

PROGRAM REQUIREMENTS for GRADUATE MEDICAL EDUCATION in MEDICAL GENETICS

Common Program Requirements Appear in Bold.

Sections of Text That Are Not Bolded Are Specialty Specific Requirements.

- I. Introduction
- A. Description of the Specialty
 - 1. Clinical medical geneticists are physicians who provide comprehensive diagnostic, management, and genetic counseling services for patients with genetic, or possibly genetic, disorders. They also plan and coordinate large-scale screening programs for inborn errors of metabolism, hemoglobinopathies, chromosome abnormalities, neural tube defects, and other genetically influenced conditions.
 - 2. Clinical medical geneticists are able to (a) diagnose and manage genetic disorders; (b) provide patient and family counseling; (c) use their knowledge of heterogeneity, variability and natural history of genetic disorders in patient-care decision making; (d) elicit and interpret individual and family medical histories; (e) interpret clinical genetic and specialized laboratory testing information; (f) explain the causes and natural history of genetic disorders and genetic risk assessment; and (g) interact with other health-care professionals in the provision of services for patients with genetically influenced disorders.
- B. Scope of Education
 - 1. Accredited graduate medical education programs in medical genetics must provide the formal instruction and appropriately clinical experience necessary for residents to develop the knowledge, skills, and attitudes essential to the practice of clinical medical genetics.
 - 2. Programs must provide (a) opportunities for residents to become involved in research and teaching and (b) education in the basic sciences and clinical areas pertinent to medical genetics, including mendelian genetics, cytogenetics, diagnosis and treatment of inborn errors of metabolism, molecular diagnosis, syndrome identification and dysmorphism, teratology, reproductive genetics, congenital malformations, multifactorial disorders, mental retardation and developmental disabilities, genetic screening, social and ethical issues in medical genetics, genetic counseling, and quantitative human genetics.
- C. Program Length
 - 1. A clinical medical genetics residency may be accredited to provide 2 and/or 4 years of graduate medical education:
 - a. Physicians who have completed an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency are eligible for appointment to a 2-year medical genetics residency.
 - b. A medical genetics program director may appoint a resident to a 2-year program following 2 or more years of ACGME-accredited residency education.
 - c. A 4-year program must include 2 years of pregenetics education in other ACGME-

accredited residencies followed by 2 years of education in clinical medical genetics. A 4-year program must be designed prospectively by the director of the medical genetics residency and the directors of the programs to which residents will be assigned during the two years of pregenetics education.

2. In both 2-year and 4-year programs, the 24 months of genetics education must include at least 18 months of broad-based, clinically-oriented medical genetics activities.

II. Institutional Support

A. Sponsoring institution

1. **One sponsoring institution must assume the ultimate responsibility for the program as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating institution.**
2. Institutions sponsoring medical genetics programs should also sponsor ACGME-accredited programs in pediatrics, internal medicine, and obstetrics/gynecology.

B. Participating institutions

1. **Assignments to participating institutions must be based on a clear educational rationale, must have clearly stated learning objectives and activities, and should provide resources not otherwise available to the program.**
2. **Assignments at participating institutions 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 institutions may vary with the various specialties' needs, all participating institutions must demonstrate the ability to promote the program goals and educational and peer activities. Exceptions must be justified and prior-approved.**
3. **Program letters of agreement must be developed for each participating institution that provides an educational experience for a resident that is one month in duration or longer. In instances where two or more participating institutions in the program function as a single unit under the authority of the program director, letters are not necessary. The agreements should**
 - a. **identify the faculty who will assume the educational and supervisory responsibility for residents and specify the faculty responsibilities for teaching, supervision, and formal evaluation of resident performance per Sections IV.D. and VI.A of the Program Requirements;**
 - b. **outline the educational goals and objectives to be attained by the resident during the assignment;**
 - c. **specify the period of resident assignment;**
 - d. **establish the policies that will govern resident education during the assignment.**

