

Maternity Care Fellowship, Goals and Objectives

Train FM physicians to practice maternity care and women's health in:

Rural areas,
International settings,
Academic institutions,

by being competent in:

Managing normal and abnormal labor, including
Cesarean Sections,
Operative vaginal deliveries,
Management of early pregnancy failure,
Medical and Surgical
Sterilization at time of Cesarean Section,
Including tubal ligation and salpingectomy,
Initiating newborn care and stabilization for transfer,
Women's Health

Supervision

Fellows will be supervised by Maternal Care Fellowship Faculty and board-certified and eligible UMKC Obstetricians. The Department of Family Medicine will supervise the fellow's teaching activities and provide administrative support to the fellow, including designation of a fellowship coordinator.

Educational Objectives

Patient Care

Provide caring, compassionate, and respectful patient care utilizing effective communication techniques

Demonstrate appropriate knowledge and skills to counsel and educate patients regarding diagnosis and all available management options

Demonstrate the ability to work with other members of a medical staff in order to provide patient focused care

Display understanding of ethical principles related to maternity care

Demonstrate appropriate use of diagnostics and technology in order to develop and implement patient care management plans

Display expertise in preventative medicine as it relates to maternity care

Medical Knowledge

Demonstrate the ability to diagnose and manage conditions pertaining to pregnancy and women's reproductive health

Demonstrate comprehension of established principles and the evolving clinical data in the field of maternity care

Display understanding of the physiology of pregnancy and the postpartum state

Display proficiency in obtaining a focused history of a patient presenting with a pregnancy or gynecologic complaint

Confidently perform a focused, comprehensive exam for a maternity or gynecological complaint

Observe and learn common obstetric and gynecologic procedures

Practiced-Based learning

Demonstrate research skills including critical appraisal of obstetric and gynecologic literature, appropriate research models, writing styles, and publishing and presentation techniques

Display proficiency with utilization of information, technology, and on-line medical information to support personal education

Obtain and utilize information from assigned patient population to improve individual patient care

Interpersonal and Communication Skills

Exemplify respectful, productive behaviors for functioning as a member of a health care team

Demonstrate therapeutic and compassionate relationships with patients

Demonstrate optimal listening and history taking skills and promote effective education and communication between the fellow and the patient

Communicate intelligently, thoughtfully, and respectfully with patients presenting with pregnancy or women's health complaints

Professionalism

Demonstrate dependability, respect, commitment, compassion, and ethical principles in carrying out the professional responsibilities which accompany this position

Demonstrate responsiveness to the needs of the patient and society that supersedes self-interest

Display sensitivity and responsibility to patients regardless of age, socioeconomic status, or disability

Engage in activities that foster professional growth as a physician

Arrive promptly for all rotation activities and remain until the clinic, lecture, or session is complete

Dress appropriately and professionally for required activities

System-Based Practice

Illustrate an awareness of the system in which we function and the relationship of that system to the global health care environment

Demonstrate understanding of how the fellow's professional practices effect other agencies and other aspects of health care

Advocate for quality patient care and assist the patient as they negotiate complex medical systems

Recognize when referral is appropriate and facilitate the encounter between consultant and the patient

Fellows Schedule

Will emphasize education

Fellow A: alternate L&D week/Outpatient week

Fellow B: alternate Outpatient week/L&D week

Reference Call Template on Web site

The fellows will participate in:

Antepartum and postpartum care

- Management of gestational diabetes
- Management of pre-eclampsia/gestational hypertension
- Management of preterm labor
- Management of chronic medical conditions in pregnancy
- Management of trial of labor after cesarean (TOLAC)
- Management of postpartum time and fourth stage
- Management of postpartum hemorrhage
- Stabilization and management of neonate

If is expected to become competent in the following Obstetrical Procedures

- Cesarean section
 And postpartum care
- Operative vaginal delivery
- Spontaneous vaginal delivery
- VBAC
- External cephalic version
- Repair of 1st and 2nd degree laceration
- Repair of 3rd and 4th degree laceration
- Obstetric Ultrasound

Gynecology Experience

- Sterilization procedures
- Medical management of early pregnancy loss
- Surgical management of early pregnancy loss (D&C)
- Contraceptive counseling
- Management of abnormal cervical cytology: colposcopy/LEEP

Quality Improvement

- Clinical Quality Improvement Project for L&D or Outpatient Obstetrical Care
- Participate in monthly QI meetings
- Participate in Perinatal Safety Meetings with OB department

Structured Study

- Participate in monthly Journal Review
- Arrange and present at weekly Friday morning Strip Review meetings with FM and OB staff
- Complete reading list provided by faculty, Dr Johnson, and give weekly lectures to residents, from reading list
- Friday 1/2 day Strip Review/Admin time
- Friday 1/2 days didactics
- Participate in Simulations
- ALSO certification
- Complete AAFP Women's Health KSA/SAM Women's care

Teaching

- Supervise and teach medical students and residents, including supervision of all L&D admissions, triage patients, vaginal deliveries, and inpatient rounds when scheduled on L&D
- Present at and attend monthly L&D M&M
- Attend Family Medicine Didactic and present twice per year
- Specific graduation expectations and criteria

Outpatient:

- FM fellow Ob consultation clinic at UHWC ½ day every other week (Wednesday morning or afternoon)
- FM fellow Gyn consultation clinic at UHWC ½ day every other week (Wednesday morning or afternoon)—contraception, EPL, abnormal cervical cytology management
- Ultrasound

Faculty oversight and evaluation of Fellow Skill, Professionalism, and Procedural Development

Quarterly reviews by Fellowship Director and OB co-director

Procedure evaluation forms submitted for each completed C-section and procedure via TIP, to be signed by attending physician

Specific criteria to move to the next level (ex CWRU criteria)

Outcomes

- Fellows will have an academic appointment through the University of Missouri Department of Family Medicine.
- Fellows will develop a manuscript for submission required for completion of the fellowship.
- Fellows will demonstrate competency in the procedural skills required to practice independent operative obstetrics.
- Fellows will demonstrate competency in resuscitation and stabilization of the neonate appropriate for delivery of maternity care in an underserved setting.

