student and resident is required to follow the dress code as established by the School of Medicine.

1. Clothing should reflect a neat appearance. Clothing should allow for adequate movement during patient care and should not be tight, low cut or expose the trunk with movement.
2. The following type of clothing is not allowed:
a. Shorts
b. Cut off, T shirts, tennis shoes
c. Short skirts or "halter" dresses
d. Tank tops, clothing with rips/tears, bare midriff
e. Jeans or leggings
f. Hats
g. Body piercing or tattoos
3. It is highly recommended that male faculty; residents and students wear a necktie especially in clinics.
4. The hair must be clean and combed.
5. White coats should be worn in clinic areas. The coats should have the school logo. Logos from pharmaceutical companies or other commerce is prohibited.
6. Fingernails should be kept trimmed and nail polish should be discreet.
7. Disposable coats and OR scrubs should not be worn outside its specific area of work

In the first offense the person will receive a verbal warning. If there were a second offense there would be a written reprimand with copy to the Deans office. If there is a third offense a conference with the administrative officials of the School of Medicine will be held.

Fatigue

Sufficient sleep and sleep hygiene are critical for the practice of good medicine and for patient safety.
Most people on average require 8 hours of sleep every 24 hours to satisfy physiological needs.

When people get less than 5 hours of sleep their peek mental performance usually deteriorates. In a medical setting or a drive home the consequences can be serious. Clinical signs of fatigue include moodiness, depression and irritability. Apathy, impoverished speech, impaired memory, confusion, sedentary nodding off, medical errors, and micro sleeps. Excessive sleepiness in a resident constitutes a performance issue. If a resident is found to be excessively sleepy a medical evaluation will be obtained to rule out a medical condition like hypothyroidism or a psychological disorder such as depression. Our residents take calls at home and so they are rarely called after 10:00pm therefore they usually have sufficient sleep. In the case that he is suspected of having sleep deprivation he will be relieved from his patient care responsibilities and sent home to sleep. Enforcement of duty hours rule helps to avoid fatigue.
The Institution has a free resident wellness program as described in the 2013 Housestaff manual.

Physician Impairment

IMPAIRED RESIDENT/FELLOW POLICIES AND PROCEDURES

POLICY

An impaired resident/fellow shall be defined as any resident/fellow who, by virtue of physical disability, mental illness, psychological impairment, chemical substance abuse or misconduct, is unable to safely care for patients, perform duties normally expected of a resident physician or engage in peer interacting necessary for patient care.
The following may be signs and symptoms of impairment. Warning signs and symptoms, although certainly not specific to problems of substance abuse, may include:
! Physical signs such as fatigue, deterioration in personal hygiene and appearance, multiple physical complaints, accidents, eating disorders.
! Disturbance in family stability.
! Social changes such as withdrawal activities, isolation from peers, embarrassing or inappropriate behavior.
! Professional behavior patterns such as unexplained absences, spending excessive time at the hospital, tardiness, decrease in quality or interest in work, inappropriate orders behavioral changes, altered interaction with other staff, and inadequate professional performance.
! Behavioral signs such as mood changes, depression, lapses of attention, chronic exhaustion, risk taking behavior and flat affect.
! Drug use indicators such as excessive agitation or edginess, dilated or pinpoint pupils, self medication with psychotropic drugs, stereotypical behavior, alcohol on breath at work, uncontrolled drinking at social events, others.

This must be documented by written reports from at least two individuals (faculty, resident/fellows or others) who have first hand knowledge of an incident involving the resident/fellow. The decision of what constituted inability to perform duties shall rest with the program director.

The remedial measures in dealing with the impaired resident/fellow require identification

and immediate institution of an appropriate treatment program. There must be available methods that identify stresses and factors within the environment that could cause problems, and personality traits that could put the resident/fellow at risk.
All residents/fellows identified as being at risk of any difficulty or in need of behavioral intervention must be referred to the Counseling Program for confidential evaluation and referrals as needed.

PROCEDURES

1. There should be regular monitoring of resident/fellow performance by the program directors and the faculty. When a suspicion of impairment is detected, an in-depth interview with the resident/fellow by the program director and one other faculty member should be carried out. Mutually agreeable resources may be utilized to establish the fact and severity of the impairment. Confidential counseling services are provided by the Medical Science Campus.
2. As soon of the program director is aware of a problem with resident/fellow impairment, an immediate method of handling the problem should be determined.
3. The program director and the resident/fellow will formulate a plan of action once the problem is identified. This plan should stipulate specific goals and objectives and must be put in writing and signed by both parties.
4. There must be a periodic review of the plan by the program director.
5. If a leave of absence is involved in the plan, it must meet criteria stated in the regulations of the appropriate specialty boards.
6. Return from leave from impairment should be based upon written reentry policies that include understanding with the resident/fellow training program and the School of Medicine. Any return from leave shall be based on a complete review of follow-up must be provided during the remainder of training.

