ACGME International

Advanced Specialty Program Requirements for Graduate Medical Education in Ophthalmology

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ACGME International Specialty Program Requirements for Graduate Medical Education in Ophthalmology

Int. Introduction

Background and Intent: Programs must achieve and maintain Foundational Accreditation according to the ACGME-I Foundational Requirements prior to receiving Advanced Specialty Accreditation. The Advanced Specialty Requirements noted below complement the ACGME-I Foundational Requirements. For each section, the Advanced Specialty Requirements should be considered together with the Foundational Requirements.

Int.I. Definition and Scope of the Specialty

~~The surgical specialty of ophthalmology focuses on ophthalmic diseases and ocular surgery.~~

Ophthalmology is a medical and surgical specialty dedicated to the comprehensive care of patients with disorders of the eye, adnexa of the eye, visual system, and surrounding facial structures. Ophthalmologists apply knowledge of systemic health, optics, and visual science to diagnose, manage, and treat ocular diseases and refractive disorders, preserving and restoring vision across all ages.

Ophthalmologists integrate clinical history, examination, imaging, and laboratory data to manage a wide range of eye conditions. They work with multidisciplinary eye care teams, including optometrists, orthoptists, ophthalmic nurses, technicians, and other allied professionals, and with primary care physicians and other specialties to ensure continuity, integration, and coordination of services through a safe, patient-centered approach.

Providing holistic care, ophthalmologists consider the visual, functional, psychological, social, and environmental dimensions of health, acknowledging broader medical and life circumstances that influence well-being. They communicate effectively with patients, patients' families, and colleagues to support shared decision-making that respects cultural values. They advocate for equitable access to services while promoting community awareness of eye health through prevention, early treatment, and rehabilitation initiatives.

Ophthalmologists lead eye care and interdisciplinary teams with professionalism, empathy, and cultural sensitivity. They uphold ethical standards; practice cost-conscious, high-value care; and pursue lifelong learning. Through evidence- and data-informed practice, engagement with research and innovation, and adoption of emerging technologies, they continually adapt to meet the evolving needs of their patients, their profession, and the global eye health community.

Int.II. Duration of Education

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Int.II.A. The educational program in ophthalmology must be 36 or 48 months in length.

Int.II.A.1. The program may include an additional 12 months of education in fundamental clinical skills of medicine.

I. Institution

I.A. Sponsoring Institution

See International Foundational Requirements, Section I.A.

I.B. Participating Sites

~~I.B.1. There should be formal teaching case presentations at each participating site to ensure optimal utilization of patients for teaching purposes.~~

~~I.B.1.a) 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.1. Each participating site must ensure that residents engage in structured academic and case-based learning activities that optimize the educational value of patients seen at that site.

I.B.1.a) Participating sites must facilitate resident participation, whether in person, virtually, or through other approved means, to maintain academic integration and consistency across all participating sites.

I.B.1.b) Assignments at participating sites must provide a quality educational experience comparable to that of the Sponsoring Institution's primary clinical site, consistent with the educational standards and expectations established by the Sponsoring Institution.

I.B.1.c) Each participating site must offer sufficient opportunities for patient follow-up to support continuity of care.

I.B.1.d) Participating sites must ensure that rotations are organized and supported in ways that safeguard resident well-being, provide appropriate on-site facilities, and ensure reasonable access to teaching and supervision.

II. Program Personnel and Resources

II.A. Program Director

II.A.1. The program director should have a term of appointment of at least three years.

II.B. Faculty

II.B.1. The program must have access to ~~members of the~~ faculty members who ~~must~~ possess expertise across a broad range of ophthalmic disciplines, including:

II.B.1.a) contact lens;

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II.B.1.b) external disease and cornea;

II.B.1.c) glaucoma, cataract, and anterior segment;

II.B.1.d) neuro-ophthalmology;

II.B.1.e) oculofacial plastic ~~surgery~~ and ~~orbital diseases~~ reconstructive surgery;

II.B.1.f) ophthalmic pathology;

II.B.1.g) optics, visual physiology, and corrections of refractive errors;

II.B.1.h) pediatric ophthalmology and strabismus;

II.B.1.i) retina and vitreous;~~, and uvea~~;

II.B.1.j) uveitis; and,

II.B.1.k) visual rehabilitation.

