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Recommended Curriculum Guidelines for Family Medicine Residents

Maternity and Gynecologic Care

This document was developed by a joint task force of the American Academy of Family Physicians (AAFP) and the American College of Obstetricians and Gynecologists (ACOG). Appreciation is extended to the Hinsdale Family Medicine Residency for their contribution to this update.

Introduction

This Curriculum Guideline defines a recommended training strategy for family medicine residents. Attitudes, knowledge and skills that are critical to family medicine should be attained through longitudinal experience that promotes educational competencies defined by the Accreditation Council for Graduate Medical Education (ACGME) http://www.acgme.org. The curriculum must include structured experience in several specified areas. Most of the resident's knowledge will be gained by caring for ambulatory patients who visit the family medicine center. Structured didactic lectures, conferences, journal clubs and workshops must be included in the curriculum with an emphasis on outcomes-oriented, evidence-based studies that delineate common and chronic diseases affecting patients of all ages. Targeted techniques of health promotion and disease prevention are hallmarks of family medicine. Appropriate referral patterns and provision of cost-effective care should also be part of the curriculum.

Program requirements specific to family medicine residencies may be found on the ACGME Web site. Current AAFP Curriculum Guidelines may be found online at http://www.aafp.org/cg. These guidelines are periodically updated and endorsed by the AAFP and, in many instances, other specialty societies as indicated on each guideline.

Each residency program is responsible for its own curriculum. ***This guideline provides a useful strategy to help residency programs form their curricula for educating family physicians.***

Preamble

One of the most important objectives in family medicine residency training should be to provide consistent, quality, evidence-based care. This is especially critical when caring for female patients, especially during their child-bearing years. While there may be different approaches to patient care, learning to take an appropriate history, perform a thorough physical exam and taking into account social and psychological aspects of care of females as must be an integral part of residency training. The knowledge, skills and judgment required in residency training are a necessary base, although they may not necessarily be utilized in the practice of every family physician.

Competencies

At the completion of residency training, a family medicine resident should:

- Be able to perform a comprehensive women's health assessment and develop acute and long-term treatment plans based on the unique aspects of the physiology of women. Special care must be given to a woman in her reproductive years and to whether or not pregnancy is a consideration. (Patient Care, Medical Knowledge)
- Create an optimal treatment plan by investigating, evaluating and improving their own patient care practices as well as utilizing women's health care resources that include local, state and governmental agencies. (Systems-based Practice, Practice-based Learning)
- Demonstrate the ability to communicate effectively with the patient, the patient's family and caregivers so that the diagnosis is clearly understood and the plan-of-care is developed in a collaborative fashion. (Interpersonal Communications)

Knowledge

In the appropriate setting, the resident should demonstrate the ability to apply knowledge of:

1. Gynecology
    a. Normal and variants of female growth and development
    b. Disease prevention, health promotion and periodic health evaluation
    c. Physiology of menstruation
    d. Abnormal uterine bleeding
    e. Gynecologic problems in children
    f. Infections and diseases of the female reproductive and urinary systems
    g. Breast health and diseases of the breast
    h. Sexual assault
    i. Domestic violence

j. Trauma to the reproductive system

k. Pelvic pain

l. Benign and malignant neoplasms of the female reproductive system

m. Menopause and geriatric gynecology

n. Indications for surgical intervention

o. Cervical lesions and abnormal cytology

2. Obstetrics

a. Pre-pregnancy planning and counseling
b. Prenatal care (including risk assessment)
c. Labor and delivery
d. Postpartum care
e. Care of the normal newborn
f. Common neonatal problems
g. Analgesia and anesthesia for labor and delivery
h. Indications for cesarean delivery
i. Obstetric complications and emergencies
j. Ectopic pregnancy
k. Lactation

3. Family life education

a. Family planning

b. Fertility problems

c. Interconceptional care

d. Family and sexual counseling

4. Consultation and referral

a. The role of the obstetrician, gynecologist and subspecialist

b. Women's health care delivery systems

c. Regionalized perinatal care for high-risk pregnancies

d. Collaboration with other health care providers (i.e., nutritionist, dietitian, childbirth educator, lactation consultant, certified nurse midwife, nurse practitioner, etc.)

