

Appendix: The ICO-OCEX

The International Council of Ophthalmology Ophthalmic Clinical Evaluation Exercise

The ICO-OCEX is an observed encounter between a resident and a new patient. The evaluator should be present in the exam room for the entire interaction. The intent is to rate the resident in all the categories listed below and then provide immediate performance feedback.

Please circle or highlight the box according to the resident's performance.

Interview skills

Skill	Novice	Beginner	Competent	Not applicable ¹
Introduction	Does not introduce himself/herself.	Introduces self, does not explain role in team.	Introduces self, explains role in team.	
Chief complaint	Does not elicit a chief complaint or makes a couple of quick questions.	Elicits chief complaint but lacks relevant details.	Elicits chief complaints and details (subtle and relevant).	
History of present illness (HPI)	Does not elicit HPI.	HPI lacks relevant details.	HPI includes relevant details (e.g., timing, duration, frequency, intensity, aggravating and alleviating factors).	
Pertinent negatives ²	Does not elicit pertinent negatives.	Elicits a few or irrelevant pertinent negatives.	Elicits important pertinent negatives.	
Pain inquiry ³	Does not elicit.	Pain is elicited, not characterized.	Elicits scale rating of pain (0-10), characteristics, relieving and exacerbating factors.	
Allergies or adverse reactions to medications	Does not elicit.	Elicits medical (or environmental if appropriate) allergies or adverse reactions to medications without symptom detail.	Elicits medical (or environmental if appropriate) allergies or adverse reactions to medications with symptom detail.	
Review of systems	Does not elicit.	Elicits incomplete review of symptoms.	Elicits appropriate review of symptoms.	
Medication list (including corticosteroids) ⁴	Does not elicit.	Obtains list, no dosage/frequency.	Obtains list with dosage/frequency, duration of herbal/traditional/nonprescribed remedies.	
Past systemic history	Does not elicit.	Omits relevant details, or includes irrelevant details.	Obtains relevant details.	
Past ocular history	Does not elicit.	Omits relevant details, or includes irrelevant details.	Obtains relevant details.	
Social history/Hygienic habits ⁵	Does not elicit.	Omits relevant details, or includes irrelevant details.	Obtains relevant details.	
Family history	Does not elicit.	Omits important details, or includes irrelevant details.	Obtains important and relevant details.	

¹This includes situations where a specific item may not be appropriate/needed.

²A pertinent negative is an element of the patient's history that aids diagnosis because the patient denies that it is present (e.g., A patient with an acute floater should be asked about photopsia to help rule out a retinal tear).

³Pain inquiry is a requirement in many countries.

⁴Ophthalmic and systemic medications currently used, including nutritional supplements and other over-the-counter products.*

⁵E.g.,: occupation; tobacco, alcohol, illicit drug use; family and living situation; social security; as appropriate*

*AAO Preferred Practice Pattern: Comprehensive Adult Examination, 2015

Examination

Skill	Novice	Beginner	Competent	Not applicable
Hand/diagnostic instruments hygiene	Does not sanitize hands/diagnostic instruments.	Sanitizes hands/diagnostic instruments before encounter.	Sanitizes hands/diagnostic instruments before and after encounter.	
Visual acuity	Does not check.	Checks, but not best corrected, or only pinhole, or some incorrect aspects of technique (distance or illumination).	Checks uncorrected and best corrected, distance and near, with refraction. Correct technique.	
Pupils/RAPD	Does not check.	Does part of the pupillary exam correctly.	Checks light reaction and for RAPD, size, symmetry, and uses correct technique.	
Visual fields (confrontational)	Does not check.	Confrontational VF done, but some aspect of the technique is incorrect (position of hands, or display of target, or distance to patient).	Confrontational VF done correctly.	
Motility	Does not check.	Checks movements incompletely or with incorrect technique in some aspect.	Checks ductions, versions and alignment (cover/uncover, cross-covered testing) in primary position.	
External	Does not check.	Checks incompletely (e.g., without measurements, or only some aspects).	Checks completely as appropriate (e.g., proptosis, lids normal color and position, skin, facial sensation/strength, head posture, etc.).	
Slit lamp exam	Does not check.	Checks incompletely (e.g., does not check AC depth or aspect or gonioscopy when shallow AC, scarce illumination techniques).	Checks completely, including AC depth and aspect and gonioscopy when shallow AC, all appropriate illumination techniques.	
IOP	Does not check.	Checks but with poor technique.	Checks IOP correctly.	
Funduscopy	Does not check.	Checks but with incorrect technique/device (e.g., does not check all fundus zones, uses indirect ophthalmoscopy to assess optic disc, difficult and too long examination).	Checks fundus correctly and with appropriate technique and device.	

Interpersonal and Communication Skills

Skill	Novice	Beginner	Competent	Not applicable
Patient Comfort	No explanation to patient on examination process, no consideration of patient's disabilities.	Limited explanation. Not proper consideration of patient comfort, safety, and disabilities.	Explanation on reason for examination. Consideration of patient comfort (e.g., appropriate adjustment of slit lamp height and chair position, not switching on the slit lamp/indirect full illumination on patient eye, putting chair unit back to zero after examination), safety, and disabilities.	
Empathy	Lacks empathy.	Appears superficially interested in patient/family's concerns.	Demonstrates understanding of patient/family's concerns, provides appropriate comfort.	
Respectfulness (e.g., eye contact while listening, gestures)	Disrespectful; inappropriate body language.	Curt, does not listen to all of patient/family's questions/concerns; questionable body language.	Listens to patient/family, responds to patient/family questions/concerns. Appropriate body language.	
Understandability	Constantly uses medical jargon the patient does not understand.	Occasionally uses medical jargon the patient does not understand.	Avoids or explains medical terms when used and makes sure he/she is understood (e.g., asking, rephrasing).	
Explanation of findings	Provides no explanation.	Cursory explanation.	Effectively and efficiently explained all pertinent findings.	
Explained diagnosis	Provides no explanation.	Cursory explanation.	Thoroughly explained diagnosis.	
Explained plan/options	Provides no explanation.	Cursory explanation.	Thoroughly explained plan (including alternate options, possible pros and cons/complications). If interventions are indicated, fills in and explains informed consent and obtains signature, when appropriate.	
Asked if patient had questions	Does not ask.	Asked but did not answer completely.	Asked and answered questions thoroughly. If interventions are indicated, fills in and explains informed consent and obtains signature, when appropriate.	

Case Presentation

Skill	Novice	Beginner	Competent	Not applicable
Conciseness, clarity, organization	Unintelligible.	Somewhat disorganized.	Clear, concise, organized.	
Pertinent facts (positives and negatives)	Omits pertinent facts.	Omits minor supporting facts.	Covers all pertinent facts.	
Differential diagnosis	Does not mention.	Provides basic but incomplete differential.	Provides appropriate and thorough differential.	
Appropriate plan	Does not mention.	Provides basic, correct but incomplete or unrealistic plan.	Provides appropriate and realistic plan, asks for patient's consent.	
Response to attending	Inappropriate.	Listens but little response.	Listens and responds appropriately and with an improvement plan.	

Specific feedback comments for the resident:

Name of resident:

Name of assessor: