

## **..FAQ –Minimum Operative Numbers**

**How were the minimum operative numbers determined?** In 2006 the RRC revisited the minimum operative numbers. As a surgical subspecialty, ophthalmology requires the development of competence in key surgical procedures and at least familiarity in others. While the RRC recognizes that achievement of minimum operative numbers does not assure individual competency, the minimums serve as a surrogate for measurement of adequacy of surgical volume offered by a program to its residents. The new minimums were set at the 20<sup>th</sup> percentile of procedures performed nationwide by residents. On review the past 2 years the RRC has decided not to change the minimums even though the numbers of surgeries nationwide has increased according to the Resident Case Log System.

**Why have surgical categories with a very low minimum (e.g. 1 or 3)?** We recognize that residents will not achieve *competency* after only performing a handful of procedures in a particular discipline, but we require that residents do have *familiarity* with the procedures in each subspecialty. Familiarity can be defined as the ability to perform a procedure with assistance. The program director and faculty are the final arbiters for the assessment of a resident's competency for a procedure.

**Why have a total surgeon plus assistant minimum number of procedures?** Instead of requiring a certain number of procedures as an assistant, the RRC decided to use this measure as a surrogate for overall surgical volume for a program.

**Does each resident have to meet the minimum operative numbers to graduate?** No. The program's per resident average should meet each minimum operative number. However, each resident must demonstrate sufficient competence to enter practice without direct supervision. In addition, the program director should ensure that residents have equivalent educational experiences (in general, there should not be wide variations in residents' surgical numbers). The program should also have a broad range of surgical experience, a progressive, graduated surgical experience (residents should assist on most procedures before acting as primary surgeon), and have appropriate supervision in surgery. A program may be cited for non-equivalent experience, lack of breadth of surgical experience, lack of a progressive, graduated experience, and inappropriate supervision despite meeting the minimum operative numbers. AND there must be an assessment of surgical competency.

**What is the definition of a resident acting as primary surgeon? How do I count multiple procedures on a single patient?** See "Definition of a Surgeon" under the Program Resources tab of the Ophthalmology Review Committee page [here](#).