

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Ophthalmology**

3
4 **Common Program Requirements are in BOLD**

5
6 Effective: July 1, 2007
7

8 Introduction
9

10 Int.A. ~~Definition and Scope of the Specialty Residency training programs in~~
11 ~~ophthalmology should provide a stable, well-coordinated, and progressive~~
12 ~~educational experience in the entire spectrum of ophthalmic diseases and ocular~~
13 ~~surgery. Residents in ophthalmology should develop diagnostic, therapeutic, and~~
14 ~~manual skills, as well as sound judgment in the application of such skills. Each~~
15 ~~resident must have major technical and patient care responsibilities in order to~~
16 ~~provide an adequate base for a comprehensive ophthalmic practice. That base~~
17 ~~must include: optics, visual physiology, and corrections of refractive errors;~~
18 ~~retina, vitreous, and uvea; neuro-ophthalmology; pediatric ophthalmology and~~
19 ~~strabismus; external disease and cornea; glaucoma, cataract, and anterior~~
20 ~~segment; oculoplastic surgery and orbital diseases; and ophthalmic pathology. A~~
21 ~~residency in ophthalmology is an educational experience designed to develop~~
22 ~~clinical diagnostic, therapeutic and surgical skills as a comprehensive~~
23 ~~ophthalmologist. Each resident is given progressive responsibility for patient care~~
24 ~~and safety.~~
25

26 Int.B. ~~Duration and Scope of Education The length of training in ophthalmology must~~
27 ~~be at least 36 calendar months, including appropriate short periods for vacation,~~
28 ~~special assignments, or exceptional individual circumstances approved by the~~
29 ~~program director. The educational program in ophthalmology must be 36 months~~
30 ~~in length.~~
31

32 Int.B.2. ~~Any program that extends the length of training beyond 36 calendar~~
33 ~~months must present an educational rationale that is consonant with the~~
34 ~~program requirements and the objectives for residency training. Approval~~
35 ~~for an extended curriculum must be obtained prior to implementation and~~
36 ~~at each subsequent review. Prior to entry in the program, each resident~~
37 ~~must be notified in writing of the required curriculum length.~~
38

39 Int.B.3. ~~The length of time of residency training for a particular resident may be~~
40 ~~extended by the program director if that resident needs additional training.~~
41 ~~If the extension is six months or less, the program director must notify the~~
42 ~~Review Committee of the extension, and must describe the proposed~~
43 ~~curriculum for that resident and the measures taken to minimize any~~
44 ~~impact on other residents. Any changes in rotation schedules should be~~
45 ~~included in the notification. Express permission must be obtained in~~
46 ~~advance from the Review Committee if the extension is greater than six~~
47 ~~months. (See Section II.A.4.r. below)~~
48

49 **I. Institutions**
50

- 51 I.A. Sponsoring Institution
52
53 One sponsoring institution must assume ultimate responsibility for the
54 program, as described in the Institutional Requirements, and this
55 responsibility extends to resident assignments at all participating sites.
56
57 The sponsoring institution and the program must ensure that the program
58 director has sufficient protected time and financial support for his or her
59 educational and administrative responsibilities to the program.
60
- 61 I.A.1. The majority of the required clinical and didactic educational experiences
62 must occur at the sponsoring institution. ~~and be coordinated by the~~
63 ~~program director at this institution.~~
64
- 65 I.B. Participating Sites
66
- 67 I.B.1. There must be a program letter of agreement (PLA) between the
68 program and each participating site providing a required
69 assignment. The PLA must be renewed at least every five years.
70
71 The PLA should:
72
- 73 I.B.1.a) identify the faculty who will assume both educational and
74 supervisory responsibilities for residents;
75
- 76 I.B.1.b) specify their responsibilities for teaching, supervision, and
77 formal evaluation of residents, as specified later in this
78 document;
79
- 80 I.B.1.c) specify the duration and content of the educational
81 experience; and,
82
- 83 I.B.1.d) state the policies and procedures that will govern resident
84 education during the assignment.
85
- 86 I.B.1.e) ~~outline the educational goals and objectives to be attained by the~~
87 ~~resident during the assignment.~~
88
- 89 I.B.2. The program director must submit any additions or deletions of
90 participating sites routinely providing an educational experience,
91 required for all residents, of one month full time equivalent (FTE) or
92 more through the Accreditation Council for Graduate Medical
93 Education (ACGME) Accreditation Data System (ADS).
94
- 95 I.B.3. ~~The participating site should provide resources not otherwise available to~~
96 ~~the program.~~
97
- 98 I.B.4. Assignments at participating sites must be ~~of sufficient length~~ at least one
99 month in length to ensure a quality educational experience, and must
100 provide opportunities for continuity of care. ~~should provide sufficient~~
101 ~~opportunity for continuity of care. Although the number of participating~~

102 sites may vary with the specialties' needs, all participating sites must
103 demonstrate the ability to promote the program goals, and educational
104 and peer activities. Exceptions must be justified and approved in
105 advance.

106
107 I.B.5. If the distance between Participating sites should not be so distant from
108 and the sponsoring institution is great enough as to make it difficult for
109 residents to regularly attend to prevent residents' regular attendance at
110 the didactic and clinical conferences. ~~or~~ If the rotation otherwise
111 precludes attendance, the program director must demonstrate that each
112 resident has a formal educational experience that fulfills the Program
113 Requirements.