III.B. Other Program Personnel

See International Foundational Requirements, Section II.C.

III.C. Resources

III.C.1. Ambulatory

III.C.1.a) The outpatient area of each participating site must have a minimum of one fully equipped examination lane for each resident in the clinic.

III.C.1.b) ~~There must be access to state-of-the-art diagnostic equipment for ophthalmic photography (including fluorescein angiography), perimetry, ultrasonography, keratometry, and retinal electrophysiology, as well as other appropriate equipment.~~ Residents must have access to core diagnostic and imaging equipment, including ophthalmic photography (with fluorescein angiography), perimetry, ultrasonography, biometry, keratometry, pachymetry, corneal topography or tomography, and optical coherence tomography (OCT).

III.C.1.c) Access to specialized diagnostic modalities, such as retinal electrophysiology and other advanced imaging technologies, should be available through the Sponsoring Institution or at participating sites.

III.C.2. Inpatient

III.C.2.a) There must be an adequate volume and variety of adult and pediatric clinical ophthalmological problems representing the entire

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spectrum of ophthalmic diseases so that residents can develop diagnostic, therapeutic, and manual skills and judge the appropriateness of treatment.

III.C.2.b) The surgical facilities at each participating site must include at least one operating room fully equipped for ophthalmic surgery, including an operating microscope.

III.C.2.c) ~~An eye examination room with a slit lamp should be easily accessible.~~ Each participating site where residents provide ophthalmology care, including inpatient, emergency, and intensive care settings, must have ready access to the essential equipment required for a comprehensive eye examination, including a slit lamp, indirect ophthalmoscope, and basic diagnostic instruments.

III.C.2.d) Residents should have access to a simulated operative setting (e.g., a wet lab) to allow them to develop competence in basic surgical techniques.

III. Resident Appointment

III.A. Eligibility Criteria

III.A.1. Residents must have successfully completed 12 months of a broad-based clinical program (PGY-1) that is:

III.A.1.a) accredited by the ACGME International (ACGME-I), the ACGME, or the Royal College of Physicians and Surgeons of Canada in preliminary general surgery, preliminary internal medicine, or the transitional year; or,

III.A.1.b) at the discretion of the Review Committee-International, a program for which a governmental or regulatory body is responsible for maintenance of a curriculum providing clinical and didactic experiences to develop competence in the fundamental clinical skills of medicine; or,

III.A.1.b).(1) A categorical residency that accept candidates from these programs must complete an evaluation of each resident's fundamental clinical skills within six weeks of matriculation and must provide remediation to residents as needed.

III.A.1.c) integrated into the residency where the program director must oversee and ensure the quality of didactic and clinical education.

III.A.2. The PGY-1 must be completed in a structured program in which residents are educated in high-quality medical care based on scientific knowledge, evidence-based medicine, and sound teaching by qualified educators.

III.A.3. With appropriate supervision, PGY-1 residents must have first-contact

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responsibility for evaluation and management for all types and acuity levels of patients.

III.A.4. PGY-1 residents must have responsibility for decision-making and direct patient care in all settings, to include writing of orders, progress notes, and relevant records.

III.A.5. Residents must develop competence in the following fundamental clinical skills during the PGY-1:

III.A.5.a) obtaining a comprehensive medical history;

III.A.5.b) performing a comprehensive physical examination;

III.A.5.c) assessing a patient's medical condition;

III.A.5.d) making appropriate use of diagnostic studies and tests;

III.A.5.e) integrating information to develop a differential diagnosis; and,

III.A.5.f) developing, implementing, and evaluating a treatment plan.

III.B. Number of Residents

III.B.1. There must be at least two residents in each year of the program.

III.C. Resident Transfers

See International Foundational Requirements, Section III.C.

III.D. Appointment of Fellows and Other Learners

See International Foundational Requirements, Section III.D.

IV. Specialty-Specific Educational Program

IV.A. ACGME-I Competencies

IV.A.1. The program must integrate the following ACGME-I Competencies into the curriculum.

