

ACGME Program Requirements for Graduate Medical Education in Ophthalmology

Common Program Requirements are in BOLD

Effective: July 1, 2007

Introduction

Int.A. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int.B. Definition and Scope of the Specialty

Residency training programs in ophthalmology should provide a stable, well-coordinated, and progressive educational experience in the entire spectrum of ophthalmic diseases and ocular surgery. Residents in ophthalmology should develop diagnostic, therapeutic, and manual skills, as well as sound judgment in the application of such skills. Each resident must have major technical and patient care responsibilities in order to provide an adequate base for a comprehensive ophthalmic practice. That base must include: optics, visual physiology, and corrections of refractive errors; retina, vitreous, and uvea; neuro-ophthalmology; pediatric ophthalmology and strabismus; external disease and cornea; glaucoma, cataract, and anterior segment; oculoplastic surgery and orbital diseases; and ophthalmic pathology.

Int.C. Duration and Scope of Education

Int.C.1. The length of training in ophthalmology must be at least 36 calendar months, including appropriate short periods for vacation, special assignments, or exceptional individual circumstances approved by the

program director.

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

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

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites.

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

I.A.1. The majority of the required clinical and didactic educational experiences must occur and be coordinated by the program director at this institution.

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents;

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;

I.B.1.c) specify the duration and content of the educational experience; and,

- I.B.1.d) **state the policies and procedures that will govern resident education during the assignment.**
- I.B.1.e) outline the educational goals and objectives to be attained by the resident during the assignment.
- I.B.2. **The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**
- I.B.3. The participating site should provide resources not otherwise available to the program.
- I.B.4. Assignments at participating sites must be of sufficient length to ensure a quality educational experience, and should provide sufficient opportunity for continuity of care. Although the number of participating sites may vary with the specialties' needs, all participating sites must demonstrate the ability to promote the program goals, and educational and peer activities. Exceptions must be justified and approved in advance.
- I.B.5. If the distance between participating sites and the sponsoring institution is great enough to prevent residents' regular attendance at the didactic and clinical conferences, or if the rotation otherwise precludes attendance, the program director must demonstrate that each resident has a formal educational experience that fulfills the program requirements.
- I.B.6. There should be formal teaching case presentations at each participating site to ensure optimal utilization of patients for teaching purposes. Alternatively, cases should be brought from participating sites to the sponsoring institution for presentation if formal teaching case presentations are held only there.
- I.B.7. Rotations to foreign countries shall not be used to meet minimum educational standards.

II. Program Personnel and Resources

II.A. Program Director

- II.A.1. **There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.**
- II.A.1.a) The program director should be a member of the medical staff of the sponsoring or integrated institution. The institution must ensure that the program director is given sufficient authority,

financial support, and facilities by the governing body of the sponsoring institution to permit him or her to organize and supervise the following activities of the training program: resident selection and evaluation, resident instruction, patient management, research, and initiation of recommendations for staff recruitment.

- II.A.1.b) The program director should have a term of at least three years.
- II.A.2. **The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.**
- II.A.3. **Qualifications of the program director must include:**
 - II.A.3.a) **requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**
 - II.A.3.b) **current certification in the specialty by the American Board of Ophthalmology, or specialty qualifications that are acceptable to the Review Committee; and,**
 - II.A.3.c) **current medical licensure and appropriate medical staff appointment.**
- II.A.4. **The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:**
 - II.A.4.a) **oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;**
 - II.A.4.b) **approve a local director at each participating site who is accountable for resident education;**
 - II.A.4.c) **approve the selection of program faculty as appropriate;**
 - II.A.4.d) **evaluate program faculty and approve the continued participation of program faculty based on evaluation;**
 - II.A.4.e) **monitor resident supervision at all participating sites;**
 - II.A.4.f) **prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;**
 - II.A.4.g) **provide each resident with documented semiannual evaluation of performance with feedback;**

- II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;**
- II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion;**
- 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:**
 - II.A.4.j).(1) distribute these policies and procedures to the residents and faculty;**
 - II.A.4.j).(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;**
 - II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,**
 - 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.**
- 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;**
- 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;**
- 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;**
- 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:**
 - II.A.4.n).(1) all applications for ACGME accreditation of new programs;**
 - II.A.4.n).(2) changes in resident complement;**
 - II.A.4.n).(3) major changes in program structure or length of training;**