114
115 I.B.6. ~~There should be formal teaching case presentations at each participating~~
116 ~~site to ensure optimal utilization of patients for teaching purposes.~~
117 ~~Alternatively, cases should be brought from participating sites to the~~
118 ~~sponsoring institution for presentation if formal teaching case~~
119 ~~presentations are held only there.~~

120
121 I.B.7. Rotations outside the United States ~~shall not be used to meet minimum~~
122 ~~educational standards~~ must comply with the following:

123
124 I.B.7.a) A rotation outside the United State must be no longer than one
125 month in length.

126
127 I.B.7.b) Surgical procedures completed during a foreign rotation must not
128 be counted toward the required minimal number of procedures.

129
130 **II. Program Personnel and Resources**

131
132 **II.A. Program Director**

133
134 **II.A.1. There must be a single program director with authority and**
135 **accountability for the operation of the program. The sponsoring**
136 **institution's GMEC must approve a change in program director.**
137 **After approval, the program director must submit this change to the**
138 **ACGME via the ADS.**

139
140 II.A.1.a) ~~The program director should be a member of the medical staff of~~
141 ~~the sponsoring or integrated institution. The institution must~~
142 ~~ensure that the program director is given sufficient authority,~~
143 ~~financial support, and facilities by the governing body of the~~
144 ~~sponsoring institution to permit him or her to organize and~~
145 ~~supervise the following activities of the training program: resident~~
146 ~~selection and evaluation, resident instruction, patient~~
147 ~~management, research, and initiation of recommendations for staff~~
148 ~~recruitment.~~

149
150 II.A.1.b) ~~The program director should~~ must have be appointed for a term of
151 at least three years.

152

- 153 **II.A.2.** **The program director should continue in his or her position for a**
154 **length of time adequate to maintain continuity of leadership and**
155 **program stability.**
156
- 157 **II.A.3.** **Qualifications of the program director must include:**
158
- 159 **II.A.3.a)** **requisite specialty expertise and documented educational**
160 **and administrative experience acceptable to the Review**
161 **Committee;**
162
- 163 **II.A.3.b)** **current certification in the specialty by the American Board of**
164 **Ophthalmology, or specialty qualifications that are acceptable**
165 **to the Review Committee; and,**
166
- 167 **II.A.3.c)** **current medical licensure and appropriate medical staff**
168 **appointment.**
169
- 170 **II.A.3.d)** staff appointment within the primary clinical site.
171
- 172 **II.A.3.e)** at least three years of experience in the specialty following
173 completion of his or her most recent graduate medical education
174 experience.
175
- 176 **II.A.4.** **The program director must administer and maintain an educational**
177 **environment conducive to educating the residents in each of the**
178 **ACGME competency areas. The program director must:**
179
- 180 **II.A.4.a)** **oversee and ensure the quality of didactic and clinical**
181 **education in all sites that participate in the program;**
182
- 183 **II.A.4.b)** **approve a local director at each participating site who is**
184 **accountable for resident education;**
185
- 186 **II.A.4.c)** **approve the selection of program faculty as appropriate;**
187
- 188 **II.A.4.d)** **evaluate program faculty and approve the continued**
189 **participation of program faculty based on evaluation;**
190
- 191 **II.A.4.e)** **monitor resident supervision at all participating sites;**
192
- 193 **II.A.4.f)** **prepare and submit all information required and requested by**
194 **the ACGME, including but not limited to the program**
195 **information forms and annual program resident updates to**
196 **the ADS, and ensure that the information submitted is**
197 **accurate and complete;**
198
- 199 **II.A.4.g)** **provide each resident with documented semiannual**
200 **evaluation of performance with feedback;**
201
- 202 **II.A.4.h)** **ensure compliance with grievance and due process**
203 **procedures as set forth in the Institutional Requirements and**

204		implemented by the sponsoring institution;
205		
206	II.A.4.i)	provide verification of residency education for all residents, including those who leave the program prior to completion;
207		
208		
209	II.A.4.j)	implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:
210		
211		
212		
213		
214	II.A.4.j).(1)	distribute these policies and procedures to the residents and faculty;
215		
216		
217	II.A.4.j).(2)	monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
218		
219		
220		
221	II.A.4.j).(3)	adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
222		
223		
224	II.A.4.j).(4)	if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.
225		
226		
227		
228	II.A.4.k)	monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
229		
230		
231		
232	II.A.4.l)	comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;
233		
234		
235		
236		
237	II.A.4.m)	be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;
238		
239		
240		
241	II.A.4.n)	obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:
242		
243		
244		
245	II.A.4.n).(1)	all applications for ACGME accreditation of new programs;
246		
247		
248	II.A.4.n).(2)	changes in resident complement;
249		
250	II.A.4.n).(3)	major changes in program structure or length of training;
251		
252		
253	II.A.4.n).(4)	progress reports requested by the Review Committee;
254		