IV.A.1.a) Professionalism

IV.A.1.a).(1) Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. Residents must demonstrate:

IV.A.1.a).(1).(a) compassion, integrity, and respect for others;

IV.A.1.a).(1).(b) responsiveness to patient needs that supersedes self-interest;

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IV.A.1.a).(1).(c) respect for patient privacy and autonomy;

IV.A.1.a).(1).(d) accountability to patients, society, and the profession;

IV.A.1.a).(1).(e) sensitivity and responsiveness to a diverse patient population, including to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation;

IV.A.1.a).(1).(f) awareness of and commitment to maintaining personal and professional well-being; and,

IV.a.1.a).(1).(g) recognition, disclosure, and appropriate management of conflicts or dualities of interest.

IV.A.1.b) Patient Care and Procedural Skills

IV.A.1.b).(1) Residents must provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents must demonstrate competence in:

IV.A.1.b).(1).(a) providing emergent, routine, and preventive ophthalmic care across outpatient, inpatient, and surgical settings;

IV.A.1.b).(1).(b) performing and interpreting comprehensive eye examinations in adults and children, including evaluation of visual function, slit-lamp biomicroscopy, direct and indirect ophthalmoscopy, sensorimotor examination, and refraction;

IV.A.1.b).(1).(c) selecting, appropriately using, and accurately interpreting ophthalmic and related diagnostic modalities, including ophthalmic imaging, visual functional testing, and laboratory or radiologic investigations; and integrating these findings into clinical decision-making;

IV.A.1.b).(1).(d) applying critical thinking in formulating differential diagnoses, prioritizing management plans, and using evidence-based approaches to patient care;

IV.A.1.b).(1).(e) conducting comprehensive pre-, intra-, and post-operative management, including:

IV.A.1.b).(1).(e).(i) administering safe local ophthalmic anesthesia (peribulbar, retrobulbar, or sub-Tenon's blocks), selection of anesthetic technique, and coordination with anesthesia teams; and,

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IV.A.1.b).(1).(e). (ii) conducting risk assessment, procedure selection, informed consent, complication management, and patient-centered communication as primary surgeon according to the minimum requirements set by the Review Committee-International.

IV.A.1.b).(1).(f) understanding the relationship between systemic and ophthalmic conditions and collaborating effectively with other medical and surgical specialties in the management of complex patients; and,

IV.A.1.b).(1).(g) recognizing and addressing barriers to equitable access and continuity of eye care, including geographic, socioeconomic, or systemic factors and contributing to community initiatives that promote visual health and the prevention of avoidable blindness.

~~IV.A.1.b).(1).(a) technical and patient care responsibilities as primary surgeon, including for treatment of:~~

~~IV.A.1.b).(1).(a).(i) cataract;~~

~~IV.A.1.b).(1).(a).(ii) strabismus;~~

~~IV.A.1.b).(1).(a).(iii) cornea;~~

~~IV.A.1.b).(1).(a).(iv) glaucoma;~~

~~IV.A.1.b).(1).(a).(v) glaucoma laser;~~

~~IV.A.1.b).(1).(a).(vi) retina/vitreous;~~

~~IV.A.1.b).(1).(a).(vii) oculoplastic/orbit; and,~~

~~IV.A.1.b).(1).(a).(viii) global trauma.~~

~~IV.A.1.b).(1).(b) optics, visual physiology, and corrections of refractive errors;~~

~~IV.A.1.b).(1).(c) retina/uvea;~~

~~IV.A.1.b).(1).(d) neuro-ophthalmology;~~

~~IV.A.1.b).(1).(e) pediatric ophthalmology;~~

~~IV.A.1.b).(1).(f) anterior segment;~~

~~IV.A.1.b).(1).(g) orbital diseases;~~

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~~IV.A.1.b).(1).(h) ophthalmic pathology;~~

~~IV.A.1.b).(1).(i) intra-operative skills;~~

~~IV.A.1.b).(1).(j) managing systemic and ocular complications that may be associated with surgery and anesthesia;~~

~~IV.A.1.b).(1).(k) providing acute and long-term post-operative care; and,~~

~~IV.A.1.b).(1).(l) using local and general anesthetics.~~

IV.A.1.c) Medical Knowledge

IV.A.1.c).(1) Residents must demonstrate knowledge of established and evolving biomedical clinical, epidemiological, and social-behavioral sciences and ~~as well as the~~ apply ~~application of~~ this knowledge to patient care. Residents must demonstrate knowledge of:

IV.A.1.c).(1).(a) basic and clinical sciences specific to ophthalmology;

IV.A.1.c).(1).(b) ~~optics, visual~~ anatomy, physiology, pharmacology, immunology, microbiology, genetics, optics, epidemiology, and the interactions between ocular and systemic disease; ~~corrections of refractive errors;~~

~~IV.A.1.c).(1).(c) retina, vitreous, and uvea~~

~~IV.A.1.c).(1).(d) neuro-ophthalmology;~~

~~IV.A.1.c).(1).(e) pediatric ophthalmology and strabismus;~~

~~IV.A.1.c).(1).(f) external disease and cornea;~~

~~IV.A.1.c).(1).(g) glaucoma, cataract, and anterior segment;~~

~~IV.A.1.c).(1).(h) oculoplastic surgery and orbital diseases; and,~~

~~IV.A.1.c).(1).(i) ophthalmic pathology; and,~~

IV.A.1.c).(1).(c) clinical optics, visual physiology, and corrections of refractive errors;

IV.A.1.c).(1).(d) major and related ophthalmic subspecialties, including retina, vitreous and uvea, neuro-ophthalmology, pediatric ophthalmology and strabismus, cornea and external disease, glaucoma, cataract and anterior

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segment, oculoplastic and orbital surgery, ophthalmic pathology, ocular oncology, visual rehabilitation, and community ophthalmology;

IV.A.1.c).(1).(e) principles and physics of ophthalmic instruments and systems (e.g., phacoemulsification, lasers, optical coherence tomography, and other established and emerging diagnostic and surgical technologies);

IV.A.1.c).(1).(f) principles and appropriate application of teleophthalmology and digital health platforms for screening, monitoring, and remote care, including the interpretation and quality assurance of images and data and referral processes;

IV.A.1.c).(1).(g) referral processes, and awareness of artificial intelligence (AI)-based diagnostic tools and their ethical application;

IV.A.1.c).(1).(h) critical appraisal of new diagnostic entities, medical and surgical treatments, and technologies, including assessment of scientific evidence, clinical effectiveness, ethical and societal implications, cost considerations, and their impact on equity and access to care; and,

IV.A.1.c).(1).(i) indications, and peri-, and post-operative considerations for all surgical procedures, including recognition and management of complications and intra-operative decision-making.

IV.A.1.d) Practice-Based Learning and Improvement

IV.A.1.d).(1) 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 lifelong learning. Residents are expected to develop skills and habits to be able to meet the following goals:

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

IV.A.1.d).(1).(b) identify and perform appropriate learning activities;

IV.A.1.d).(1).(c) incorporate formative evaluation feedback into daily practice;

IV.A.1.d).(1).(d) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;

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IV.A.1.d).(1).(e) participate in the education of patients, patients' families, students, residents, and other health professionals;

IV.A.1.d).(1).(f) set learning and improvement goals;

IV.A.1.d).(1).(g) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;

IV.A.1.d).(1).(h) use information technology to optimize learning; and,

IV.A.1.d).(1).(i) demonstrate the ability to learn, evaluate, and apply new diagnostic and therapeutic advances in ophthalmology in a manner consistent with current evidence, patient safety, and available resources.

IV.A.1.e) Interpersonal and Communication Skills

IV.A.1.e).(1) 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 must:

IV.A.1.e).(1).(a) communicate effectively with patients, patients' families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

IV.A.1.e).(1).(b) communicate effectively with physicians, other health professionals, and health-related agencies;

IV.A.1.e).(1).(c) work effectively as both a member ~~or~~ and a leader of ~~a~~ interprofessional health care teams, ~~or other professional group~~ including with optometrists, ophthalmic technicians, nurses, and other allied professionals, by communicating clearly, coordinating responsibilities, setting shared goals, and incorporating feedback to improve team function;

IV.A.1.e).(1).(d) act in a consultative role to other physicians and health professionals;

IV.A.1.e).(1).(e) maintain comprehensive, timely, and legible medical records, if applicable;

IV.A.1.e).(1).(f) provide inpatient and outpatient consultation during the course ~~of three years~~ of education;

IV.A.1.e).(1).(h) effectively communicate unexpected diagnoses, adverse outcomes, or procedural

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complications with patients and/or patients' caregivers with empathy, honesty, and professionalism, involving supervising faculty members as appropriate;

IV.A.1.e).(1).(i) understand principles of patient-centered communication related to informed consent and post-operative counseling; and,

IV.A.1.e).(1).(j) demonstrate professionalism and self-advocacy when managing difficult interactions, including disrespectful or inappropriate behavior by patients, patients' families, or members of the care team.