- II.A.4.n).(4) **progress reports requested by the Review Committee;**
- II.A.4.n).(5) **responses to all proposed adverse actions;**
- II.A.4.n).(6) **requests for increases or any change to resident duty hours;**
- II.A.4.n).(7) **voluntary withdrawals of ACGME-accredited programs;**
- II.A.4.n).(8) **requests for appeal of an adverse action;**
- II.A.4.n).(9) **appeal presentations to a Board of Appeal or the ACGME; and,**
- II.A.4.n).(10) **proposals to ACGME for approval of innovative educational approaches.**

- 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:**
 - II.A.4.o).(1) **program citations, and/or**
 - II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.**

- II.A.4.p) ensure that all residents have equivalent educational experiences;
- 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;
- 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;
- II.A.4.s) prepare explicit written descriptions of the lines of responsibility for the care of patient, and 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;
- 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 included in Definition and Scope of Specialty, above. This series should include a minimum of 360 hours during the 36 month training program, at least 200 hours of which are intramural. In addition, a minimum of six hours per month should be devoted to case presentation conferences (e.g., Grand Rounds, Continuous Quality Improvement) attended by several faculty and a majority of residents. The program director or designee is responsible for documenting residents' attendance at conferences;

II.A.4.u) ensure the residents are entering their operative cases into the resident case log system; and,

II.A.4.v) verify the surgical experiences of each resident, including the number of cases in each category where the resident has served as the primary surgeon or the assistant surgeon. This documentation must be provided to the Review Committee on its program information forms; individual resident logs must be available at the time of the site visit.

II.B. Faculty

II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and

II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.

II.B.2. The physician faculty must have current certification in the specialty by the American Board of Ophthalmology, or possess qualifications acceptable to the Review Committee.

II.B.2.a) The faculty must have subspecialty expertise across a broad range of ophthalmic disciplines, including those described in Introduction Section A. of these program requirements. Such expertise will usually be acquired by subspecialty fellowship training.

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.

II.B.4. The nonphysician faculty must have appropriate qualifications in

their field and hold appropriate institutional appointments.

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b).(1) peer-reviewed funding;

II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;

II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,

II.B.5.b).(4) participation in national committees or educational organizations.

II.B.5.c) Faculty should encourage and support residents in scholarly activities.

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.

II.D.1. Clinic

The outpatient area of each participating site must have a minimum of one fully-equipped examining lane for each resident in the clinic. There must be access to current diagnostic equipment. This should encompass equipment designed for ophthalmic photography (including fluorescein angiography), perimetry, ultrasonography, keratometry, and retinal electrophysiology, as well as other appropriate equipment.

II.D.2. Operating Room Facilities

The surgical facilities for ophthalmology resident training at each participating site must include at least one operating room fully-equipped

for ophthalmic surgery, including an operating microscope.

II.D.3. Inpatient Facilities

There must be inpatient facilities with access to sufficient space and beds for good patient care. An eye examination room with a slit lamp should be easily accessible.

II.D.4. Residents must have access to a surgical skills development facility (e.g., a wet lab, materials or simulators) and instruction within the program.

II.D.5. The volume and variety of clinical ophthalmological problems in children and adults must be sufficient to afford each resident a graduated and supervised experience with the entire spectrum of ophthalmic diseases, so that the resident may develop diagnostic, therapeutic, and manual skills and judgment as to their appropriate use.

II.E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

III. Resident Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.

III.A.1. All applicants entering ophthalmology training programs must have taken a post-graduate clinical year (PGY-1) in a program accredited by either the ACGME or the Royal College of Physicians and Surgeons of Canada. The PGY-1 year must include training in which the resident has primary responsibility for patient care in fields such as internal medicine, neurology, pediatrics, surgery, family medicine, or emergency medicine. At minimum, six months of this year must be a broad experience in direct patient care.

III.B. Number of Residents

The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program.

III.B.1. A critical mass or minimum number of residents is essential to provide an opportunity for meaningful interaction throughout the training period. Each program must be structured to have at least two residents in each year of training.