255	II.A.4.n).(5)	responses to all proposed adverse actions;
256		
257	II.A.4.n).(6)	requests for increases or any change to resident duty hours;
258		
259		
260	II.A.4.n).(7)	voluntary withdrawals of ACGME-accredited programs;
261		
262		
263	II.A.4.n).(8)	requests for appeal of an adverse action;
264		
265	II.A.4.n).(9)	appeal presentations to a Board of Appeal or the ACGME; and,
266		
267		
268	II.A.4.n).(10)	proposals to ACGME for approval of innovative educational approaches.
269		
270		
271	II.A.4.o)	obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:
272		
273		
274		
275	II.A.4.o).(1)	program citations, and/or
276		
277	II.A.4.o).(2)	request for changes in the program that would have significant impact, including financial, on the program or institution.
278		
279		
280		
281	II.A.4.p)	ensure that all residents have equivalent <u>educational opportunities</u> educational experiences;
282		
283		
284	II.A.4.q)	seek approval from the Review Committee for a required rotation of six months or more to any site other than the primary teaching site;
285		
286		
287		
288	II.A.4.r)	seek approval from the Review Committee for any change in resident complement, either the total number or the number at any level. If the change in resident complement results from an extension of a single resident's training, and is not greater than six months, only prior notification of the Review Committee is required;
289		
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294		
295	II.A.4.s)	prepare <u>and distribute a explicit written descriptions of the lines of program policy describing resident responsibility for the care of patients, and the faculty's responsibility for supervision.</u> make these clear to all members of teaching teams. Residents must be provided with rapid, reliable systems for communication with and appropriate involvement of supervisory physicians in a manner appropriate for quality patient care and educational programs;
296		
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302		
303	II.A.4.t)	ensure that residents are educated in basic and clinical sciences through a structured and regularly scheduled series of conferences and lectures, including but not limited to those topics
304		
305		

- 306 included in Definition and Scope of Specialty, above. This series
307 should include a minimum of 360 hours during the 36-month
308 training program, at least 200 hours of which are intramural. In
309 addition, a minimum of six hours per month should be devoted to
310 case presentation conferences (e.g., Grand Rounds, Continuous
311 Quality Improvement) attended by several faculty and a majority of
312 residents. The program director or designee is responsible for
313 documenting residents' attendance at conferences;
314
- 315 II.A.4.u) ensure the residents are entering their operative cases into the
316 resident case log system; and,
317
- 318 II.A.4.v) verify the surgical experiences of each resident, including the
319 number of cases in each category where the resident has served
320 as the primary surgeon or the assistant surgeon. This
321 documentation must be provided to the Review Committee on its
322 program information forms; individual resident logs must be
323 available at the time of the site visit.
324
- 325 **II.B. Faculty**
326
- 327 **II.B.1. At each participating site, there must be a sufficient number of**
328 **faculty with documented qualifications to instruct and supervise all**
329 **residents at that location.**
330
331 **The faculty must:**
332
- 333 **II.B.1.a) devote sufficient time to the educational program to fulfill**
334 **their supervisory and teaching responsibilities; and to**
335 **demonstrate a strong interest in the education of residents,**
336 **and**
337
- 338 **II.B.1.b) administer and maintain an educational environment**
339 **conducive to educating residents in each of the ACGME**
340 **competency areas.**
341
- 342 **II.B.2. The physician faculty must have current certification in the specialty**
343 **by the American Board of Ophthalmology, or possess qualifications**
344 **acceptable to the Review Committee.**
345
- 346 **II.B.2.a) The faculty must have subspecialty expertise across a broad**
347 **range of ophthalmic disciplines, including contact lens, cornea,**
348 **glaucoma, neuro-ophthalmology, ophthalmic plastic and**
349 **reconstructive surgery, pediatric ophthalmology and strabismus,**
350 **refractive surgery, retina, and visual rehabilitation, those described**
351 **in Introduction Section A. of these program requirements. Such**
352 **expertise will usually be acquired by subspecialty fellowship**
353 **training.**
354
- 355 **II.B.3. The physician faculty must possess current medical licensure and**
356 **appropriate medical staff appointment.**

- 357
358 **II.B.4.** **The nonphysician faculty must have appropriate qualifications in**
359 **their field and hold appropriate institutional appointments.**
360
- 361 **II.B.5.** **The faculty must establish and maintain an environment of inquiry**
362 **and scholarship with an active research component.**
363
- 364 **II.B.5.a)** **The faculty must regularly participate in organized clinical**
365 **discussions, rounds, journal clubs, and conferences.**
366
- 367 **II.B.5.b)** **Some members of the faculty should also demonstrate**
368 **scholarship by one or more of the following:**
369
- 370 **II.B.5.b).(1)** **peer-reviewed funding;**
371
- 372 **II.B.5.b).(2)** **publication of original research or review articles in**
373 **peer-reviewed journals, or chapters in textbooks;**
374
- 375 **II.B.5.b).(3)** **publication or presentation of case reports or clinical**
376 **series at local, regional, or national professional and**
377 **scientific society meetings; or,**
378
- 379 **II.B.5.b).(4)** **participation in national committees or educational**
380 **organizations.**
381
- 382 **II.B.5.c)** **Faculty should encourage and support residents in scholarly**
383 **activities.**
384
- 385 **II.C.** **Other Program Personnel**
386
- 387 **The institution and the program must jointly ensure the availability of all**
388 **necessary professional, technical, and clerical personnel for the effective**
389 **administration of the program.**
390
- 391 **II.D.** **Resources**
392
- 393 **The institution and the program must jointly ensure the availability of**
394 **adequate resources for resident education, as defined in the specialty**
395 **program requirements.**
396
- 397 **II.D.1.** **Clinic**
398
- 399 **II.D.1.a)** **The outpatient area of each participating site must have a**
400 **minimum of one fully-equipped examining lane for each resident in**
401 **the clinic.**
402
- 403 **II.D.1.b)** **There must be access to ~~current appropriate~~ diagnostic**
404 **equipment. This must include ~~should encompass~~ equipment**
405 **designed for keratometry, ophthalmic photography (including**
406 **fluorescein angiography), pachymetry, perimetry, retinal**
407 **electrophysiology, and ultrasonography, ~~keratometry, and retinal~~**