IV.A.1.f) Systems-Based Practice

IV.A.1.f).(1) 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 must:

IV.A.1.f).(1).(a) work effectively in various health care delivery settings and systems relevant to their clinical specialty;

IV.A.1.f).(1).(b) coordinate patient care within the health care system relevant to their clinical specialty;

IV.A.1.f).(1).(c) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;

IV.A.1.f).(1).(d) advocate for quality patient care and optimal patient care systems that enhance visual function, patient safety, and quality of life;

IV.A.1.f).(1).(e) work in interprofessional teams to enhance patient safety and improve patient care quality;

IV.A.1.f).(1).(f) participate in identifying system errors and implementing potential systems solutions; and,

IV.A.1.f).(1).(g) demonstrate the ability to identify and use available health system and community resources to address social, economic, and environmental factors that affect patients' eye health and access to care.

IV.B. Regularly Scheduled Educational Activities

IV.B.1. If it includes an integrated PGY-1, the educational program must contain

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regularly scheduled didactic sessions that enhance and correspond to the residents' fundamental clinical skills education.

IV.B.2. The following topics must be covered during the educational program: 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.

IV.B.3. There must be a structured and regularly scheduled series of conferences and lectures on basic and clinical ophthalmic sciences, directed by faculty members and delivered through in-person or virtual, synchronous or asynchronous formats, as appropriate to program resources and educational objectives, to promote accessibility and support continuous learning.

IV.B.4. There must be didactic sessions in practice management, health economics and resource stewardship, ethics, leadership development, advocacy, visual rehabilitation, and ~~socioeconomics~~ care for patients with disabilities, social determinants of health, and care for vulnerable populations.

IV.B.5. Additional topics should include environmental sustainability and responsible resource use in ophthalmic practice, and the principles and workflows of teleophthalmology and digital health, including the safe and ethical application of emerging technologies, such as AI.

IV.B.6. Residents must regularly attend all required didactic and clinical conferences.

IV.B.7. The formal didactic series should be a minimum of 360 hours.

IV.B.7.a) ~~At least 200 of these hours must be provided at the primary clinical site~~ These activities must include case discussions, morbidity and mortality reviews, multidisciplinary meetings, or other comparable teaching formats appropriate to the site's scope of practice.

IV.B.7.b) At least ~~six~~ four hours per month should be devoted to case presentation conferences (e.g., grand rounds, continuous quality improvement) attended by several members of the faculty and majority of the residents.

IV.C. Clinical Experiences

IV.C.1. If the program includes an integrated PGY-1, this experience must include a minimum of 11 months of direct patient care.

IV.C.1.a) During the integrated PGY-1, each resident's experiences must include responsibility for patient care commensurate with the resident's ability.

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IV.C.1.a).(1) Residents must have responsibility for decision-making and direct patient care in all settings, subject to review and approval by senior-level residents and/or attending physicians, to include planning care and writing orders, progress notes, and relevant records.

IV.C.1.b) At a minimum, 28 weeks must be in rotations provided by a discipline or disciplines that offer fundamental clinical skills in the primary specialties, such as emergency medicine, family medicine, general surgery, internal medicine, obstetrics and gynecology, or pediatrics.

IV.C.1.b).(1) Subspecialty experiences, with the exception of critical care unit experiences, must not be used to meet fundamental clinical skills curriculum requirements.

IV.C.1.b).(2) Each experience must be at minimum a four-week continuous block.

IV.C.1.c) At a minimum, residents must have 140 hours of experience in ambulatory care in family medicine or primary care internal medicine, general surgery, obstetrics and gynecology, or pediatrics.

IV.C.1.d) Residents must have a maximum of 20 weeks of elective experiences.

IV.C.1.d).(1) Elective rotations should be determined by the educational needs of each individual resident.