Who does what on L&D

1. Fellows Education

- a. Fellowship oversight: Dr Vierthaler
Fellowship director, in consultation with L&D Medical Director
- b. Fellowship faculty: those with C-section privileges, including OB/GYN faculty
- c. Content of Fellowship: fellowship Faculty with assistance from FM GME Office
- d. Fellowship Didactics: Those with C-Section Privileges, including OB/GYN faculty
- e. Clinical education: Those with C-Section Privileges, including OB/GYN faculty
- f. Evaluation: Fellowship Director and OB-Codirector
- g. Procedure evaluation forms submitted for each completed C-section and procedure via TIP, to be signed by attending physician

2. Resident Education

- a. Residency Program Director: Dr Rosemergey, in consultation with faculty with L&D privileges
- b. Residency Faculty for L&D (non-continuity deliveries)
 - i. Fellows and other faculty with L&D Privileges
 - ii. Fellows will be primary faculty attending for residents when managing non-continuity L&D patients
 - iii. In the absence of a fellow, the Faculty assigned to L&D or the Faculty-In-Charge will provide attending oversight.
- c. Content of Residency training: Residency Program Director and Faculty
- d. Residency Didactics for L&D: Fellows and other faculty with L&D Privileges
- f. Evaluation: Associate Residency Director: Karen Foote and Residency faculty for L&D

3. Resident Continuity Deliveries

- a. Resident/Faculty shared patients preferred
- b. If without a faculty attending partner, FM fellows provide supervision, or, in their absence the on-call FM Faculty-In-Charge provides supervision

4. Faculty Continuity Deliveries

- a. Attending Faculty responsible for care within the scope of their privileges
- b. Given the approximately 25% chance of C-Section on L&D, Attendings without operative delivery privileges are encouraged to inform the FM Faculty-In-Charge (or Fellow, if present) of the status of the patient
- c. Consultation with LW OB/GYN must occur if transfer to HSD is considered or the Tier System indicates consultation

Roles, Responsibilities and Patient Care Activities of Residents

1. Triage and Laboring Patients

- a. Residents must review each assigned patient's chart and examine each assigned patient before morning and evening rounds and shortly after any transfer of care (e.g. new resident relieves post-call resident). Separate notes will be generated after morning and evening rounds.
- b. At a minimum, the resident must know:
 - i. Status and plan for any current Medical and Obstetrical concerns
 - ii. Patient's pertinent past obstetrical, surgical, medical history, and social history
 - iii. Abnormalities noted during pregnancy and antepartum period, including pertinent lab, sono, and other test findings
 - iv. Current exam with an emphasis on:
 1. Current vital signs including O2 saturation
 2. Pertinent neurological findings
 3. Pertinent cardiopulmonary exam
 4. Stage of labor
 5. Fetal activity and fetal monitoring history
 6. Status of current anesthesia/analgesia (primarily laboring patients)
 - v. Current laboratory and other testing findings
 - vi. Delivery plan, including patient awareness of potential for operative delivery
 - vii. Laboring patients must be seen and personally examined at least hourly, more often as indicated. Vaginal exam need not occur hourly, unless indicated.
 - viii. Progress notes are expected every four hours during latent phase, every two hours during active phase, every 15-30 minutes during second stage, and with any significant event, unless events preclude writing a note.
- c. Residents must inform attending faculty:
 - i. Any significant change in patient's exam or other findings
 - ii. Completion of first stage of labor
 - iii. Failure to progress according to expectations based on gravidity and other factors
 - iv. Report patient status at a minimum of every two hours or as otherwise required by faculty attending. Every report must include vital signs and a focused physical exam
 - v. Inform the supervising faculty member about current state of L&D management on a frequent basis (suggested at least every two hours)
 - vi. Notify the FM attending of the following
 1. patients in triage at the time of presentation and nature of presenting problem
 2. admissions to L&D
 3. status of laboring patients and any high-risk conditions of patients on L&D, Including impending deliveries and risk factors for each delivery
 4. Significant events at the time of those events
 5. Consultations in ED
 6. Consultations with OB/GYN

2. Post-partum Patients: as above excepting where highlighted
 - a. Residents must have reviewed each assigned patient's chart and examined each assigned patient before morning rounds and shortly after any transfer of care (e.g. new resident relieves post-call resident)
 - b. Status and plan for any current Medical and Obstetrical concerns
 - c. Patient's pertinent past obstetrical, surgical, medical history, and social history
 - d. Conditions noted during pregnancy with change care (antepartum, intrapartum, and post-partum periods), including pertinent lab, sono, and other test findings (e.g. gHTN, PPH, gDM)
 - e. Current exam with an emphasis on:
 - i. Current vital signs, including O2 saturation
 - ii. Pertinent neurological findings
 - iii. Pertinent cardiopulmonary exam
 - iv. Status of current anesthesia/analgesia
 - v. Uterine firmness, diminution of lochia
 - vi. Breast tenderness or redness
 - ix. if post C-Section, status of wound and urine output
 - f. Current laboratory and other testing findings
 - g. Current/Future plans
 - i. Birth Control
 - ii. Breast Feeding
 - iii. Resumption of Intercourse
 - iv. Mental Status (post-partum depression, etc.)
 - v. Home safety/ Social Work update (infant care, potential for partner or child abuse, food insecurity, etc.)
 - h. Post-Partum patients should be seen daily by each assigned resident (e.g. daily and at relief post call)

Faculty Expectations for L&D

1. Leadership:

Laborist Faculty (Fellows and Faculty-in-Charge), Responsible for conduct of Family Medicine patient care while assigned to L&D