- 408 electrophysiology, as well as other appropriate equipment.
- 409
- 410 II.D.2. Operating Room Facilities ~~The~~ There must be surgical facilities for
411 ophthalmology resident training at each participating site must include at
412 least one operating room fully-equipped for ophthalmic surgery, including
413 that includes an operating microscope.
- 414
- 415 II.D.3. Inpatient Facilities ~~There must be inpatient facilities with access to~~
416 sufficient space and beds for good patient care. An eye examination room
417 with a slit lamp should be easily accessible. Each inpatient facility must
418 have an easily accessible eye examination room with a slit lamp.
- 419
- 420 II.D.4. ~~Residents must have access to a~~ A surgical skills development facility
421 resource (e.g., a wet lab, materials or simulators) must be available, and
422 instruction within the program.
- 423
- 424 II.D.5. Each resident must be provided with a ~~The volume and variety of clinical~~
425 ophthalmological problems in children and adults, must be sufficient to
426 afford each resident a graduated and supervised experience with the
427 entire spectrum of ophthalmic diseases so that the resident may develop
428 required diagnostic, therapeutic, and manual skills and judgment as to
429 their appropriate use.
- 430
- 431 II.D.6. Residents must be provided with rapid, reliable systems for
432 communication with, and involvement of, physician faculty.
- 433
- 434 **II.E. Medical Information Access**
- 435
- 436 **Residents must have ready access to specialty-specific and other**
437 **appropriate reference material in print or electronic format. Electronic**
438 **medical literature databases with search capabilities should be available.**
- 439
- 440 **III. Resident Appointments**
- 441
- 442 **III.A. Eligibility Criteria**
- 443
- 444 **The program director must comply with the criteria for resident eligibility**
445 **as specified in the Institutional Requirements.**
- 446
- 447 III.A.1. Prior to appointment in the program, all residents ~~All applicants entering~~
448 ophthalmology training programs must have taken successfully
449 completed a post-graduate clinical year (PGY-1) in a program accredited
450 by either the ACGME or the Royal College of Physicians and Surgeons of
451 Canada.
- 452
- 453 III.A.1.a) The PGY-1 year must be in one of the following specialties:
454 include training in which the resident has primary responsibility for
455 patient care in fields such as emergency medicine, family
456 medicine, internal medicine, neurology, obstetrics and
457 gynecology, pediatrics, surgery, family medicine, or emergency
458 medicine, or the transitional year.

- 459
460 III.A.1.b) At minimum, six months of this year must be a broad experience
461 in direct patient care. During the PGY-1 the resident must have
462 primary responsibilities for patient care.
463
464 III.A.1.c) A summative evaluation of each resident must accompany entry
465 into the program.
466
467 III.A.2. Prior to appointment in the program, each resident must be notified in
468 writing of the required program length.
469
470 **III.B. Number of Residents**
471
472 **The program director may not appoint more residents than approved by the**
473 **Review Committee, unless otherwise stated in the specialty-specific**
474 **requirements. The program’s educational resources must be adequate to**
475 **support the number of residents appointed to the program.**
476
477 III.B.1. ~~A critical mass or minimum number of residents is essential to provide an~~
478 ~~opportunity for meaningful interaction throughout the training period. Each~~
479 ~~program must be structured to have at least a minimum of two residents~~
480 ~~in each year of training education.~~
481
482 **III.C. Resident Transfers**
483
484 **III.C.1. Before accepting a resident who is transferring from another**
485 **program, the program director must obtain written or electronic**
486 **verification of previous educational experiences and a summative**
487 **competency-based performance evaluation of the transferring**
488 **resident.**
489
490 **III.C.2. A program director must provide timely verification of residency**
491 **education and summative performance evaluations for residents**
492 **who leave the program prior to completion.**
493
494 **III.D. Appointment of Fellows and Other Learners**
495
496 **The presence of other learners (including, but not limited to, residents from**
497 **other specialties, subspecialty fellows, PhD students, and nurse**
498 **practitioners) in the program must not interfere with the appointed**
499 **residents’ education. The program director must report the presence of**
500 **other learners to the DIO and GMEC in accordance with sponsoring**
501 **institution guidelines.**
502
503 **IV. Educational Program**
504
505 **IV.A. The curriculum must contain the following educational components:**
506
507 **IV.A.1. Overall educational goals for the program, which the program must**
508 **distribute to residents and faculty annually;**
509