Skills

A. Core skills: These skills should be independently performed by the resident or have had the exposure to as well as the opportunity to train for independent performance.

1. Gynecology
    a. Appropriate screening examination of the female (including breast examination)
    b. Obtaining vaginal and cervical cytology
    c. Colposcopy
    d. Cervical biopsy and polypectomy
    e. Endometrial biopsy
    f. Cryosurgery and cautery for benign disease
    g. Microscopic diagnosis of urine and vaginal smears
    h. Bartholin duct cyst management
2. Family planning and contraception
    a. Oral contraceptive counseling and prescribing
    b. Intrauterine contraceptive device counseling, insertion and removal
    c. Diaphragm fitting and counseling
    d. Insertion and removal of subcutaneous contraceptive implants and counseling
    e. Injectable long term contraceptives and counseling
3. Pregnancy
    a. Pre-conceptual counseling
    b. Initial pregnancy visit
    c. Risk assessment
    d. History, physical examination, laboratory monitoring, and counseling throughout pregnancy
    e. Noninvasive evaluation of fetal gestational age and fetoplacental adequacy (including limited obstetric ultrasound examination)
    f. Management of labor
    g. Pudendal and local block anesthesia
    h. Fetal assessment, antepartum and intrapartum (including limited obstetric ultrasound examination)
    i. Induction of labor
    j. Internal fetal monitoring and amnioinfusion
    k. Normal cephalic delivery (including use of vacuum extraction and outlet forceps)
    l. Episiotomy and repair (including third-degree lacerations)
    m. Management of common intrapartum problems (e.g., hypertension, mild pre-eclampsia, fever, infection, nonreassuring fetal status, unanticipated shoulder dystocia, manual removal of placenta)
    n. Exploration of the vagina, cervix and uterus
    o. Emergency breech delivery
    p. Neonatal resuscitation
    q. Management of common postpartum problems (e.g., hemorrhage, endometritis)
    r. First assisting at cesarean delivery
    s. Vaginal delivery after previous cesarean delivery

4. Surgery
    a. Assist at common major surgical procedures including hysterectomies and bilateral tubal ligation

B. Advanced skills: For family medicine residents who are planning to practice in communities without readily available obstetric-gynecologic consultation and need to provide a more complete level of obstetric-gynecologic services for the proper care of patients, additional, intensified experience is recommended. This experience should be agreed on by the joint training committee and be tailored to the needs of the resident's intended practice. This additional training may occur within the three years of residency. Family medicine residents planning to include the following procedures in their practices should obtain additional experience taught by or in collaboration with obstetrician-gynecologists. In programs where obstetrician-gynecologists are not available, these skills should be taught by appropriately skilled family physicians.

1. Gynecology
    a. Loop electrosurgical excision procedures with paracervical block
    b. Culdocentesis
2. Family planning and contraception
    a. Voluntary interruption of pregnancy up to 10 weeks of gestation
3. Pregnancy
    a. Ultrasound-guided amniocentesis during mid and third trimesters
    b. Conduction anesthesia and analgesia (not routinely taught by obstetrician-gynecologists)
    c. Management of preterm labor
    d. Management of multiple gestation
    e. Management of breech delivery
    f. External cephalic version
    g. Dilation and curettage for incomplete abortion
    h. Use of low forceps
    i. Fourth-degree laceration repair
    j. Management of severe pre-eclampsia
    k. Performance of cesarean delivery
    l. Management of complications of vaginal birth after previous cesarean delivery
4. Surgery
    a. Postpartum tubal ligation with and without cesarean delivery

Implementation

Core knowledge and skills should require a minimum of three months of experience in a structured obstetric-gynecologic educational program, with adequate emphasis on ambulatory and hospital care. Residents will obtain substantial additional obstetric-gynecologic experience throughout the three years of their experience in the family medicine center and within their continuity practices. Residents will return to the family medicine center for their scheduled continuity clinics.