- a. Must be aware of and personally see each patient
 - i. Must receive detailed report from off going faculty and assigned residents at time of relief, before 8 AM morning rounds and 5 PM attending-to-attending hand-off
 - ii. Laboring patients within one hour of completion of report at beginning of assignment, including 8 AM morning rounds and 5 PM attending-to-attending hand-off
 - iii. Post-Partum patients within two hours of completion of report at beginning of assignment, including 8 AM morning rounds and 6 PM evening resident hand-off, preferably on 8 PM evening rounds
 - iv. Triage patients within 30 minutes of arrival
 - v. Emergent patients, immediately
 - vi. Continue awareness and management of all FM patients in L&D according to condition
 1. Assist attendings performing continuity deliveries as requested
- b. Special Instructions for Fellows
 - i. Morning rounds are run by the supervising fellow under supervision of the FM faculty attending
 - ii. All patients are assigned to the supervising fellow
 - iii. Fellows must inform the supervising fellowship faculty member about current state of L&D management on a frequent basis (suggested at least every two hours)
 - iv. Fellows are responsible for notifying the FM attending of the following
 1. patients in triage at the time of presentation and nature of presenting problem
 2. admissions to L&D
 3. status of laboring patients and any high-risk conditions of patients on L&D, Including impending deliveries and risk factors for each delivery
 4. Significant events at the time of those events
 5. Consultations in ED
 6. Consultations with OB/GYN
 - v. Fellows are to follow the instructions of the supervising fellowship faculty member
 - vi. Should issues arise with the instruction or performance of residents on the service the fellow is to:
 1. Inform the supervising fellowship faculty member
 2. Inform the residency office
 - vii. Fellows will be primary participants in the evaluation of resident performance, including procedural skill other than at C-Section delivery, including an in-person feedback halfway through resident rotation

2. Management of Stages of Labor: All FM Faculty attendings with L&D privileges

- a. First Stage
 - i. Receive resident report on patient assessing and assuring quality of resident review and examination of patient
 - ii. Develop and review plan for labor including:
 1. Ascertain current presentation and station of fetus
 2. Likelihood of C-Section delivery
 3. Anticipated need for OB/GYN help and early consultation where warranted
 4. Assure resident understands role during care of laboring patient, including frequent in-person evaluation of patient
 - iii. Personally see patient as soon as possible after resident evaluation and report

- iv. Assure resident, nursing, or personal appropriate, timely, and ongoing quality review of vital signs, physical, maternal-fetal monitoring, and other tests
- v. Review with resident progress of the patient at least every two hours. It is recommended that patient be personally seen at this time period as well
- vi. Intervene where needed should resident plan and care need correction
- vii. Discuss care with nursing staff and be certain they are aware of means to contact you
- b. Second Stage
 - i. Assure personal, resident, and or nursing presence in room at all times during second stage
 - ii. Assure personal, resident, or nursing appropriate, timely, and ongoing quality review of vital signs, physical maternal-fetal monitoring, and other tests
 - iii. Limit vaginal and cervical exam to the minimum appropriate for the patient's progress and condition. Limit perineal trauma.
 - iv. If not in the room, during second stage, remain in the L&D unit to enable presence at delivery
 - v. If resident delivering, assist resident in adequate control of neonate's head during delivery
 - vi. Control bleeding
- c. Third Stage
 - i. Assess neonate at birth for need of emergent intervention
 - ii. Assist resident in delivery of placenta
 - iii. Inspect placenta for completeness of missing cotyledons
 - iv. Control bleeding
 - v. Assess cervix, vagina, and perineum. Plan for any necessary repairs, and initiate consultation when appropriate
 - vi. Assist resident in any necessary vaginal, cervical, or perineal repairs
 - vii. Assure appropriate instigation of post-partum measures
- d. Post-Partum Care
 - i. Attending present at the time of continuity delivery remains responsible for post-partum care unless there is an agreed upon hand-off to another faculty member

3. Special Instructions for Faculty attending supervising resident continuity delivery – (instructions to Faculty Attendings designated as Fellows are above noted)

- a. Should issues arise with the instruction or performance of residents on the service:
 - i. Inform the Resident-in-Charge
 - ii. Inform the Faculty-in-Charge
 - iii. Inform the residency office
- b. Faculty attendings will be primary participants in the evaluation of resident performance during continuity deliveries and are required to complete appropriate assessment of performance

4. Attending Faculty with Operative Delivery privileges

- a. When Fellows are present Attending Faculty with Operative Deliver privileges are expected to
 - i. Delegate faculty supervision of residents and students on L&D to Fellows
 - ii. Support Fellow in their teaching and supervision roles
 - iii. Anticipate the need for additional help
 - 1. Participate directly with fellow in the management of patients with complications
 - 2. Encourage collegial early consultation when the need arises
 - 3. Where Operative delivery is required, utilize fellow as primary learners
- b. When fellows are not present in L&D
 - i. Faculty directly assume teaching and clinical supervision responsibilities for resident and students
 - ii. Faculty directly assume management of FM patients in L&D as noted in Item 2 above
 - iii. Faculty are primary surgeons for FM patients requiring operative delivery, unless consulting OB/GYN assumes care of patient
 - 1. Primary surgeon may invite other physician to participate in operative delivery, at their discretion

Roles, Responsibilities and Patient Care Activities of Residents

Definitions

Resident:

A physician who is engaged in a graduate training program in medicine and who participates in patient care under the direction of attending physicians as approved by each review committee. Note: The term “resident” includes all residents and fellows including individuals in their first year of training (PGY1), often referred to as “interns,” and individuals in approved subspecialty graduate medical education programs who historically have also been referred to as “fellows.”

As part of their training program, residents are given graded and progressive responsibility according to the individual resident’s clinical experience, judgment, knowledge, and technical skill. Each resident must know the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence. Residents are responsible for asking for help from the supervising physician for the service they are rotating on when they are uncertain of diagnosis, how to perform a diagnostic or therapeutic procedure, or how to implement an appropriate plan of care.

Attending of Record (Attending):

An identifiable, appropriately credentialed and privileged attending physician who is ultimately responsible for the management of the individual patient and for the supervision of residents involved in the care of the patient. The attending delegates portions of care to residents based on the needs of the patient and the skills of the residents.

