International Advanced Specialty Program Requirements
Summary of Revisions and Rationale
ACGME-I

Advanced Specialty Requirements for: **Ophthalmology**
Proposed Effective Date of Revised Requirements: **1 July 2027**

Comments are currently being solicited on revisions to the International Advanced Specialty Program Requirements for the specialty listed above. To aid those providing comment, the following table summarizes and provides a rationale for these revisions.

The Review Committee-International will use the comments provided to determine the final revision of the Program Requirements, which will be posted on the ACGME-I website.

SECTIONS DELETED

Requirement Number	Line Number	Rationale
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.	703-707	The requirement for an exact number of hours of education in ophthalmic pathology has been removed to provide greater flexibility to programs. Knowledge of ophthalmic pathology is required [IV.A.1.c).(1).(d)] and ophthalmic pathology is a required topic for educational sessions [IV.B.2.]. The program must also have access to faculty members with expertise in ophthalmic pathology [II.B.1.f)].

SECTIONS ADDED

Requirement Number	Line Number	Rationale
I.B.1.a)-d) 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. a) Participating sites must facilitate resident participation, whether in person, virtually, or through other approved means, to maintain academic integration and consistency across all training sites. b) Assignments at participating sites must provide a quality educational experience comparable to that of the Sponsoring Institution's primary	70-88	Participating sites provide important experiences for residents. These additions acknowledge that importance by requiring the program to ensure that residents receive quality educational experiences at those sites that follow established program policies, support continuity of care, and protect resident well-being.

training site, consistent with the educational standards and expectations established by the Sponsoring Institution. c) Each participating site must offer sufficient opportunities for patient follow-up to support continuity of care. d) Participating sites must ensure that rotations are organized and supported in ways that safeguard trainee well-being, provide appropriate on-site facilities, and ensure reasonable access to teaching and supervision.		
IV.A.1.e).(1).(h)-(j) Residents must: h) effectively communicate unexpected diagnoses, adverse outcomes, or procedural complications with patients and/or their caregivers with empathy, honesty, and professionalism, involving supervising faculty as appropriate; i) understand principles of patient-centered communication related to informed consent and postoperative counseling; and, j) demonstrate professionalism and self-advocacy when managing difficult interactions, including disrespectful or inappropriate behavior by patients, families, or members of the care team.	514-529	Interpersonal and communication skills competencies were added to ensure residents are competent in communicating with a diverse health care team, patients, and patients' families.
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 artificial intelligence.	592-595	The addition of these topics for didactic sessions recognizes new and emerging issues in ophthalmology. Programs can include these as they apply to ophthalmic practice in the country or jurisdiction.
IV.C.6. Residents must have surgical skills instruction in a simulated setting (for example, wet lab, model eyes,	695-696	Simulation is important for providing clinical instruction in a safe environment. However, it is recognized that not all programs have

simulator) including a structured curriculum.		access to sophisticated simulation equipment. The requirement was written to provide options for simulation that should be achievable for all programs.
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.	698-701	Specifying the equipment residents must use as part of ophthalmic care will provide standardization and guidance to programs.
V.A.1. The program must include annual administration of a standardized examination as a component of assessing each resident's ophthalmic knowledge during the PGY-2-4.	730-732	The Ophthalmic Knowledge Assessment Program (OKAP) would fulfill this requirement; however, any national, regional, or local examination that is standardized and regularly reviewed and updated is acceptable. Examination results may not be used as the sole criteria for decisions regarding resident promotion or graduation.
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.	777-779	The addition of this requirement recognizes that telecommunication can be used to supervise residents if the program adheres to its supervision policy and patient safety is not compromised.