C. Facilities and Resources

1. Program institutions should have a clinical cytogenetics laboratory, a clinical biochemical genetics laboratory, and a clinical molecular genetics laboratory, each of which provides an appropriate volume and variety of medical genetics-related services and has an adequate number of qualified staff. If a laboratory is not located in a program institution, a written letter of agreement from the laboratory director detailing the laboratory's contributions to the education of medical genetics residents must be prepared and kept on file by the program director.
2. Program institutions must provide a sufficient number and variety (e.g., pregnant and non-pregnant, all ages) of inpatients and outpatients to permit residents to gain experience with the natural history of a wide range of genetic disorders.
3. Adequate space and equipment must be available to meet the educational goals of the program. In addition to space for patient care activities, this requires meeting rooms, classrooms, office space, research facilities, and facilities for record storage and retrieval.
4. Office and laboratory space must be provided for the residents for both patient-care work and participation in scholarly activities.
5. Residents must have ready access to a major medical library, either at the institution where the residents are located or through arrangement with convenient nearby institutions. The institutional library should contain standard journals and texts in genetics and related fields of medicine and provide services for the electronic retrieval of information from national medical databases to permit timely literature review.
6. Residents must have access to an on-site library or to a collection of appropriate texts and journals in each institution participating in a residency program. On-site libraries and/or collections of texts and journals must be readily available during nights and weekends.
7. Residents should have access to computer-based genetic diagnostic systems.
8. The audiovisual resources available for educational purposes should be adequate to meet the goals and objectives of the program.

III. Resident Appointment

A. Eligibility Criteria

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

B. Number of Residents

The RRC will approve the number of residents based upon established written criteria that include the adequacy of resources for resident education such as quality and volume of patients and related clinical material available for education, faculty-resident ratio, institutional funding, and the quality of faculty teaching.

C. Resident Transfer

To determine the appropriate level of education for a resident who is transferring from another residency program, the program director must

receive written verification of the previous educational experiences and a statement regarding the performance evaluation of the transferring resident, including an assessment of competence in the six areas described in section V. B., prior to acceptance into the program. A program director is required to provide verification of residency education for any residents who may leave the program prior to completion of their education.

D. Appointment of Fellows and Other Students

1. The presence of other learners in medical genetics and in other specialties within program institutions is essential to the maintenance of a stimulating educational environment.
2. **The appointment of fellows and other specialty residents or students must not dilute or detract from the educational opportunities of the regularly appointed specialty residents.**

IV. Faculty

The program director and faculty are responsible for the general administration of the program and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for the program director and faculty are essential to maintaining such an environment. The length of appointment for the program director should provide for continuity of leadership. Institutions must develop and implement policies and procedures to ensure continuity when the program director departs, is on sabbatical, or is unable to meet his or her duties for any other reason.

A. Qualifications of the Program Director

1. **There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program and should be a member of the staff of the sponsoring or integrated institution.**
2. **The program director must**
 - a. **possess requisite specialty expertise as well as documented educational and administrative abilities and experience in his or her field.**
 - b. **be certified in Clinical Genetics by the American Board of Medical Genetics (ABMG) or possess qualifications judged to be acceptable by the RRC.**
 - c. **be appointed in good standing and based at the primary teaching site.**

B. Responsibilities of the Program Director

1. **Overseeing and organizing the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and monitoring appropriate resident supervision at all participating institutions.**
2. **Preparing an accurate statistical and narrative description of the program as requested by the RRC as well as updating annually the program and resident**

- records through the ACGME Accreditation Data System (ADS).
3. Promptly notifying the executive director of the RRC using the ADS of a change in program director or department chair.
 4. Ensuring the implementation of fair policies and procedures, as established by the sponsoring institution, to address resident grievances and due process in compliance with the Institutional Requirements.
 5. Monitoring resident stress, including mental or emotional conditions inhibiting performance or learning, and drug- or alcohol-related dysfunction. Both the program director and faculty should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. Situations that demand excessive service or that consistently produce undesirable stress on residents must be evaluated and modified.
 6. Obtaining prior approval of the RRC for changes in the program that may significantly alter the educational experience of the residents, for example:
 - a. The addition or deletion of major participating institution(s) as specified in section II.B. of this document.
 - b. Change in the approved resident complement for those specialties that approve resident complement.
 - c. Change in the format of the educational program.On review of a proposal for a major change in a program, the RRC may determine that a site visit is necessary.
 7. Maintaining continuing involvement in scholarly activities, participation in key national scientific human genetics meetings, and contribution to medical education both locally and nationally.
- C. Faculty Qualifications**
1. The physician faculty must
 - a. possess requisite specialty expertise as well as documented educational and administrative abilities and experience in their field.
 - b. be certified by the ABMG or possess qualifications judged by the RRC to be acceptable.
 - c. be appointed in good standing to the staff of an institution participating in the program.
 2. Nonphysician faculty must be appropriately qualified in their field and possess appropriate institutional appointments.
- D. Faculty Responsibilities**
1. Number and Type of Faculty
 - a. At each institution participating in the program, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately the residents in the program.
 - b. There must be at least three members of the teaching staff (including the program

director), who are certified by the ABMG (or possess equivalent qualifications) and are members of the medical staffs at program institutions. At least two of these individuals must be certified in Clinical Medical Genetics.