Supervision

To ensure oversight of resident supervision and graded authority and responsibility, the following levels of supervision are recognized:

1. Direct Supervision: the supervising physician is physically present with the resident and patient.
2. Indirect Supervision:
 - a) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care and is immediately available to provide Direct Supervision.
 - b) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care but is immediately available by means of telephonic and/or electronic modalities and is available to come to the site of care in order to provide Direct Supervision.
3. Oversight: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Clinical Responsibilities

The clinical responsibilities for each resident are based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. The specific role of each resident varies with their clinical rotation, experience, duration of clinical training, the patient's illness and the clinical demands placed on the team. The following is a guide to the specific patient care responsibilities by year of clinical training. Residents must comply with the supervision standards of the service on which they are rotating unless otherwise specified by their program director.

PGY-4 (FM Maternity Care Fellow)

Fellows and residents are part of a team of providers responsible for patient care. The team includes an attending and may include other licensed independent practitioners, other trainees and medical students.

Fellows and residents are physicians-in-training. They learn the skills necessary for their chosen specialty through didactic sessions, literature review, and provision of patient care under the direct supervision of the medical staff (i.e. attending physicians). As part of their training program, fellows are given progressively greater responsibility according to their level of education, ability and experience.

Sub-specialty trainees, having completed a residency in Family Medicine, are generally referred to as fellows. Fellows are engaged in a program of study intended to qualify them for subspecialty board certification.

Fellows and residents evaluate patients, obtain the medical history, and perform physical examinations. They are expected to develop a differential diagnosis and problem list. Using this information, they arrive at a plan of care or a set of recommendations in conjunction with the attending. They will document the provision of patient care as required by hospital/clinic policy.

Fellows and residents may write orders for diagnostic studies and therapeutic interventions as specified in the medical center bylaws and rules/regulations. They may interpret the results of laboratory and other diagnostic testing. They may request consultation for diagnostic studies, the evaluation by other physicians, physical/rehabilitation therapy, specialized nursing care, and social services. They may participate in procedures performed in the operating room or procedure suite under appropriate supervision. Fellows and residents may initiate and coordinate hospital admission and discharge planning. Fellows and residents discuss the patient's status and plan of care with the attending and the team regularly. Fellows help provide for the educational needs and supervision of any junior trainees and medical students.

Attending of Record

In the clinical learning environment, each patient must have an identifiable, appropriately credentialed and privileged primary attending physician who is ultimately responsible for that patient's care. The attending physician is responsible for assuring the quality of care provided and for addressing any problems that occur in the care of patients and thus must be available to provide direct supervision when appropriate for optimal care of the patient and/or as indicated by individual program policy. The availability of the attending to the resident is expected to be greater with less experienced residents and with increased acuity of the patient's illness.

The attending must notify all residents on his or her team of when he or she should be called regarding a patient's status. In addition to situations the individual attending would like to be notified of, the attending should include in his or her notification to residents all situations that require attending notification per program or hospital policy. The primary attending physician may at times delegate supervisory responsibility to a consulting attending physician if a procedure is recommended by that consultant. This information should be available to residents, faculty members, and patients.

The attending may specifically delegate portions of care to residents based on the needs of the patient and the skills of the residents and in accordance with hospital and/or departmental policies. The attending may also delegate partial responsibility for supervision of junior residents to senior residents assigned to the service, but the attending must assure the competence of the senior resident before supervisory responsibility is delegated. Over time, the senior resident is expected to assume an increasingly larger role in patient care decision making. The attending remains responsible for assuring that appropriate supervision is occurring and is ultimately responsible for the patient's care. Residents and attendings should inform patients of their respective roles in each patient's care.

The attending, fellow, and supervisory resident are expected to monitor competence of more junior residents through direct observation, formal ward rounds and review of the medical records of patients under their care. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

Supervision of invasive procedures, Maternity Care Fellows

In a training program, as in any clinical practice, it is incumbent upon the physician to be aware of his/her own limitations in managing a given patient and to consult a physician with more expertise when necessary. When a resident requires supervision, this may be provided by a qualified member of the medical staff or by a resident who is authorized to perform the procedure independently. In all cases, the attending physician is ultimately responsible for the provision of care by residents. When there is any doubt about the need for supervision, the attending should be contacted.

The following procedures may be performed with the indicated level of supervision:

1. Direct supervision ALWAYS required:
 - a. Cesarean Sections
 - b. Operative Vaginal Delivery
 - c. Third and Fourth Degree perineal and all vaginal or cervical lacerations
 - d. External Versions
 - e. Management of early pregnancy failure, Surgical
 - f. D&C for retained placenta

2. Direct supervision required until the fellow is deemed competent to perform independently
 - a. Obstetrical Care Competencies
 - i. Triage Precepting, 10
 - ii. Labor Admission, 5
 - iii. Induction Admission, 5
 - iv. Postpartum Rounding, 5
 - v. Postpartum Discharge, 5
 - vi. Antepartum Rounding, 5
 - vii. Antepartum Discharge, 5
 - viii. Labor Management, 5
 - ix. Attending-to-attending sign-out, 10
 - x. Perineal Laceration Repair, first or second degree, 5
 - xi. Prenatal Clinic Visit, 10
 - xii. Induction Request Review, 5
 - xiii. Limited obstetric ultrasound examination (fetal position, amniotic fluid index, placental location, cardiac activity), 5
 - xiv. Performance and interpretation of non-stress and stress tests, 5
 - xv. Management of category 2 and 3 tracings, 10
 - b. Newborn Care Competencies
 - i. Newborn Rounding, 5
 - ii. Newborn Circumcision, 5
 - iii. Maintain NRP certification
 - c. Inpatient Care competencies
 - i. inpatient Admission, 5

d. Gynecology Competencies

- i. MCC IUD insertion/removal, 2
- ii. MCC Nexplanon insertion/removal, 1
- iii. Colposcopy

Emergency Procedures

It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. The resident may attempt any of the procedures normally requiring supervision in a case where death or irreversible loss of function in a patient is imminent, and an appropriate supervisory physician is not immediately available, and to wait for the availability of an appropriate supervisory physician would likely result in death or significant harm. The assistance of more qualified individuals should be requested as soon as practically possible. The appropriate supervising practitioner must be contacted and apprised of the situation as soon as possible.