III.C. Resident Transfers

III.C.1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;

IV.A.3. Regularly scheduled didactic sessions;

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum:

IV.A.5.a) Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents:

- IV.A.5.a).(1) will understand, in particular, the *care of the surgical patient*, to have the medical and technical knowledge, as well as the skills, necessary to care for the surgical patient. Included here is the understanding of the preoperative ophthalmic and general medical evaluation and assessment of indications for surgery and surgical risks and benefits, informed consent, intraoperative skills, local and general anesthetic considerations, acute and longer-term postoperative care, and management of systemic and ocular complications that may be associated with surgery and anesthesia;
- IV.A.5.a).(2) should be responsible for the care of an adequate number of outpatients who represent a broad range of ophthalmic diseases. There must be appropriate faculty supervision of the residents in all outpatient clinic visits. Appropriate faculty supervision occurs when the faculty provides direct supervision (resident primarily sees the patient, faculty sees patient with resident, and collaborative effort determines management), or when the faculty is on site and readily available to see any patient upon request of the resident;
- IV.A.5.a).(3) should participate in a minimum of 3,000 outpatient visits in which the resident performs a substantial portion of the examination;
- IV.A.5.a).(4) should have access to a simulated operative setting (e.g., wet lab) to allow them to develop proficiency in basic surgical techniques;
- IV.A.5.a).(5) must perform and assist at a sufficient number of surgeries to become skilled as comprehensive ophthalmic surgeons. While the total number of operative procedures to be performed is not specified, the Review Committee will consider a minimum number of key procedures as acceptable. (The minimum numbers are listed on the ACGME website); and,
- IV.A.5.a).(6) must have graduated technical and patient care responsibilities in the surgery (including laser surgery) of cataract, strabismus, cornea, glaucoma, retina/vitreous, oculoplastic, and trauma to provide an adequate base for a comprehensive ophthalmic practice.

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:

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

IV.A.5.b).(2) should have documented experiences in practice management, ethics, advocacy, visual rehabilitation, and socio-economics.

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

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

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

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

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

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

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

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

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

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

IV.A.5.d) Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families,

and health professionals. Residents are expected to:

- IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies;
- IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group;
- IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; and,
- IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable.
- IV.A.5.d).(6) receive experience in providing inpatient and outpatient consultation during the course of three years of education.

IV.A.5.e) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

- IV.A.5.e).(1) compassion, integrity, and respect for others;
- IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest;
- IV.A.5.e).(3) respect for patient privacy and autonomy;
- IV.A.5.e).(4) accountability to patients, society and the profession; and,
- 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.

IV.A.5.f) Systems-based Practice

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:

- IV.A.5.f).(1) work effectively in various health care delivery

- settings and systems relevant to their clinical specialty;
- IV.A.5.f).(2) coordinate patient care within the health care system relevant to their clinical specialty;
- IV.A.5.f).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
- IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems;
- IV.A.5.f).(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,
- IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions.

IV.B. Residents' Scholarly Activities

- 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.
- IV.B.2. Residents should participate in scholarly activity.
- IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

V. Evaluation

V.A. Resident Evaluation

V.A.1. Formative Evaluation

- V.A.1.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.
- V.A.1.b) The program must:
 - V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;
 - V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients,

self, and other professional staff);

V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level; and,

V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.

V.A.1.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

V.A.1.d) Assessment will include the care of the surgical patient.

V.A.1.e) Assessment should include an annually required objective test as a component of evaluating the resident's cognitive ability. While each program may utilize its own test instruments, the Ophthalmic Knowledge Assessment Program (OKAP) examination is an example. However, results of the OKAP examination should not be used as the only criterion of resident performance. An analysis of the results of these tests should guide the faculty in assessing the strengths and weaknesses of individual residents and of the program.

V.A.2. Summative Evaluation

The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:

V.A.2.a) document the resident's performance during the final period of education, and

V.A.2.b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.

V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

V.B.3. This evaluation must include at least annual written confidential evaluations by the residents.

V.C. Program Evaluation and Improvement

- V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:**
- V.C.1.a) resident performance;**
 - V.C.1.b) faculty development;**
 - V.C.1.c) graduate performance, including performance of program graduates on the certification examination; and,**
- V.C.1.c).(1) In its evaluation of residency programs, the Review Committee will take into consideration the information provided by the American Board of Ophthalmology (ABO) regarding the resident performance on the certifying examination. The program should:
- V.C.1.c).(1).(a) maintain a pass rate on both the written and oral examination of the American Board of Ophthalmology for first-time examinees from the program that is equal to or greater than 60% averaged over the past five years, and
 - V.C.1.c).(1).(b) have 80% or more of those eligible to take the examination over the past five years actually take the examination.
- V.C.1.d) program quality. Specifically:**
- V.C.1.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and**
 - V.C.1.d).(2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.**
- V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.**
- V.C.3. The Review Committee for Ophthalmology will evaluate the overall effectiveness of the program director as an administrator and educator.

