Reviewer’s report

Title: Comparison of Resident and Glaucoma Faculty Practice Patterns in the Care of Open-Angle Glaucoma

Version: 1 Date: 6 January 2015

Reviewer: Philip Chen

Reviewer’s report:

This is an interesting manuscript and important for all who teach residents. While it is clear that residents are not doing quite as well as glaucoma subspecialty faculty in the PPP core measures, there are factors which should be mentioned/considered, that could provide more insight into the results. My apologies if some of these were already stated in the paper but I missed them.

1. What is the setting of the resident clinic: is it a general ophthalmology clinic or a resident-run glaucoma subspecialty clinic?
2. What is the faculty staffing of the resident clinic - glaucoma fellow? other fellow? non-glaucoma faculty? glaucoma faculty? What is their responsibility - see every patient? See only patients as requested by the residents, but sign off on all patient charts? Or not even required to sign off on patient charts? If they do sign off, do they comment on recommended future steps?
3. Is the resident clinic one where the residents have longterm follow up (e.g. continuity clinic), or do they rotate through for a short time, and if so for how long?
4. During the time period of record, how many patients did the residents see (by year of training) in the clinic per half day? How many patients did the average glaucoma faculty see per half day?
5. What is the average support staffing for the resident and faculty clinics: How many technicians per resident and per faculty member? What is the technician patient load (i.e. number of patients per half day divided by number of techs in that clinic) for the resident and faculty practices? How many technicians dedicated to visual field testing for the resident clinic and for the faculty practice? It is mentioned that faculty (but not residents) used an EHR, did the faculty use scribes or other physician extenders to enter data?
6. What is the insurance status of the patients in each group? Are there a higher number of uninsured patients in the resident clinic? Is it possible that some residents may have decided to conserve limited resources by, for example, not ordering CCT when it might not make an appreciable difference to patient management, or not getting a VF in a patient whose VF results were consistently unreliable?
7. Related - How many patients in each group had "unreliable" VF (take your pick of criteria - perhaps use the manufacturer’s printout notation)? On the other hand,
a higher rate of unreliable VF would typically mean a greater reliance on optic nerve imaging, which appeared not to be the case. Is access to quantitative imaging (such as OCT or HRT) the same for the resident and faculty clinics?

8. As far as target pressure, were residents given credit if the starting IOP was listed? After all, targets are simply % decreases from either the starting IOP, or the IOP at which progression has been noted.

9. While family history is important for glaucoma suspects, I am unaware of data that shows a FH of glaucoma is a risk factor for progression in a patient with known glaucoma (frankly I do not know if the PPP recommends obtaining FH in known glaucoma patients). While this is not the point of the manuscript, it is worth noting.


The point has been made in the Discussion that patient flow and work burden in the resident clinic may contribute to the study findings, but quantifying it as above wouldn’t take much effort (given the study N in each group) and would help put the findings in perspective.