Supervision of Consults

Residents may provide consultation services under the direction of supervisory residents including fellows. The attending of record is ultimately responsible for the care of the patient and thus must be available to provide direct supervision when appropriate for optimal care and/or as indicated by individual program policy. The availability of the attending and supervisory residents or fellows should be appropriate to the level of training, experience and competence of the consult resident and is expected to be greater with increasing acuity of the patient's illness. Information regarding the availability of attendings and supervisory residents or fellows should be available to residents, faculty members, and patients.

Residents performing consultations on patients are expected to communicate verbally with their supervising attending at regular time intervals, typically on the same day as the consultation. Any resident performing a consultation where there is credible concern for patient's life or limb requiring the need for immediate invasive intervention MUST communicate directly with the supervising attending as soon as possible prior to intervention or discharge from the hospital, clinic or emergency department so long as this does not place the patient at risk. If the communication with the supervising attending is delayed due to ensuring patient safety, the resident will communicate with the supervising attending as soon as possible. Residents performing consultations will communicate the name of their supervising attending to the services requesting consultation.

Additional specific circumstances and events in which residents performing consultations must communicate with appropriate supervising faculty members include:

1. Fellows must inform the supervising fellowship faculty member about current state of L&D management on a frequent basis (suggested at least every two hours)
2. Fellows are responsible for notifying the FM attending of the following
 - a. patients in triage at the time of presentation and nature of presenting problem
 - b. admissions to L&D
 - c. status of laboring patients and any high-risk conditions of patients on L&D,
Including impending deliveries and risk factors for each delivery
 - d. Significant events at the time of those events
 - e. Consultations in ED
 - f. Consultations with OB/GYN

Supervision of Hand-Offs

Each program must have a policy regarding hand-offs. This policy must include expectations of supervision with each type of hand-off situation. As documented in the ACGME's common program requirements, programs must design clinical assignments to minimize the number of handoffs and must ensure and monitor

effective, structured handoff processes to facilitate both continuity of care and patient safety. Programs must ensure that residents are competent in communicating with team members in the handoff process.

Circumstances in which Supervising Practitioner MUST be Contacted:

There are specific circumstances and events in which residents must communicate with appropriate supervising faculty members.

1. Significant events or changes in patient status
2. Admissions and discharges
3. Presence of patient in triage

If the attending of record is not available for urgent matters in any of the above circumstances, another faculty member with similar privileges and/or an OB/GYN attending physician could be contacted to provide supervision.

Fellow Competence & Delegated Authority

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. The program director and faculty must evaluate each fellow's or resident's abilities based on specific criteria and the program milestones:

Direct supervision (0-12 months, barring obtaining privileges)

1. Cesarean Sections
2. Operative vaginal deliveries,
3. Management of early pregnancy failure, Surgical
4. Sterilization at time of Cesarean Section, Including tubal ligation and salpingectomy,
5. Performance of D&C for retained placenta
6. External cephalic version

Direct supervision (0–3 months)

1. Vaginal deliveries
2. Morning Rounds
3. Afternoon 6 PM hand-offs
4. Labor management
5. All admissions, discharges, and discharge of triage patients
6. Management of common intrapartum problems (malpresentation, unanticipated shoulder dystocia, manual removal of placenta
7. Vaginal birth after previous Cesarean Section

Conditional independence (3-6 months)

Reference: 1. Leadership, b. Special instructions for fellows, pg 10, above

1. Vaginal deliveries
2. Morning Rounds
3. Afternoon 6 PM hand-offs
4. Labor management
5. All admissions, discharges, and discharge of triage patients

Progressive authority (6-9 months)

1. Discuss management of routine and complex OB patients with confidence with attendings, surgeons, and other consulting physicians
2. Presenting lectures and presentations confidently in front of peers and faculty
3. Discusses relevant topics in OB literature and ways to improve patient care
4. Manages more complicated patients and performs more complicated procedures
5. Teaches residents and students routinely

Transitional independence (9-12 months)

1. Demonstrates increasing ability to singularly handle a full day of new and established patients in clinic
2. Routinely demonstrates the ability to manage established patients who are either worsening or not improving
3. Ability to make clinical decisions based upon historical, physical, laboratory, imaging, and consultation becomes routine
4. "Commanding presence" with residents, nursing staff, etc.

The fellowship program uses a multifaceted assessment process to determine a fellow's progressive involvement and independence in providing patient care. Fellows are observed directly by the attending staff throughout clinical training. Supervising physicians provide formal assessments. Fellows are evaluated on their medical knowledge, technical skills, professional attitudes, behavior, and overall ability to manage the care of a patient.

In addition, fellow performance is discussed at faculty meetings on a regular basis. Direct feedback regarding the fellow's performance is provided by the program director on a structure quarterly basis and additionally on an as-needed basis.

The attending staff evaluates trainees continuously. If, at any time, their performance is judged to be below expectations, the fellowship program director (or designee) will meet with the trainee to develop a remediation plan. If the trainee fails to follow that plan, or the intervention is not successful, the trainee may be dismissed from the program. If a trainee's clinical activities are restricted (e.g., they require a supervisor's presence during a procedure, when one would not normally be required for that level of training) that information will be made available to the appropriate attending and hospital staff.

Faculty Development and Resident Education around Supervision and Progressive Responsibility

Residency programs must provide faculty development and resident education on best practices around supervision and the balance of supervision and autonomy. One best practice to consider is the SUPERB SAFETY model:

Attendings should adhere to the SUPERB model when providing supervision. They should:

1. **Set Expectations:** set expectations on when they should be notified about changes in patient's status.
2. **Uncertainty is a time to contact:** tell resident to call when they are uncertain of a diagnosis, procedure or plan of care.
3. **Planned Communication:** set a planned time for communication (i.e. each evening, on call nights)
4. **Easily available:** Make explicit your contact information and availability for any questions or concerns.
5. **Reassure resident not to be afraid to call:** Tell the resident to call with questions or uncertainty.
6. **Balance supervision and autonomy.**

Residents should seek supervisor (attending or senior resident) input using the SAFETY acronym:

1. **Seek attending input early.**
2. **Active clinical decisions:** Call the supervising resident or attending when you have a patient whose clinical status is changing, and a new plan of care should be discussed. Be prepared to present the situation, the background, your assessment and your recommendation.
3. **Feel uncertain about clinical decisions:** Seek input from the supervising physician when you are uncertain about your clinical decisions. Be prepared to present the situation, the background, your assessment and your recommendation.
4. **End-of-life care or family/legal discussions:** Always call your attending when a patient may die or there is concern for a medical error or legal issue.
5. **Transitions of care:** Always call the attending when the patient becomes acutely ill and you are considering transfer to the intensive care unit (or have transferred the patient to the ICU if patient safety does not allow the call to happen prior to the ICU becoming involved).
6. **Help with system/hierarchy:** Call your supervisor if you are not able to advance the care of a patient because of system problems or unresponsiveness of consultants or other providers.