- c. The individual responsible for resident education in biochemical genetics must be ABMG-certified in biochemical genetics. The person responsible for resident education in molecular genetics must be ABMG-certified in molecular genetics. The individual responsible for resident education in clinical cytogenetics must be ABMG-certified in clinical cytogenetics.
2. **Faculty members must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. The faculty must evaluate in a timely manner the residents whom they supervise.**
3. **The faculty must demonstrate a strong interest in the education of residents, demonstrate competence in both clinical care and teaching abilities, support the goals and objectives of the educational program, and demonstrate commitment to their own continuing medical education by participating in scholarly activities as described in Section V.E.1, including regular and active participation in program rounds, conferences, and journal clubs.**

E. Other Program Personnel

The program must be provided with the additional professional, technical, and clerical personnel needed to support the administration and educational conduct of the program.

V. The Educational Program

The program design and sequencing of educational experiences will be approved by the RRC as part of the accreditation process. The residency must be organized to provide a well structured, integrated and progressive educational experience in clinical medical genetics. The residents must have the opportunity to develop the abilities to diagnose genetic disorders, counsel patients, and manage the broad range of clinical problems that are encompassed within medical genetics. Because of the complex nature and multiple system involvement of genetic disorders, residents must be exposed to multidisciplinary and interdisciplinary models during the program and must become proficient at organizing teams of health-care professionals in order to provide the necessary resources for their patients. As medical genetics involves families and individuals of all ages, residents must be competent to work with adults and children and must have an opportunity to gain an understanding of family dynamics as they relate to issues of diagnosis, counseling and management.

A. Role of Program Director and Faculty

The program director, with assistance of the faculty, is responsible for developing and implementing the academic and clinical program of resident education by

1. **preparing and implementing a written statement outlining the educational goals of the program with respect to the knowledge, skills, and other**

attributes of residents for each major assignment and each level of the program. The statement must be distributed to residents and faculty and reviewed with residents prior to the assignment.

2. **preparing and implementing a comprehensive, well-organized, and effective curriculum, both academic and clinical, which includes the presentation of core specialty knowledge supplemented by the addition of current information.**
3. **providing residents with direct experience in progressive responsibility for patient management.** The responsibility given to residents for patient care should depend on their knowledge, skill, experience, and the complexity of the patient's counseling or medical problems. This includes responsibility in such areas as patient care, leadership, teaching, organization, and administration. The program must provide residents with experience in direct and progressively responsible patient management as they advance through the program so that those completing the program will have developed sound clinical judgment.

B. ACGME Competencies

The residency program must require that its residents obtain competence in the six areas listed below to the level expected of a new practitioner.

Programs must define the specific knowledge, skills, behaviors, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate the following:

1. ***Patient care* that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.** Residents are expected to
 - a. gather essential and accurate information about the patient using the following clinical skills:
 - i. medical interviewing, including the taking and interpretation of a complete family history, including construction of a pedigree
 - ii. physical examination
 - iii. diagnostic studies, including the interpretation of laboratory data generated from biochemical genetic, cytogenetic, and molecular genetic analyses
 - b. make informed decisions about diagnostic and therapeutic interventions based on patient and family information and preferences, up-to-date scientific evidence, and clinical judgment by
 - i. demonstrating effective and appropriate clinical problem-solving skills
 - ii. understanding the limits of one's knowledge and expertise
 - iii. appropriate use of consultants and referrals
 - c. develop and carry out patient management plans
 - d. prescribe and perform medical interventions essential for the care of patients with heritable disorders
 - e. counsel and educate patients and their families
 - i. to take measures needed to enhance or maintain health and function and prevent