SECTIONS WITH MAJOR REVISIONS

Requirement Number	Line Number	Rationale
II.B.1.a)-k) The program must have access to ~~members of the~~ faculty members who ~~must~~ possess expertise across a broad range of ophthalmic disciplines, including: a) contact lens; b) external disease and cornea; c) glaucoma, cataract, and anterior segment; d) neuro-ophthalmology; e) oculofacial plastic ~~surgery~~ and ~~orbital diseases~~ reconstructive surgery; f) ophthalmology pathology; g) optics, visual physiology, and corrections of refractive errors; h) pediatric ophthalmology and strabismus; i) retina, vitreous and uvea; j) uveitis; and, k) visual rehabilitation.	98-122	This was changed to require that programs have access to faculty members who can provide programs with flexibility in how faculty members are available for resident education and patient care. Additionally, the list of ophthalmic disciplines was revised to reflect current practice.

III.D.1.b) and c) ~~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). 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.	135-148	The list of equipment required for ambulatory care was revised to reflect current practice. The requirement for specialized diagnostic modalities in III.C.1.c) can be modified based on ophthalmic practice in the country or jurisdiction where the program is located.
IV.A.1.b).(1).a)-g) Residents must demonstrate competence in ~~(a) technical and patient care responsibilities as primary surgeon, including for treatment of: (i) cataract; (ii) strabismus; (iii) cornea; (iv) glaucoma; (v) glaucoma laser; (vi)retina/vitreous; (vii) oculoplastic/orbit; and, (viii) global trauma.~~ ~~(b) optics, visual physiology, and corrections of refractive errors; (c) retina/uvea; (d) neuro-ophthalmology; (e) pediatric ophthalmology; (f) anterior segment; (g) orbital diseases; (h) ophthalmic pathology; (i) intra-operative skills; (j) managing systemic and ocular complications that may be associated with surgery and anesthesia; (k) providing acute and long-term post-operative care; and, (l)using local and general anesthetics.~~	278-372	Patient care and procedural skills competencies have been revised from a list of specific diseases and procedures to competency statements that outline comprehensive skills in assessing ophthalmic disease; determining the best treatment; and conducting pre-, intra-, and post-operative management.

Residents must demonstrate competence in: a) providing emergent, routine, and preventive ophthalmic care across outpatient, inpatient, and surgical settings; 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; 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; d) applying critical thinking in formulating differential diagnoses, prioritizing management plans, and using evidence-based approaches to patient care; e) conducting comprehensive preoperative, intraoperative, and postoperative management including (i) administering safe local ophthalmic anesthesia (peribulbar, retrobulbar, or sub-Tenon's blocks), selection of anesthetic technique, and coordination with anesthesia teams; and, (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. 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 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.c).(1).(a)-IV.A.1.c).(1).(i) Residents must demonstrate knowledge of: a) basic and clinical sciences specific to ophthalmology; b) ~~optics, visual~~ anatomy, physiology, pharmacology, immunology, microbiology, genetics, optics, epidemiology and the interactions between ocular and systemic disease;~~corrections of refractive errors; (c)retina, vitreous, and uvea; (d) neuro-ophthalmology; (e)pediatric ophthalmology and strabismus;(f)external disease and cornea; (g) glaucoma, cataract, and anterior segment; (h) oculoplastic surgery and orbital diseases; and, (i) ophthalmic pathology;~~ c) clinical optics, visual physiology and corrections of refractive errors; 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 segment, oculoplastic and orbital	379-441	Medical knowledge competencies have been revised from a list of diseases to competency statements that represent a more comprehensive set of knowledge requirements needed for ophthalmology practice today.

surgery, ophthalmic pathology, ocular oncology, visual rehabilitation, and community ophthalmology; 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); 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; g) referral processes, and awareness of artificial-intelligence-based diagnostic tools and their ethical application; 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, i) indications, peri-operative and post-operative considerations for all surgical procedures including recognition and management of complications, intra-operative decision-making.		
IV.B.7.a) At last 200 of these hours [formal didactics] 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.	602-605	The requirement for an exact number of hours was deleted to provide greater flexibility for programs that use multiple clinical sites. The number of hours was replaced by a description of the types of conferences that must be included.