Appendix A (general AAFP Curriculum Guidelines for reference only):**AAFP Reprint No. 261****Recommended Curriculum Guidelines for Family Medicine Residents Maternity Care**

This Curriculum Guideline is endorsed by the American Academy of Family Physicians (AAFP) to be used in conjunction with the recommended AAFP Curriculum Guideline No. 282 – Women’s Health and Gynecologic Care.

Introduction

This AAFP Curriculum Guideline defines a recommended training strategy for family medicine residents. Attitudes, behaviors, 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), www.acgme.org. The family medicine curriculum must include structured experience in several specified areas. Much of the resident’s knowledge will be gained by caring for ambulatory patients who visit the family medicine center, although additional experience gained in various other settings (e.g., an inpatient setting, a patient’s home, a long-term care facility, the emergency department, the community) is critical for well-rounded residency training. The residents should be able to develop a skillset and apply their skills appropriately to all patient care settings.

Structured didactic lectures, conferences, journal clubs, and workshops must be included in the curriculum to supplement experiential learning, with an emphasis on outcomes-oriented, evidence-based studies that delineate common diseases affecting patients of all ages. Patient-centered care, and targeted techniques of health promotion and disease prevention are hallmarks of family medicine and should be integrated in all settings. Appropriate referral patterns, transitions of care, and the provision of costeffective care should also be part of the curriculum.

Program requirements specific to family medicine residencies may be found on the ACGME website. Current AAFP Curriculum Guidelines may be found online at 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.

Please note that the term “manage” occurs frequently in AAFP Curriculum Guidelines. “Manage” is used in a broad sense indicating that the family physician takes responsibility that optimal and complete care is provided to the patient. To manage does not necessarily mean that all aspects of care need to be directly delivered personally by the family physician and may include appropriate referral to other health care providers, including other specialists for evaluation and treatment.

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

While the scope of practice for family physicians continues to evolve, competency in providing high-quality, evidence-based, consistent care to women throughout their lifetimes, including during pregnancy, continues to be an important objective of residency training. Maternity care experience varies widely among training programs but acquiring a core set of knowledge and skills is required by both allopathic and osteopathic residency accreditation councils and is recommended to ensure that the opportunity for family physicians to offer maternity care in their practices remains widely available.

Family physicians generally offer a unique model of prenatal and intrapartum/postpartum care in which physicians attend the majority of their own patients' deliveries, and both the woman and her baby often continue to see their family physician for ongoing women's health, medical, and well-child care. This unique experience continues to be essential in residency training, but it must be underpinned by achievement of competency in appropriate history taking and physical examination skills, knowledge of the physiologic and psychosocial aspects of caring for women, and certain specific, hands-on procedural skills. Even those family physicians who do not choose to include maternity care in their scope of practice should be comfortable with and competent in the care of medical issues in women during pregnancy and lactation, as well as the management of contraception and preconception counseling. This is particularly relevant to the preconception care family physicians can choose to provide for healthy women and for women with chronic medical conditions.

Due to the unique model family medicine offers for maternity care, family physicians often provide care in the immediate neonatal period to newborns they deliver. This model helps support maintenance of a well-child population in the continuity clinic and gives residents the opportunity to provide care of young children while simultaneously having the opportunity to monitor and provide interconception care to mothers. While the care of infants and children is covered extensively in the recommended AAFP Curriculum Guideline No. 260 – Care of Infants and Children, elements of newborn care are often included in residency maternal health curricula for this reason.

This AAFP Curriculum Guideline provides an outline of the attitudes, knowledge, and skills family physicians should attain during residency training to provide high-quality maternity care to their female patients. Broader physical and psychological gender specific health issues of women, including gynecologic care, are addressed in the recommended AAFP Curriculum Guideline No. 282 – Women's Health and Gynecologic Care.

Competencies

At the completion of residency training, family medicine residents should be able to:

- Communicate effectively with female patients of all ages, demonstrating active listening skills, a respectful approach to issues that may be sensitive for women, and collaborative care planning with the patient (Interpersonal and Communication Skills, Professionalism)
- Perform comprehensive physical examinations of female anatomy, with appropriate screening tests for pregnant women, and be able to perform obstetrical procedures (detailed below) (Patient Care, Medical Knowledge)
- Develop and implement treatment plans for common pregnancy complications (prenatal, intrapartum, and postpartum) and utilize community resources when indicated (Medical Knowledge, Systems-based Practice, Practice-based Learning and Improvement)
- Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive issues in women, as well as comprehensive wellness counseling based on the patient's age and risk factors (Patient Care, Interpersonal and Communication Skills)
- Consult and communicate appropriately with obstetrician-gynecologists (OB-GYNs), maternal-fetal medicine specialists, and allied health care professionals to provide optimum health services for women (Medical Knowledge, Systems-based Practice)
- Act as patient advocate and coordinator of care for female patients across the continuum of outpatient, inpatient, and institutional care (Systems-based Practice, Professionalism)

Attitudes and Behaviors

The resident should develop attitudes that encompass:

- A caring, compassionate, and respectful approach to the female patient's role as an informed participant in her own health care decisions and those affecting her family
- Recognition that a woman's health and childbearing is affected not only by medical problems, but also by family, career, life cycle, relationships, and community