- 510 **IV.A.2.** **Competency-based goals and objectives for each assignment at**
511 **each educational level, which the program must distribute to**
512 **residents and faculty annually, in either written or electronic form.**
513 **These should be reviewed by the resident at the start of each**
514 **rotation;**
- 515
- 516 **IV.A.3.** **Regularly scheduled didactic sessions;**
- 517
- 518 IV.A.3.a) There should be formal teaching case presentations at each
519 participating site.
- 520
- 521 IV.A.3.a).(1) A minimum of six hours per month must be devoted to
522 case presentation conferences (e.g., Grand Rounds,
523 Continuous Quality Improvement, Morbidity and Mortality)
524 attended by several faculty and a majority of residents.
- 525
- 526 IV.A.3.b) Residents must be educated in basic and clinical sciences through
527 a structured and regularly-scheduled series of conferences and
528 lectures.
- 529
- 530 IV.A.3.b).(1) This series must include a minimum of 360 hours during
531 the 36-month education program, with 200 hours of this
532 total being intramural.
- 533
- 534 IV.A.3.b).(2) Resident and faculty attendance at didactic sessions must
535 be documented.
- 536
- 537 | IV.A.3.b).(3) Topics must include: cataract surgery, contact lenses,
538 cornea and external disease, eyelid abnormalities,
539 glaucoma, neuro-ophthalmology, ocular trauma, optics and
540 general fraction, orbital disease and ophthalmic plastic
541 surgery, pathology, pediatric ophthalmology and
542 strabismus, systemic disease consults, uveitis, visual
543 rehabilitation and refractive surgery, and vitreo-retinal
544 diseases.
- 545
- 546 IV.A.3.b).(4) Residents must have documented didactic sessions in
547 each of the following: advocacy, ethics, practice
548 management, and socio-economics.
- 549
- 550 IV.A.3.c) Residents must have surgical skills instruction in a surgical skills
551 development resource.
- 552
- 553 **IV.A.4.** **Delineation of resident responsibilities for patient care, progressive**
554 **responsibility for patient management, and supervision of residents**
555 **over the continuum of the program; and,**
- 556
- 557 **IV.A.5.** **ACGME Competencies**
- 558
- 559 **The program must integrate the following ACGME competencies**
560 **into the curriculum:**

561		
562	IV.A.5.a)	Patient Care
563		
564		Residents must be able to provide patient care that is
565		compassionate, appropriate, and effective for the treatment of
566		health problems and the promotion of health. Residents:
567		
568	IV.A.5.a).(1)	will understand, in particular, the care of the surgical
569		patient, to have the medical and technical knowledge, as
570		well as the skills, necessary to care for the surgical patient.
571		Included here is the understanding of the preoperative
572		ophthalmic and general medical evaluation and
573		assessment of indications for surgery and surgical risks
574		and benefits, informed consent, intraoperative skills, local
575		and general anesthetic considerations, acute and longer-
576		term postoperative care, and management of systemic and
577		ocular complications that may be associated with surgery
578		and anesthesia;
579		
580	IV.A.5.a).(2)	should be responsible for the care of an adequate number
581		of outpatients who represent a broad range of ophthalmic
582		diseases. There must be appropriate faculty supervision of
583		the residents in all outpatient clinic visits. Appropriate
584		faculty supervision occurs when the faculty provides direct
585		supervision (resident primarily sees the patient, faculty
586		sees patient with resident, and collaborative effort
587		determines management), or when the faculty is on site
588		and readily available to see any patient upon request of
589		the resident;
590		
591	IV.A.5.a).(3)	should have access to a simulated operative setting (e.g.,
592		wet lab) to allow them to develop proficiency in basic
593		surgical techniques;
594		
595	IV.A.5.a).(4)	must perform and assist at a sufficient number of surgeries
596		to become skilled as comprehensive ophthalmic surgeons.
597		While the total number of operative procedures to be
598		performed is not specified, the Review Committee will
599		consider a minimum number of key procedures as
600		acceptable. (The minimum numbers are listed on the
601		ACGME website); and,
602		
603	IV.A.5.a).(5)	must have graduated technical and patient care
604		responsibilities in the surgery (including laser surgery) of
605		cataract, strabismus, cornea, glaucoma, retina/vitreous,
606		oculoplastic, and trauma to provide an adequate base for a
607		comprehensive ophthalmic practice.
608		
609	IV.A.5.a).(6)	<u>must demonstrate competence in patient care including:</u>
610		
611	IV.A.5.a).(6).(a)	<u>evaluating and assessing preoperative ophthalmic</u>

612		<u>and general medical indications for surgery and surgical risks and benefits;</u>
613		
614		
615	IV.A.5.a).(6).(b)	<u>intraoperative skills;</u>
616		
617	IV.A.5.a).(6).(c)	<u>managing systemic and ocular complications that may be associated with surgery and anesthesia;</u>
618		
619		
620	IV.A.5.a).(6).(d)	<u>obtaining informed consent;</u>
621		
622	IV.A.5.a).(6).(e)	<u>performing ophthalmic procedures as primary surgeon, including:</u>
623		
624		
625	IV.A.5.a).(6).(e).(i)	<u>cataract;</u>
626		
627	IV.A.5.a).(6).(e).(ii)	<u>strabismus;</u>
628		
629	IV.A.5.a).(6).(e).(iii)	<u>cornea;</u>
630		
631	IV.A.5.a).(6).(e).(iv)	<u>glaucoma;</u>
632		
633	IV.A.5.a).(6).(e).(v)	<u>glaucoma laser;</u>
634		
635	IV.A.5.a).(6).(e).(vi)	<u>retina/vitreous;</u>
636		
637	IV.A.5.a).(6).(e).(vii)	<u>oculoplastics/orbit; and</u>
638		
639	IV.A.5.a).(6).(e).(viii)	<u>globe trauma.</u>
640		
641	IV.A.5.a).(6).(f)	<u>providing acute and long term postoperative care;</u>
642		<u>and,</u>
643		
644	IV.A.5.a).(6).(g)	<u>using local and general anesthetics.</u>
645		

IV.A.5.b)

Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents:

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653	IV.A.5.b).(1)	should have a minimum of 36 hours of experience in gross and microscopic examination of pathological specimens, including the residents' review of pathological specimens of their patients with a pathologist who has demonstrated expertise in ophthalmic pathology. The experience with such a pathologist may take place intramurally or extramurally at a laboratory considered by the Review Committee to be capable of providing such training, and
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661		
662	IV.A.5.b).(2)	should have documented experiences in practice

663 management, ethics, advocacy, visual rehabilitation, and
664 socio-economics.