If a resident or faculty member is noted to exhibit a behavior that deviates from the standards or ethical conduct required by our profession it should be notified to the chief resident or program director in order to deal with the situation. Ideally the notification should be written. The program director will talk to the involved physician and follow the procedures described previously. If the involved physician refuses all help the Grievance committee will be activated and the office of Graduated Medical Education notified.

Grievance

Due process for residents in our program is held in a stepwise fashion. The first offense usually involves a verbal reprimand from a member of the grievance committee or program director. No written action is taken at this time unless it constitutes gross misbehavior like sexual harassment or violation of moonlighting policy. We will enforce zero tolerance on these issues. The second offense will require a report letter and activation of the grievance committee.
The third offenses will require formal disciplinary action as described below.

Institutional Grievance Procedure

GRADUATE MEDICAL EDUCATION • SCHOOL OF MEDICINE • UNIVERSITY OF PUERTO RICO

TRAINEES GRIEVANCE POLICY AND PROCEDURE

POLICY STATEMENT

The purpose of this policy is to describe procedures by which deficiencies in performance and misconduct of trainees in graduate medical programs may be addressed. This policy is applicable to physician trainees in all specialty and subspecialty-accredited programs.

I. PROCEDURAL GUIDELINES

A. Preliminary Academic Actions

Program directors are encouraged to use the following preliminary measures to resolve minor instances of poor performance or misconduct. If these preliminary measures are unsuccessful the Program Director may initiate formal disciplinary actions.

1. Report Letter

A report letter may be issued by the Program Director to a trainee notifying an academic or professional deficiency that needs to be improved or remedied. The Program Director will review the letter with the trainee and a plan of action will be recommended. The time to complete this plan will be determined by the Program Director. Failure to achieve immediate and/or sustained improvement or a repetition of the conduct may lead to other disciplinary actions. This letter does not constitute a disciplinary action.

B**. Formal Disciplinary Actions**

1. Causes

Formal disciplinary action may be taken for any appropriate reason, including but not limited to any of the following:

a) Failure to satisfy the academic or clinical requirement or standards of the training program.

b) Professional incompetence, misconduct or conduct that might be inconsistent with or harmful to patient care and/or safety.

c) Conduct which calls into question the professional qualifications, ethics, or judgment of the trainee, or which could prove detrimental to patients, employees, staff, or volunteers

d) Violation of the policies or procedures of the any participating institution, or applicable department, section or training program

e) Scientific misconduct

2**. Procedures:**

Formal disciplinary actions may include, but not limited to:

A) **Probation**

• Probation is a period of time in which the trainee has a temporarily modification of his/her responsibilities within the training program. These modifications are designed to facilitate the trainee's accomplishment of program requirements. There will be increased supervision and monitoring of the resident until a satisfactory evaluation is achieved. The time period will be determined by the Program Director in accordance to the specific

terms of the probation.

• Probation may include, but not be limited to, special requirement or alterations in scheduling responsibilities, a reduction or limitation in clinical responsibilities, or enhanced supervision of the trainee's activities.

• The Program Director **must** notify the trainee and the DIO in writing of the probation. Written notification should include:

a) Reason of the probation
b) Assignment of mentor
c) Method and timetable for evaluation and correction
d) Date upon which the decision will be re-evaluated
e) Statement regarding the trainee right to request a review of the probation in accordance with the procedures outlined below
• To initiate a review of the probation decision, the trainee must submit a written request for a review within three (3) working days of receiving notification of the decision. The Program Director shall interview the trainee within the next three (3) working days, and give the trainee the opportunity to provide all the information for his/her appeal. After this meeting the program director should discuss with the faculty or personnel involved and will submit a written notification of the decision.

Failure to correct the deficiency within the specified period of time may lead to an extension of the probatory period or other academic sanctions including dismissal from the program.

• A trainee shall be paid while on probation

B) **Suspension**
 The Program Director or his/her designee may temporarily suspend the trainee from part
or all the trainee's usual and regular assignments in the GME training program, including, but not limited to, clinical and/or didactic duties, when the removal of the trainee from the clinical service is required for the best interests of patients, staff and/or trainee due to seriously deficient performance or seriously inappropriate conduct.