IV.C.2. Residents must participate in pre-operative decision making and subsequent operative procedures, as well as post-surgical care and follow-up evaluation of their patients.

IV.C.3. Residents must have the opportunity to develop competence in:

IV.C.3.a) pre-operative ophthalmic and general medical evaluation and assessment of indications for surgery and surgical risks and benefits;

IV.C.3.b) obtaining informed consent;

IV.C.3.c) intra-operative skills;

IV.C.3.d) local and general anesthetic considerations;

IV.C.3.e) acute and longer-term post-operative care; and,

IV.C.3.f) management of systemic and ocular complications that may be associated with surgery and anesthesia.

IV.C.4. Residents must participate in a minimum of 3,000 outpatient visits in which

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they perform a substantial portion of the examination.

IV.C.4.a) Outpatients must represent a broad range of ophthalmic diseases.

IV.C.5. By completion of the residency, each resident must have completed each of these procedures as primary surgeon:

IV.C.5.a) cataract,

IV.C.5.b) strabismus,

IV.C.5.c) corneal surgery,

IV.C.5.d) glaucoma,

IV.C.5.e) glaucoma laser,

IV.C.5.f) other retinal,

IV.C.5.g) oculoplastic/orbital, and

IV.C.5.h) globe trauma.

IV.C.6. Residents must have surgical skills instruction in a simulated setting (e.g., wet lab, model eyes, simulator), including a structured curriculum.

IV.C.7. Residents must have experience operating ophthalmic equipment that is used to perform biometry, corneal topography/tomography, fundus photography, laser procedures, ophthalmic ultrasound, optical coherence tomography, perimetry, and phacoemulsification.

IV.C.7. ~~Residents should have a minimum of 36 hours of experience in gross and microscopic examination of pathological specimens through conferences and/or study sets in addition to their review of pathological specimens of their own patients with a pathologist who has demonstrated expertise in ophthalmic pathology~~.

IV.C.8. By completion of the residency, each resident must have completed the following procedures as either primary surgeon or first assistant:

IV.C.8.a) refractive surgery; and,

IV.C.8.b) retina/vitreous.

IV.C.9. ~~By completion of the residency, each resident should complete at least 364 total surgical procedures~~ Each graduating resident must have performed and/or assisted in the minimum number of essential operative cases and case categories as established by the Review Committee-International.

IV.D. Scholarly Activity

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See International Foundational Requirements, Section IV.D.

V. Evaluation

V.A. Resident Evaluation

V.A.1. The program should include structured, standardized assessments of ophthalmic knowledge as part of the evaluation of residents' cognitive progress.

V.B. Clinical Competency Committee

See International Foundational Requirements, Section V.B.

V.C. Faculty Evaluation

See International Foundational Requirements, Section V.C.

V.D. Program Evaluation and Improvement

See International Foundational Requirements, Section V.D.

V.E. Program Evaluation Committee

See International Foundational Requirements, Section V.E.

VI. The Learning and Working Environment

VI.A. Principles

See International Foundational Requirements, Section VI.A.

VI.B. Patient Safety

See International Foundational Requirements, Section VI.B.

VI.C. Quality Improvement

See International Foundational Requirements, Section VI.C.

VI.D. Supervision and Accountability

VI.D.1. Faculty members must provide direct supervision or be on site and readily available to see any patient.

VI.D.1.a) Direct supervision must include the resident serving as primary care provider with the faculty member present followed by resident and faculty member collaboration to determine management.

VI.D.2. The program's supervision policy must describe resident responsibilities for patient care and faculty member responsibilities for supervision, including levels of supervision, escalation pathways, and after-hours coverage.

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VI.D.3. Telecommunication technology may be used to support supervision in ambulatory or consultative settings when appropriate, provided that patient safety and quality of care are not compromised.

VI.E. Professionalism

See International Foundational Requirements, Section VI.E.

VI.F. Well-Being

See International Foundational Requirements, Section VI.F.

VI.G. Fatigue

See International Foundational Requirements, Section VI.G.

VI.H. Transitions of Care

See International Foundational Requirements, Section VI.H.

VI.I. Clinical Experience and Education

See International Foundational Requirements, Section VI.I.

VI.J. On-Call Activities

See International Foundational Requirements, Section VI.J.

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