VI. Resident Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety

- VI.A.1.** Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.
- VI.A.2.** The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.
- VI.A.3.** The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.
- VI.A.4.** The learning objectives of the program must:
- VI.A.4.a)** be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,
 - VI.A.4.b)** not be compromised by excessive reliance on residents to fulfill non-physician service obligations.
- VI.A.5.** The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:
- VI.A.5.a)** assurance of the safety and welfare of patients entrusted to their care;
 - VI.A.5.b)** provision of patient- and family-centered care;
 - VI.A.5.c)** assurance of their fitness for duty;
 - VI.A.5.d)** management of their time before, during, and after clinical assignments;
 - VI.A.5.e)** recognition of impairment, including illness and fatigue, in themselves and in their peers;
 - VI.A.5.f)** attention to lifelong learning;
 - VI.A.5.g)** the monitoring of their patient care performance improvement indicators; and,
 - VI.A.5.h)** honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.
- VI.A.6.** All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest.

Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

VI.B. Transitions of Care

VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.

VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

VI.B.3. Programs must ensure that residents are competent in communicating with team members in the hand-over process.

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

VI.C.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;

VI.C.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and,

VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.

VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.

VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.

VI.D. Supervision of Residents

VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.

- VI.D.1.a)** This information should be available to residents, faculty members, and patients.
- VI.D.1.b)** Residents and faculty members should inform patients of their respective roles in each patient's care.
- VI.D.2.** The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.
- Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.
- VI.D.3.** Levels of Supervision
- To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:
- VI.D.3.a)** Direct Supervision – the supervising physician is physically present with the resident and patient.
- VI.D.3.b)** Indirect Supervision:
- VI.D.3.b).(1)** with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
- VI.D.3.b).(2)** with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
- VI.D.3.c)** Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
- VI.D.4.** The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

- VI.D.4.a)** The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.
- VI.D.4.b)** Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
- VI.D.4.c)** Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.
- VI.D.5.** Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.
- VI.D.5.a)** Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.
- VI.D.5.a).(1)** In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.
- VI.D.6.** Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.
- VI.E. Clinical Responsibilities**
- The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.
- VI.F. Teamwork**
- Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.
- VI.G. Resident Duty Hours**
- VI.G.1. Maximum Hours of Work per Week**
- Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all

moonlighting.

VI.G.1.a) Duty Hour Exceptions

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

The Review Committee for Ophthalmology will not consider requests for exceptions to the 80-hour limit to the residents' work week.

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

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

VI.G.2.b) Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

VI.G.2.c) PGY-1 residents are not permitted to moonlight.

VI.G.3. Mandatory Time Free of Duty

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

VI.G.4. Maximum Duty Period Length

VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration.

VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

- VI.G.4.b).(1)** It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
- VI.G.4.b).(2)** Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
- VI.G.4.b).(3)** In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.
- VI.G.4.b).(3).(a)** Under those circumstances, the resident must:
- VI.G.4.b).(3).(a).(i)** appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
- VI.G.4.b).(3).(a).(ii)** document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
- VI.G.4.b).(3).(b)** The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.
- VI.G.5.** **Minimum Time Off between Scheduled Duty Periods**
- VI.G.5.a)** PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
- VI.G.5.b)** Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.
- PGY-3 residents are considered to be at the intermediate level.
- VI.G.5.c)** Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

PGY-4 residents are considered to be in the final years of education.

VI.G.5.c).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

VI.G.5.c).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

VI.G.5.c).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

VI.G.6. Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float.

VI.G.7. Maximum In-House On-Call Frequency

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

VI.G.8.b) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the

80-hour weekly maximum, will not initiate a new “off-duty period”.

VII. Innovative Projects

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

ACGME Approved: September 2005

Effective: January 1, 2006

Revised Common Program Requirements:

Effective: July 1, 2007

ACGME Approved Focused Revision: June 14, 2009

Effective: July 1, 2009

Revised Common Program Requirements Effective: July 1, 2011