• The suspension will be informed in writing by the Program Director, stating the reasons for the suspension. Suspension generally should not exceed sixty (60) calendar days. Written notification must include:

a) Reasons for the suspension
b) Required method and timetable for evaluation and correction
c) Date upon the decision will be re-evaluated
d) Statement regarding the trainee's rights to request a review of the suspension in

accordance with the procedures outlined below
• To initiate a review of the suspension decision, the trainee must submit a written request for a review of the suspension of the program within three (3) working days of notification of the action. The Program Director shall interview the trainee within the next three (3) working days, and give the trainee and opportunity to provide all the information to his/her appeal. After this meeting the program director should discuss with the faculty or personnel involved and will submit a written notification of the decision.

• The Program Director **must** send a written notification to the DIO.

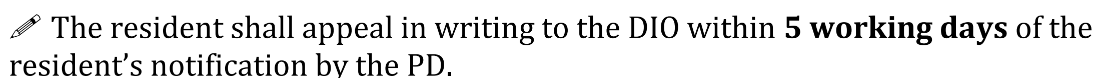
• The trainee stipend will not be paid while the trainee is on suspension.

C) Dismissal
A dismissal occurs when the trainee is permanently withdrawn of all institutional responsibilities and privileges. The trainee has the right to request formal review of the dismissal decision. Written notice of the dismissal must include the reasons for the decision and the effective date. The Program Director must send a written notification to the DIO.
The Program Director shall have the authority to dismiss a trainee from a training program for reasonable cause, including but not limited to:
• A failure to achieve or maintain programmatic requirements or standards in the GME training program.

• Unprofessional, unethical or other behavior that is otherwise considered unacceptable by the GME training program including but not limited to:
a) Sexual misconduct with patient, peer, faculty or other member of the health team
b) Repeated unauthorized absences or tardiness to teaching activities,
continuity clinics, clinical rotations, in- house calls ("guardias")
c) Being under the effects of alcoholics beverages or drugs while performing his/her academic and clinical duties
d) Problems related to the resident's behavior and/or attitudes toward patients, other residents, faculty or supervisors
• A material omission or falsification of a GME training program application, a medical record, a prescription, ACGME document, cases log or any other official document.

• A serious or repeated act of physical or psychological harm to patient

Once a trainee has completed all Departmental Procedures concerning disciplinary actions he/she may appeal in writing to the Institutional Graduate Medical Education Office.



✐ The resident shall appeal in writing to the DIO within **5 working days** of the resident's notification by the PD.

! Failure to request an appeal within that time period shall be deemed acceptance of the adverse action and shall constitute a waiver of the right to appeal.

! Within **5 working days** of request for appeal the DIO will activate the GMEC Grievance Subcommittee. This subcommittee shall consist of not less than 4 persons, all who are members of the GMEC. One member shall be a trainee member of the GMEC.
No person who has actively participated in the initiation of the adverse action shall be appointed to the hearing committee.

! The Subcommittee shall request the resident's departmental file and any other material on which the adverse action was based.

! The resident shall receive written notice of the day, time and place of the hearing within **5 working days** and shall also be advised of his/her right to provide evidence supporting the appeal.

! This hearing will be held within **10 working days** of the hearing notice.

! The Subcommittee will hold hearings with the resident and the PD separately.
The hearings are academic proceedings.

The PD shall present evidence for upholding the action.

! The Subcommittee shall determine:
• The adequacy of the documentation on which the decision was based.
• The appropriateness of the departmental procedures.

! The Subcommittee will make its determination within **5 working days** from the completion of the hearing process.

! The Subcommittee will submit a written report with recommendations to the Dean.

! The Dean shall notify his decision within **5 working days** to the resident in writing with copy to the PD and the DIO.
! If the resident or the PD wishes to appeal the decision, he/she may do so in writing to the Medical Sciences Chancellor within **5 working days** of receiving the notification.
! The resident shall complete the above process within **40 working days** of the initial appeal.

! If the resident is not satisfied with the decision , he/she may appeal to the University Presidents and the Board of Trustees, according to the procedures established in the "Ley de Procedimiento Uniforme de Puerto Rico"(Law #170, August 12 1988 as amended on November 30, 1990).

Resident Grievance

Any grievance sustained by the resident staff from a faculty member must be informed to the chief resident or the chairman of the department. The chairman will meet with involved parties and try to resolve the issues verbally. If there is continued grievance by the faculty member, the grievance committee will be activated for appropriate action. A report letter will precede formal disciplinary action if the misconduct is not resolved.

Interruption in Training due to Medical or other justifiable cause

Interruption in training due to medical or other justifiable cause, exceeding two weeks, constitutes a deficiency in the requirement of "length of residency training" of 36 months. The resident and program director must design a period of compensatory training so as to eliminate the gap in the training. If this period of compensatory training is done after the 36 months of residency training it will be done without compensation.
If the resident in training is a pregnant woman and birth occurs while she is in training she shall be entitled to a maternity leave for a period of eight weeks. The concession and use of this priviledge shall be coordinated with the Graduate Medical Education Office. The application for maternity leave must enclose a physicians certificate indicating the approximate birth date.
In case of a paternity leave, the resident is entitled to one paternity leave per year of service of up to two weeks following the birth of a child, that he/she shall certify through a birth certificate of the newborn or sworn statement to that effect.