- A patient-centered approach to prenatal care, labor management, and postpartum care that is respectful of the wishes of women and their families for their birth experience, while ensuring safe and evidence-based care to optimize health outcomes for women and their babies
- Recognition that major depression is common throughout prenatal and postnatal time frames, particularly for women in low-income, poorly supported environments and that serial screening, diagnosis, and treatment for this disorder is recommended
- Recognition of the impact of addiction on pregnancy outcomes, and a compassionate and supportive approach to women struggling with addiction during pregnancy
- Awareness of issues facing heterosexual, lesbian, bisexual, and transgender patients, particularly with regard to reproductive health
- Awareness of the widespread and complex health effects of psychological, physical, and sexual abuse on women, including on their subsequent experience of pregnancy and the birth process
- Awareness of issues related to female circumcision/female genital mutilation when caring for women from cultures that support such practices

Knowledge

In the appropriate setting, the resident should demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, and demonstrate the ability to apply knowledge of:

I. Family-centered maternity care

A. Preconception counseling and planning

1. Counseling in the areas of:

- a. Nutrition, including for women with eating disorders and all classes of obesity
- b. Contraception and identifying chronic medical conditions in which certain contraceptives are contraindicated (thrombophilia in estrogen-containing contraception, Wilson's disease for copper containing intrauterine device [IUD], etc.)
- c. Understanding and utilizing the quick start method for initiation of contraception, as appropriate
- d. Prevention of birth defects with the use of peri-conceptual folic acid/multivitamins and limiting the use of known teratogenic medications (valproic acid, etc.)
- e. Optimization of health prior to conception, such as aiming for euglycemic control in a type 2 diabetic prior to conception to decrease the incidence of congenital heart disease in the newborn
- f. Identification of chronic mental health conditions to optimize treatment and to avoid known teratogens
- g. Identification of women with addiction disorders to arrange for multidisciplinary treatment and support programs
- h. Assessment of immunization status and appropriate vaccinations, as needed
- i. Screening for preconception genetic counseling
- j. Exercise, particularly in women who are overweight or obese
- k. Occupational hazards assessment
- l. Anticipatory guidance regarding realistic assessment of expectations about work during antenatal and postnatal period

B. Antenatal care: first trimester

1. Diagnosis of pregnancy, including differentiation and management or referral of abnormal gestations (e.g., gestational trophoblastic disease, ectopic pregnancy)

2. Initial prenatal history and evaluation, including clinical assessment of gestational age and ascertaining accurate dating with ultrasounds if indicated

3. Obtaining baseline laboratory testing
 - a. Maternal blood type and Rh, rubella titer, varicella IgG (if status unknown)
 - b. QuantiFERON and lead levels (if risk factors present)
 - c. Urine culture (at 11-16 weeks)
 - d. Sexually transmitted infections (STI) testing: hep B surface antigen, rapid plasma regain (RPR), gonorrhea (GC), chlamydia, HIV, hep C antibody (if risk factors present)
4. Assessment and management of complications and symptoms in the first trimester
 - a. Spotting/bleeding
 - b. Pelvic pain
 - c. Hyperemesis gravidarum
 - d. Multi-fetal gestation
 - e. Musculoskeletal changes and discomforts
 - f. Body image changes
 - g. Life cycle stresses and changes in family dynamics
5. Risk-factor screening
 - a. Appropriate counseling to help patients make personal decisions regarding risk factor screening and assessment
 - i. Options for early screening for chromosomal abnormalities through noninvasive prenatal testing, including ultrasound examination for nuchal translucency/PAPP, combined or sequential screening protocols, cell-free DNA testing and alpha-fetoprotein (AFP)/quadruple marker testing
 - ii. Cystic fibrosis, Tay-Sachs disease and hemoglobinopathy screening, if indicated
 - iii. Referral for genetic counseling regarding other genetic diseases, with attention to maternal age and other risk factors
 - iv. Referral for amniocentesis or chorionic villus sampling, when indicated
6. Counseling for prevention or treatment of substance abuse and STIs, to specifically include:
 - a. Tobacco cessation counseling in pregnancy
 - b. Alcohol abuse risks and fetal alcohol syndrome
 - c. Opiate abuse and referral for treatment with methadone or buprenorphine, and counseling with regard to neonatal abstinence syndrome
 - d. Other substances of abuse and pregnancy risks
 - e. Risk factors for STIs (including viral hepatitis and HIV) and their impact on pregnancy and fetal outcome
7. Prenatal nutrition counseling for optimal nutrition for the developing fetus and the mother, including:
 - a. Vitamins, including vitamin D, iron, and folic acid supplementation, as needed
 - b. Counseling regarding appropriate weight gain based on maternal prepregnancy body mass index (BMI), and counseling regarding increased risks of obesity (or inadequate weight gain in normal or underweight women) in pregnancy
 - c. Screening/treatment of eating disorders
8. Psychosocial stressors of pregnancy
 - a. Counseling and support of the patient and her family through the multiple adjustments required for normal and complicated pregnancies, including the impact on her partner and other children in the family, and referral to psychological support services, as appropriate.

b. Providing longitudinal screening, diagnosis, and treatment for depression throughout pregnancy and the postnatal period. 22

9. Counseling for unintended pregnancy (including options of adoption and termination of pregnancy; see also AAFP Curriculum Guideline No. 282 – Women’s Health and Gynecologic Care)

10. First trimester pregnancy loss

- a. Diagnosis and differentiation of failed pregnancies (threatened, incomplete, complete, embryonic demise), and recognition and referral of ectopic pregnancies
- b. Management of uncomplicated spontaneous abortion, including expectant, medical, aspiration, and surgical evacuation
- c. Referral for surgical intervention when indicated for spontaneous abortion complicated by infection, retained products of conception, or in otherwise high-risk situations
- d. Counseling regarding grief in event of any first trimester loss, whether planned or spontaneous abortion
- e. Counseling regarding risk factors for first trimester loss, most common causes, and appropriate counseling for interpregnancy interval
- f. Appropriate medical evaluation for recurrent early pregnancy loss

11. Breastfeeding: early promotion and support of breastfeeding, as well as support in decision making throughout pregnancy using knowledge and education of the patient as a means of optimizing the health of the mother and newborn

12. Adolescent pregnancy: special considerations with regard to nutrition requirements, confidentiality, and social and psychological needs with the awareness of community resources