- disease and injury
- ii. by encouraging them to participate actively in their care and providing information that will contribute to their care
- iii. to empower patients to make informed decisions, interpret risk assessment, and to use predictive testing for themselves and family members
- f. use information technology to support patient care decisions and patient education
- g. assist patients in accomplishing their personal health goals
- h. work with health care professionals, including those from other disciplines, to provide patient-focused care
- 2. *Medical knowledge about established and evolving biomedical, clinical, and cognate (eg, epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.*** Residents must
 - a. know, critically evaluate and use current medical information and scientific evidence for patient care, including
 - i. results from genetics laboratory tests
 - ii. quantitative risk assessment
 - iii. available bioinformatics
 - b. be able to locate, appraise, and assimilate evidence from scientific research studies related to their patients' health problems
- 3. *Practice-based learning and improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.*** Residents are expected to
 - a. obtain and use information about their own patients and the larger population from which their patients are drawn
 - b. use information technology to manage information, access on-line medical information, and support their own education
 - c. facilitate the education of patients, families, students, residents, other health care professionals, and the general public
- 4. *Interpersonal and communication skills that result in effective information exchange and collaboration with patients, their families, and other health professionals.*** Residents must be able to
 - a. communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
 - b. communicate effectively with patients and families to create and sustain a professional and therapeutic relationship
 - c. communicate effectively with physicians, other health care professionals, health-related agencies, and the general public
 - d. work effectively as a member or leader of a health care team or organization
 - e. maintain comprehensive, timely and legible medical records
- 5. *Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.*** Residents are expected to:

- a. demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supercedes self-interest; accountability to patients, society, and the profession, and a commitment to excellence and on-going professional development
- b. demonstrate a commitment to ethical principles pertaining to patient privacy and autonomy, the provision or withholding of clinical care, confidentiality of patient information, informed consent, conflict of interest, and business practices
- c. demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

6. *Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.* Residents must be able to

- a. advocate for quality patient care and assist patients in dealing with system complexities
- b. work effectively in various health care delivery settings and systems
- c. provide optimal value for the patient by incorporating the considerations of cost-awareness and risk-benefit analysis
- d. promote health and function and prevent disease and injury in populations
- e. possess the basic economic and business knowledge necessary to function effectively in one's practice setting

C. Didactic components

1. Basic Sciences

Each resident must participate formally, through lectures or other didactic sessions, in the equivalent of a 1-year graduate level course in basic, human, and medical genetics, including but not limited to population and quantitative genetics, mendelian and non-mendelian genetics, cytogenetics, biochemical genetics, and molecular genetics. (An introductory medical genetics course for medical students does not satisfy this requirement.)

- b. Research seminars should be a part of the training experience but shall not be considered an acceptable alternative to this basic science didactic component.

2. Clinical Conferences

Clinical teaching conferences must be organized by the faculty for the residents, and attendance by the residents and the faculty must be documented. These conferences must be distinct from the basic science lectures and didactic sessions. Clinical teaching conferences may include formal didactic sessions on clinical laboratory topics, medical genetics rounds, journal clubs, and follow-up conferences for genetic clinics.

D. Clinical components

1. Patient Population

Residents must have the opportunity to care for a number of patients and families sufficient to permit them to develop an understanding of the wide variety of medical genetic problems, including mendelian disorders, inborn errors of metabolism,

diseases of chromosome number and structure, multifactorial disorders, syndromes, congenital malformations, other birth defects, and other genetically influenced conditions. Typically, this will mean that programs will care for at least 100 different patients or families per year for each resident. These patients and families must be seen in outpatient and inpatient settings.

2. Correlation of Laboratory and Clinical Experiences

Clinical biochemical genetic, molecular genetic, and cytogenetic laboratories must be integral components of each program. Residents must spend a minimum of 2 continuous weeks in each type of laboratory so that they will be able to develop their abilities to understand and critically interpret laboratory data. Residents must develop an understanding of the appropriate use of laboratories during diagnosis, counseling, and management of patients with genetic disorders. Toward this end, resident education must include participation in the working conferences of laboratories as well as ongoing discussion of laboratory data during other clinical conferences.

3. Other Health Care Professionals

Residents must have regular opportunities to work with genetic counselors, nurses, nutritionists and other health care professionals who are involved in the provision of clinical medical genetics services.

4. Responsibilities for Patient Care

The development of mature clinical judgement requires that residents, properly supervised, be given responsibility for patient care commensurate with their ability. This can be achieved only if the resident is involved in the decision-making process and in the continuity of patient care. Residents must be given the responsibility for direct patient care in all settings, including planning and management, both diagnostic and therapeutic, subject to review and approval by the attending physician.

E. Scholarly Activities

Graduate medical education must take place in an environment of inquiry and scholarship in which residents participate in the development of new knowledge, learn to evaluate research findings, and develop habits of inquiry as a continuing professional responsibility.

1. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included within each program. Both faculty and residents must participate actively in scholarly activity. Scholarship is defined as one of the following:

- a. **The scholarship of discovery, as evidenced by peer-reviewed funding or publication of original research in peer-reviewed journals.**
- b. **The scholarship of dissemination, as evidenced by review articles or chapters in textbooks.**
- c. **The scholarship of application, as evidenced by the publication or presentation at local, regional, or national professional and scientific society**

- meetings, for example, case reports or clinical series.
- d. **Active participation of the faculty in clinical discussions, rounds, journal club, and research conferences in a manner that promotes a spirit of inquiry and scholarship; offering of guidance and technical support, e.g., research design, statistical analysis, for residents involved in research; and provision of support for resident participation as appropriate in scholarly activities.**
 2. **Adequate resources for scholarly activities for faculty and residents must be available, eg, sufficient laboratory space, equipment, computer services for data analysis, and statistical consultation services.**
 - F. **Resident Duty Hours and the Working Environment**

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.
 1. **Supervision of Residents**
 - a. **All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.**
 - b. **Faculty schedules must be structured to provide residents with continuous supervision and consultation. Attending physicians or supervising residents with appropriate experience for the severity and complexity of the patient's condition must be available to residents at all times and must be able to respond in a timely fashion.**
 - c. **Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.**
 2. **Duty Hours**
 - a. **Duty hours are defined as all clinical and academic activities related to the residency program, ie, patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.**
 - b. **Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**
 - c. **Residents must be provided with 1 day in 7 free from all educational and**

clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

- d. A 10-hour time period for rest and personal activities must be provided between all daily duty periods, and after in-house call.

3. On-Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

- a. In-house call must occur no more frequently than every third night, averaged over a four-week period.
 - b. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, maintain continuity of medical and surgical care, transfer care of patients, or conduct outpatient continuity clinics.
 - c. No new patients may be accepted after 24 hours of continuous duty. A new patient is defined as any patient for whom the resident has not previously provided care.
 - d. At-home call (pager call) is defined as call taken from outside the assigned institution.
 - 1.) The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
 - 2.) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
 - 3.) The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.
- 4. Moonlighting**
- a. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
 - b. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the Institutional Requirements III. D.1.k.
 - c. Moonlighting that occurs within the residency program and/or the sponsoring institution or the non-hospital sponsor's primary clinical site(s),

ie, internal moonlighting, must be counted toward the 80-hour weekly limit on duty hours.

5. Oversight

a. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.

b. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

6. Duty Hours Exception

An RRC may grant exceptions for up to 10 % of the 80-hour limit, to individual programs based on a sound educational rationale. However, prior permission of the institution's GMEC is required.

VI. Evaluation

A. Resident Evaluation

1. The residency program must demonstrate that it has an effective plan for assessing resident performance throughout the program and for utilizing the results to improve resident performance. This plan should include

a. the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

b. mechanisms for providing regular and timely performance feedback to residents that includes at least

1) written semiannual evaluation that is communicated to each resident in a timely manner and

2) the maintenance of a record of evaluation for each resident that is accessible to the resident.

c. a process involving use of assessment results to achieve progressive improvements in residents' competence and performance. Appropriate sources of evaluation include faculty, patients, peers, self, and other professional staff.

2. The program director must provide a final evaluation for each resident who completes the program. The evaluation must include a review of the resident's performance during the final period of education and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record maintained by the institution.

B. Faculty Evaluation

The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. Annual written confidential evaluations by residents must be included in this process.

C. Program Evaluation

The educational effectiveness of a program must be evaluated at least annually in a systematic manner.

1. Representative program personnel, ie, at least the program director, representative faculty, and at least one resident, must be organized to review program goals and objectives and the effectiveness of the program in achieving them. The group must have regular documented meetings at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution (see Institutional Requirements I.B.3.d), and the residents' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes.
2. Outcome assessment
 - a. The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program.
 - b. The program should have in place a process for using resident and performance assessment results together with other program evaluation results to improve the residency program.
3. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness.

VII. Experimentation and Innovation

- A. Since responsible innovation and experimentation are essential to improving professional education, experimental projects supported by sound educational principles are encouraged.
- B. Requests for experimentation or innovative projects that may deviate from the program requirements must be RRC prior-approved and must include the educational rationale and a method for evaluating the project.
- C. The sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

VIII. Board Certification

Residents who plan to seek certification by the American Board of Medical Genetics should communicate with the Executive Vice President/Secretary of the Board to ascertain the current requirements for acceptance as a candidate for certification.

ACGME June 1996 Effective: July 1997
Minor revision: September 1999
Common Program Requirements: July 2003