Definition of a Surgeon

Basic Principle: To be recorded as the surgeon, a resident must be present for **all** of the critical portions, and must perform the **majority** of the critical portions of the procedure under appropriate faculty supervision. Involvement in the preoperative assessment and the postoperative management of that patient is an important element of that participation. Only the first assistant (not the second, third, etc.) may record a procedure as assistant. A resident may only record a case as assistant if the resident is first assistant to: 1) a faculty member performing the procedure, or, 2) another resident performing the procedure under faculty supervision.

Clarifications:

1. If a resident completes **one** side of a bilateral procedure, the resident can count that as one case, surgeon. If a resident completes **both** sides of a bilateral procedure, this still counts as one case, surgeon. If two residents **each do one** side of a bilateral procedure, each resident can record the procedure as the surgeon, provided that each fulfills the stated criteria for performance as surgeon on one side.

Example: If a resident performs a bilateral blepharoplasty, then the resident counts it as one case as surgeon. If, however, one resident does one side of the blepharoplasty and the other resident performs the procedure on the other side, each resident may record the procedure as a surgeon case.

2. If a resident completes an operation, which involves multiple procedures, the resident may record all the procedures as separate cases, provided that the resident performs the majority of the critical portions of the procedures. However, if the multiple procedures all fall within the same subspecialty category (e.g., Cataract, Cornea, Strabismus, Glaucoma, Retina/Vitreous, Oculoplastics/Orbit, Globe Trauma), then only one case may be recorded.

Example: A resident performs a combined procedure involving trabeculectomy and cataract extraction. The resident may record both procedures as surgeon cases.

Example: A resident performs a peripheral corneal relaxing incision to correct preexisting astigmatism in conjunction with cataract extraction. The resident may record both procedures as surgeon cases.

Example: A resident performs bilateral medial rectus muscle recessions and anterior transposition of the right superior oblique muscle on a patient. The resident may record only one procedure as surgeon.

Example: A resident performs a scleral buckle procedure combined with pars plana vitrectomy. The resident may record only one procedure as surgeon.

Example: A resident performs bilateral blepharoplasty combined with bilateral ptosis repair. The resident may record only one procedure as surgeon.

3. In an operation, which involves multiple procedures, more than one resident may be recorded as the surgeon, provided that the resident perform the majority of the critical portions of one or more of the procedures.

Example: During planned pars plana vitrectomy combined with phacoemulsification of cataract, one resident performs the pars plana vitrectomy while another resident performs the cataract extraction. Each resident may record the procedure they performed as a surgeon case.

Disclaimer Statement

The stated minimum numbers of listed surgical procedures for ophthalmology residency education reflect the minimum clinical volume of these procedures which is acceptable per resident for program accreditation. Achievement of the minimum number of listed procedures is not tantamount to achievement of competence of an individual resident in a particular listed procedure. A resident may need to perform an additional number of listed procedures before that resident can be deemed competent in each procedure by the program director. Moreover, the listed procedures represent only a fraction of the total operative experience of a resident within the designated program length. The intent is to establish a minimum number of listed procedures for accreditation purposes, without detracting from the latitude that the program director must have to blend the entire educational operative experience for each resident, taking into account each resident's particular abilities.

This requirement does not supplant the requirement that, upon the resident's completion of the program, the program director should verify that the resident has demonstrated sufficient professional ability to practice competently and independently.

Minimums effective July 1, 2014 for 2015 graduates

Category	Minimums
Cataract - Total (S)	86
Laser Surgery - YAG Capsulotomy (S)	5
Laser Surgery - Laser Trabeculoplasty (S)	5
Laser Surgery - Laser Iridotomy (S)	4
Laser Surgery - Panretinal Laser Photocoagulation (S)	10
Intravitreal injections(S)	10
Corneal Keratoplasty(S+A)	5
Pterygium /other cornea,conjunctiva(S)	3
Keratorefractive Surgery - Total (S+A)	6
Strabismus - Total (S)	10
Glaucoma - Filtering / Shunting Procedures (S)	5
Retinal Vitreous - Total (S+A)	10
Oculoplastic and orbit - Total (S)	28
Oculoplastic and orbit - Eyelid Laceration (S)	3
Oculoplastic and orbit - Chalazia Excision (S)	3
Oculoplastic and orbit - Ptosis/Blepharoplasty (S)	3
Globe Trauma - Total (S)	4

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