665
666 IV.A.5.b).(3) must demonstrate competence in their knowledge of the
667 basic and clinical sciences specific to ophthalmology.
668

669 **IV.A.5.c) Practice-based Learning and Improvement**
670

671 Residents must demonstrate the ability to investigate and
672 evaluate their care of patients, to appraise and assimilate
673 scientific evidence, and to continuously improve patient care
674 based on constant self-evaluation and life-long learning.
675 Residents are expected to develop skills and habits to be able
676 to meet the following goals:
677

678 IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's
679 knowledge and expertise;

680
681 IV.A.5.c).(2) set learning and improvement goals;

682
683 IV.A.5.c).(3) identify and perform appropriate learning activities;

684
685 IV.A.5.c).(4) systematically analyze practice using quality
686 improvement methods, and implement changes with
687 the goal of practice improvement;

688
689 IV.A.5.c).(5) incorporate formative evaluation feedback into daily
690 practice;

691
692 IV.A.5.c).(6) locate, appraise, and assimilate evidence from
693 scientific studies related to their patients' health
694 problems;

695
696 IV.A.5.c).(7) use information technology to optimize learning; and,

697
698 IV.A.5.c).(8) participate in the education of patients, families,
699 students, residents and other health professionals.

700
701 **IV.A.5.d) Interpersonal and Communication Skills**
702

703 Residents must demonstrate interpersonal and
704 communication skills that result in the effective exchange of
705 information and collaboration with patients, their families,
706 and health professionals. Residents are expected to:
707

708 IV.A.5.d).(1) communicate effectively with patients, families, and
709 the public, as appropriate, across a broad range of
710 socioeconomic and cultural backgrounds;

711
712 IV.A.5.d).(2) communicate effectively with physicians, other health
713 professionals, and health related agencies;

714		
715	IV.A.5.d).(3)	work effectively as a member or leader of a health care team or other professional group;
716		
717		
718	IV.A.5.d).(4)	act in a consultative role to other physicians and health professionals; and,
719		
720		
721	IV.A.5.d).(5)	maintain comprehensive, timely, and legible medical records, if applicable.
722		
723		
724	IV.A.5.d).(6)	receive experience in providing inpatient and outpatient consultation during the course of three years of education.
725		
726		
727	IV.A.5.e)	Professionalism
728		
729		Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:
730		
731		
732		
733	IV.A.5.e).(1)	compassion, integrity, and respect for others;
734		
735	IV.A.5.e).(2)	responsiveness to patient needs that supersedes self-interest;
736		
737		
738	IV.A.5.e).(3)	respect for patient privacy and autonomy;
739		
740	IV.A.5.e).(4)	accountability to patients, society and the profession; and,
741		
742		
743	IV.A.5.e).(5)	sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.
744		
745		
746		
747		
748	IV.A.5.f)	Systems-based Practice
749		
750		Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:
751		
752		
753		
754		
755		
756	IV.A.5.f).(1)	work effectively in various health care delivery settings and systems relevant to their clinical specialty;
757		
758		
759		
760	IV.A.5.f).(2)	coordinate patient care within the health care system relevant to their clinical specialty;
761		
762		
763	IV.A.5.f).(3)	incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-
764		

765		based care as appropriate;
766		
767	IV.A.5.f).(4)	advocate for quality patient care and optimal patient care systems;
768		
769		
770	IV.A.5.f).(5)	work in interprofessional teams to enhance patient safety and improve patient care quality; and,
771		
772		
773	IV.A.5.f).(6)	participate in identifying system errors and implementing potential systems solutions.
774		
775		
776	IV.A.6.	<u>Curriculum Organization and Resident Experiences</u>
777		
778	IV.A.6.a)	<u>Residents must have experiences in providing continuity patient care.</u>
779		
780		
781	IV.A.6.a).(1)	should <u>Residents must</u> participate in a minimum of 3,000 outpatient visits in which the resident performs a substantial portion of the examination <u>with 1,000 of those under direct supervision.</u>
782		
783		
784		
785		
786	IV.A.6.a).(1).(a)	<u>Direct faculty supervision must include examining the patient with the resident and discussing the management of the patient with the resident before the patient leaves the clinic.</u>
787		
788		
789		
790		
791	IV.A.6.b)	<u>Education in ophthalmic pathology must include conferences and/or study sets, and must cover the full spectrum of ophthalmic disease.</u>
792		
793		
794		
795	IV.A.6.b).(1)	<u>Each resident must participate in grossing and microscopic evaluation of specimens they directly obtained.</u>
796		
797		
798	IV.A.6.b).(2)	<u>Any physician faculty with demonstrated expertise in ophthalmic pathology must direct ophthalmic pathology education for residents.</u>
799		
800		
801		
802	IV.A.6.c)	<u>Each resident must enter his or her surgical cases into the ACGME Case Log System, including those for which he or she is the primary surgeon as well as those for which he or she is first assistant.</u>
803		
804		
805		
806		
807	IV.A.6.d)	<u>Each resident must perform a minimum number of procedures, as determined by the Committee, by the completion of the program.</u>
808		
809		
810	IV.B.	Residents' Scholarly Activities
811		
812	IV.B.1.	The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.
813		
814		
815		