Programs for family medicine residents should have a joint training committee composed of obstetricians-gynecologists and family physicians, with members of the committee approved by the chairs of the respective departments in the sponsoring educational institution. These physicians should collaborate in the design, implementation and evaluation of the training of family medicine residents in obstetrics-gynecology. It shall be the responsibility of the joint training committee to develop objectives commensurate with the goals of the training program, to monitor resident experiences and to assist in the evaluation of faculty teaching skills. Educational institutions sponsoring graduate medical education should assume corporate responsibility for the overall program. A curriculum in obstetrics-gynecology for family medicine residents should incorporate knowledge of diagnosis, management, core skills and advanced skills. In this document, management implies responsibility for and provision of care and, when necessary, consultation and/or referral.

This Curriculum Guideline in maternity care for family medicine residents is intended to aid residency directors in developing curricula and to assist residents in identifying areas of necessary training. Following these recommendations, which are designed as guidelines rather than as residency program requirements, should result in graduates of family medicine residency programs who are well prepared to provide quality medical care in the areas of maternity care, labor and delivery. These guidelines are not intended to serve as criteria for hospital privileging or credentialing. The assignment of hospital privileges is a local responsibility and is based on training, experience and current competence.

Resources

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Web Sites

The Centers for Disease Control and Prevention
http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/

Association of Maternal & Child Health Programs
http://www.amchp.org/

The American College of Obstetricians and Gynecologists
http://www.acog.org/

National Guideline Clearinghouse
http://www.guideline.gov/index.aspx
The Centers for Disease Control and Prevention
http://www.cdc.gov/women/

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AAFP--ACOG Joint Statement
Cooperative Practice and Hospital Privileges

This document was developed by a joint task force of the American Academy of Family Physicians and the American College of Obstetricians and Gynecologists.

Access to maternity care is an important public health concern in the United States. Providing comprehensive perinatal services to a diverse population requires a cooperative relationship among a variety of health professionals, including social workers, health educators, nurses and physicians. Prenatal care, labor and delivery, and postpartum care have historically been provided by midwives, family physicians and obstetricians. All three remain the major caregivers today. A cooperative and collaborative relationship among obstetricians, family physicians and nurse midwives is essential for provision of consistent, high quality care to pregnant women.

Regardless of specialty, there should be shared common standards of perinatal care. This requires a cooperative working environment and shared decision-making. Clear guidelines for consultation and referral for complications should be developed jointly. When appropriate, early and ongoing consultation regarding a woman's care is necessary for the best possible outcome and is an important part of risk management and prevention of professional liability problems. All family physicians and obstetricians on the medical staff of the obstetric unit should agree to such guidelines and be willing to work together for the best care of patients. This includes willingness on the part of obstetricians to provide consultation and support for family physicians who provide maternity care. The family physician should have the knowledge, skills and judgment to determine when timely consultation and/or referral may be appropriate.

The most important objective of the physician must be the provision of the highest standards of care, regardless of specialty. Quality patient care requires that all providers should practice within their degree of ability as determined by training, experience and current competence. A joint practice committee with obstetricians and family physicians should be established in health care organizations to determine and monitor standards of care and to determine proctoring guidelines. A collegial working relationship between family physicians and obstetricians is essential if we are to provide access to quality care for pregnant women in this country.

1. Practice privileges

   The assignment of hospital privileges is a local responsibility and privileges should be granted on the basis of training, experience and demonstrated current competence. All physicians should be held to the same standards for granting of privileges, regardless of specialty, in order to assure the provision of high quality patient care. Prearranged, collaborative relationships should be established to ensure ongoing consultations, as well as consultations needed for emergencies.

The standard of training should allow any physician who receives training in a cognitive or surgical skill to meet the criteria for privileges in that area of practice. Provisional privileges in primary care, obstetric care and cesarean delivery should be granted regardless of specialty as long as training criteria and experience are documented. All physicians should be subject to a proctorship period to allow demonstration of ability and current competence. These principles should apply to all health care systems.

2. Interdepartmental relationships

   Privileges recommended by the department of family medicine shall be the responsibility of the department of family medicine. Similarly, privileges recommended by the department of obstetrics-gynecology shall be the responsibility of the department of obstetrics-gynecology. When privileges are recommended jointly by the departments of family medicine and obstetrics-gynecology, they shall be the joint responsibility of the two departments.

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