- 816 **IV.B.2. Residents should participate in scholarly activity.**
817
- 818 **IV.B.3. The sponsoring institution and program should allocate adequate**
819 **educational resources to facilitate resident involvement in scholarly**
820 **activities.**
821
- 822 **V. Evaluation**
823
- 824 **V.A. Resident Evaluation**
825
- 826 **V.A.1. Formative Evaluation**
827
- 828 **V.A.1.a) The faculty must evaluate resident performance in a timely**
829 **manner during each rotation or similar educational**
830 **assignment, and document this evaluation at completion of**
831 **the assignment.**
832
- 833 **V.A.1.b) The program must:**
834
- 835 **V.A.1.b).(1) provide objective assessments of competence in**
836 **patient care, medical knowledge, practice-based**
837 **learning and improvement, interpersonal and**
838 **communication skills, professionalism, and systems-**
839 **based practice;**
840
- 841 **V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients,**
842 **self, and other professional staff);**
843
- 844 **V.A.1.b).(3) document progressive resident performance**
845 **improvement appropriate to educational level; and,**
846
- 847 **V.A.1.b).(4) provide each resident with documented semiannual**
848 **evaluation of performance with feedback.**
849
- 850 **V.A.1.b).(4).(a) The program director should discuss this evaluation**
851 **with the resident in person semiannually.**
852
- 853 **V.A.1.c) The evaluations of resident performance must be accessible**
854 **for review by the resident, in accordance with institutional**
855 **policy.**
856
- 857 **V.A.1.d) Assessment ~~will~~must include the care of the surgical patient.**
858
- 859 **V.A.1.e) Assessment must include verification of the surgical experiences**
860 **of each resident, including the number of completed cases in each**
861 **category where the resident has served as the primary surgeon or**
862 **the assistant surgeon.**
863
- 864 **V.A.1.f) Assessment should include ~~an annually required annual~~**
865 **administration of an objective test as a component of evaluating**
866 **each resident's cognitive ability. ~~While each program may utilize~~**

867 its own test instruments,
868
869 V.A.1.f).(1) Use of the Ophthalmic Knowledge Assessment Program
870 (OKAP) examination is an example suggested. However,
871 results of the OKAP examination should not be used as
872 the only criterion of resident performance. An analysis of
873
874 V.A.1.f).(2) The results of these tests should must only be used to
875 guide the faculty in assessing the strengths and
876 weaknesses of individual residents and guide the
877 development of needed remediation, as well as to assess
878 the strengths and weaknesses of the program. Test results
879 must not be used for decisions regarding resident
880 promotion or graduation.
881
882 **V.A.2. Summative Evaluation**
883
884 **The program director must provide a summative evaluation for each**
885 **resident upon completion of the program. This evaluation must**
886 **become part of the resident’s permanent record maintained by the**
887 **institution, and must be accessible for review by the resident in**
888 **accordance with institutional policy. This evaluation must:**
889
890 **V.A.2.a) document the resident’s performance during the final period**
891 **of education, and**
892
893 **V.A.2.b) verify that the resident has demonstrated sufficient**
894 **competence to enter practice without direct supervision.**
895
896 **V.B. Faculty Evaluation**
897
898 **V.B.1. At least annually, the program must evaluate faculty performance as**
899 **it relates to the educational program.**
900
901 **V.B.2. These evaluations should include a review of the faculty’s clinical**
902 **teaching abilities, commitment to the educational program, clinical**
903 **knowledge, professionalism, and scholarly activities.**
904
905 **V.B.3. This evaluation must include at least annual written confidential**
906 **evaluations by the residents.**
907
908 **V.C. Program Evaluation and Improvement**
909
910 **V.C.1. The program must document formal, systematic evaluation of the**
911 **curriculum at least annually. The program must monitor and track**
912 **each of the following areas:**
913
914 **V.C.1.a) resident performance;**
915
916 **V.C.1.b) faculty development;**
917

- 918 V.C.1.c) graduate performance, including performance of program
919 graduates on the certification examination; and,
920
- 921 V.C.1.d) program quality. Specifically:
922
- 923 V.C.1.d).(1) Residents and faculty must have the opportunity to
924 evaluate the program confidentially and in writing at
925 least annually, and
926
- 927 V.C.1.d).(2) The program must use the results of residents'
928 assessments of the program together with other
929 program evaluation results to improve the program.
930
- 931 V.C.2. If deficiencies are found, the program should prepare a written plan
932 of action to document initiatives to improve performance in the
933 areas listed in section V.C.1. The action plan should be reviewed
934 and approved by the teaching faculty and documented in meeting
935 minutes.
936
- 937 V.C.3. ~~The Review Committee for Ophthalmology will evaluate the overall~~
938 ~~effectiveness of the program director as an administrator and educator.~~
939
- 940 V.C.4. At least 60% of the program's graduates from the preceding five years
941 who take the American Board of Ophthalmology certifying examination for
942 ophthalmology for the first time must pass.
943
- 944 VI. Resident Duty Hours in the Learning and Working Environment
945
- 946 VI.A. Principles
947
- 948 VI.A.1. The program must be committed to and be responsible for
949 promoting patient safety and resident well-being and to providing a
950 supportive educational environment.
951
- 952 VI.A.2. The learning objectives of the program must not be compromised by
953 excessive reliance on residents to fulfill service obligations.
954
- 955 VI.A.3. Didactic and clinical education must have priority in the allotment of
956 residents' time and energy.
957
- 958 VI.A.4. Duty hour assignments must recognize that faculty and residents
959 collectively have responsibility for the safety and welfare of patients.
960
- 961 VI.B. Supervision of Residents
962
- 963 The program must ensure that qualified faculty provide appropriate
964 supervision of residents in patient care activities.
965
- 966 VI.B.1. ~~There should be direct faculty supervision of each resident in at least~~
967 ~~1,000 outpatient visits. Direct faculty supervision occurs when faculty~~
968 ~~members also examine the patient with the resident and discuss the~~

969		management of the patient with the resident before the patient leaves the
970		clinic.
971		
972	VI.B.2.	For emergency care, faculty must be readily available to see any patient
973		upon request by the resident.
974		
975	VI.C.	Fatigue
976		
977		Faculty and residents must be educated to recognize the signs of fatigue
978		and sleep deprivation and must adopt and apply policies to prevent and
979		counteract its potential negative effects on patient care and learning.
980		
981	VI.D.	Duty Hours (the terms in this section are defined in the ACGME Glossary
982		and apply to all programs)
983		
984		Duty hours are defined as all clinical and academic activities related to the
985		program; i.e., patient care (both inpatient and outpatient), administrative
986		duties relative to patient care, the provision for transfer of patient care,
987		time spent in-house during call activities, and scheduled activities, such as
988		conferences. Duty hours do <i>not</i> include reading and preparation time spent
989		away from the duty site.
990		
991	VI.D.1.	Duty hours must be limited to 80 hours per week, averaged over a
992		four-week period, inclusive of all in-house call activities.
993		
994	VI.D.2.	Residents must be provided with one day in seven free from all
995		educational and clinical responsibilities, averaged over a four-week
996		period, inclusive of call.
997		
998	VI.D.3.	Adequate time for rest and personal activities must be provided.
999		This should consist of a 10-hour time period provided between all
1000		daily duty periods and after in-house call.
1001		
1002	VI.E.	On-call Activities
1003		
1004	VI.E.1.	In-house call must occur no more frequently than every third night,
1005		averaged over a four-week period.
1006		
1007	VI.E.2.	Continuous on-site duty, including in-house call, must not exceed 24
1008		consecutive hours. Residents may remain on duty for up to six
1009		additional hours to participate in didactic activities, transfer care of
1010		patients, conduct outpatient clinics, and maintain continuity of
1011		medical and surgical care.
1012		
1013	VI.E.3.	No new patients may be accepted after 24 hours of continuous duty.
1014		
1015	VI.E.3.a)	A new patient is defined as any patient for whom the resident has
1016		not previously provided care.
1017		
1018	VI.E.4.	At-home call (or pager call)
1019		

- 1020 VI.E.4.a) The frequency of at-home call is not subject to the every-
 1021 third-night, or 24+6 limitation. However at-home call must not
 1022 be so frequent as to preclude rest and reasonable personal
 1023 time for each resident.
 1024
- 1025 VI.E.4.b) Residents taking at-home call must be provided with one day
 1026 in seven completely free from all educational and clinical
 1027 responsibilities, averaged over a four-week period.
 1028
- 1029 VI.E.4.c) When residents are called into the hospital from home, the
 1030 hours residents spend in-house are counted toward the 80-
 1031 hour limit.
 1032

1033 VI.F. Moonlighting

1034

1035 VI.F.1. Moonlighting must not interfere with the ability of the resident to
 1036 achieve the goals and objectives of the educational program.
 1037

1038 VI.F.2. Internal moonlighting must be considered part of the 80-hour weekly
 1039 limit on duty hours.
 1040

1041 VI.G. Duty Hours Exceptions

1042

1043 A Review Committee may grant exceptions for up to 10% or a maximum of
 1044 88 hours to individual programs based on a sound educational rationale.
 1045

1046 VI.G.1. In preparing a request for an exception the program director must
 1047 follow the duty hour exception policy from the ACGME Manual on
 1048 Policies and Procedures.
 1049

1050 VI.G.2. Prior to submitting the request to the Review Committee, the
 1051 program director must obtain approval of the institution's GMEC and
 1052 DIO.
 1053

1054 VII. Experimentation and Innovation

1055

1056 Requests for experimentation or innovative projects that may deviate from the
 1057 institutional, common and/or specialty specific program requirements must be
 1058 approved in advance by the Review Committee. In preparing requests, the
 1059 program director must follow Procedures for Approving Proposals for
 1060 Experimentation or Innovative Projects located in the ACGME Manual on Policies
 1061 and Procedures. Once a Review Committee approves a project, the sponsoring
 1062 institution and program are jointly responsible for the quality of education offered
 1063 to residents for the duration of such a project.
 1064

1065 ***

1066

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