13. Substance abuse in pregnancy: special consideration for prenatal monitoring and testing, and to anticipate needs for pain management and/or withdrawal symptoms during pregnancy, and the intrapartum and postpartum periods

14. Counseling regarding and promotion of appropriate immunizations in pregnancy

C. Antenatal care: second and third trimester

1. Counseling, assessment, and management regarding discomforts of and adjustments to the growing pregnancy, including musculoskeletal complaints, vaginal bleeding, and normal physiologic changes

2. Second and third trimester screening and risk assessment for:

- a. Gestational diabetes (including first trimester screening for pre-gestational diabetes when appropriate based on risk factors)
- b. Sexually transmitted infections
- c. Vaginal infections
- d. Group B beta-hemolytic strep screening
- e. Asymptomatic bacteriuria, urinary tract infection, and pyelonephritis
- f. Iron deficiency anemia

3. Gestational diabetes: management with appropriate counseling and referral for nutritional care, glucose testing, oral medication or insulin management, antenatal fetal surveillance, and obstetrical consultation, if indicated

4. Obstetrical complications: assessment and management, including indications for consultation with obstetrician or need for transfer of care

- a. Preterm labor
- b. Preterm prelabor rupture of membranes (PPROM)
- c. Intrauterine growth restriction (IUGR)
- d. Malpresentation
- e. Placental abruption
- f. Trauma/deceleration injuries
- g. Blood factor iso-immunization
- h. Hypertensive disorders of pregnancy, including essential hypertension, gestational hypertension, preeclampsia, preeclampsia with severe features (severe headache, visual disturbances), HELLP syndrome, and eclampsia. Note increasing awareness that preeclampsia may present for the first time in the postpartum period up to six weeks after delivery
- i. Intrahepatic cholestasis of pregnancy
- j. Poly- and oligohydramnios
- k. Fetal demise

l. Collaboration in management of high-risk patients with obstetric consultation; development of skills for early identification of patients at high risk of morbidity or mortality to mother or fetus; and appropriate, timely referral to maternal fetal medicine specialists

5. Medical complications during pregnancy, with appropriate consultation or referral to obstetrician/medical subspecialist:

- a. Asthma
- b. Pyelonephritis and renal calculi
- c. Thyroid disease (hypo and hyper)
- d. Chronic kidney disease
- e. Epilepsy
- f. Autoimmune disease (i.e., lupus)
- g. Cholelithiasis and acute cholecystitis
- h. Preexisting hypertension or diabetes
- i. Thromboembolic disease/thrombophilia
- j. Dilated cardiomyopathy
- k. Chronic pulmonary hypertension
- l. Valvular heart disease
- m. Obesity
- n. History of bariatric surgery and pregnancy

D. Peripartum care: labor and delivery

1. Normal labor and delivery

a. Understand the physiology of the three stages of labor and demonstrate effective management of all three stages, including management of contemporary normal and abnormal labor curves and active management of the third stage of labor

b. Demonstrate appropriate utilization and interpretation of external electronic fetal monitoring, with knowledge of the benefits and limitations of use and respect for individual and family desires for labor

c. Use appropriate obstetric analgesia and anesthesia; evaluate the need for pain control interventions and counsel appropriately. Include family presence and awareness of labor support methods such as Lamaze and Bradley methods

d. Anticipate and plan for needs of special populations (e.g., opiate-dependent patients or other substance-abusing patients, women with extreme obesity)

e. Utilize non-pharmacologic methods of pain control in labor and delivery such as ambulation, hydrotherapy, change of positions, counterpressure, self-hypnosis, use of TENS units, use of intradermal sterile water injections for persistent back labor, etc.

- f. Understand the evidence that supports the use of a doula to improve a number of birth and postpartum outcomes
- g. Understand and demonstrate methods for protecting the perineum during the second stage of labor; understand indications for episiotomy
- h. Understand the normal course of the third stage of labor and the steps involved to prevent excessive bleeding and reduce risk of postpartum hemorrhage using the active management techniques, as described in Advanced Life Support in Obstetrics (ALSO®)
- i. Support and counsel patients regarding breastfeeding in the immediate postpartum period, utilizing support staff, such as lactation consultants, when indicated

2. Complications during labor and delivery

- a. Fetal malpresentation: understand fetal-pelvic relationships and the importance of early detection of different types of malpresentation and understand their compatibility with vaginal delivery
- b. Understand that latent phase labor lasts until 6 cm dilation and that patience is warranted unless maternal or fetal health is jeopardized
- c. Active phase labor dystocia: understand risk factors, prevention, recognition, and management, including placement of intrauterine pressure catheter monitors to titrate oxytocin infusion until adequate uterine contractions are maintained for (a minimum of) up to four hours
- d. Post-term pregnancy: understand indications and risk assessments for induction of post-term pregnancy, including post-dates monitoring, and selection of management options, including cervical ripening agents, Pitocin induction, and artificial rupture of membranes; understand appropriate assessment and use of Bishop scoring for induction management
- e. Premature and prolonged rupture of membranes: knowledge of appropriate interventions, including induction or augmentation of labor and use of prophylactic antibiotics, when indicated
- f. Understand the important role that fetal malposition (occiput posterior/occiput transverse) plays in active phase dystocia and during stage two labor
- g. Meconium: demonstrate awareness of the need for appropriate personnel to be present at the time of delivery and for appropriate intrapartum management of the neonate born with meconium-stained fluid, including counseling mothers and families about expectations for delivery
- h. Emergencies: recognize signs and symptoms of potentially life-threatening emergencies during the peripartum period and utilize appropriate resuscitative techniques for mothers and babies; with obstetric consultation, co-manage placental abruption/hemorrhage, preeclampsia, eclampsia, amniotic fluid embolism, and disseminated intravascular coagulation (DIC)
- i. Postpartum hemorrhage: recognize, diagnose, and appropriately manage, including knowledge of different medications, potential side effects, and medical comorbidities in which certain medications should not be used
- j. Category 2 and 3 tracings: recognize early signs of fetal compromise and demonstrate appropriate interventions, including position change, tocolytics, maternal fluid administration, oxygen resuscitation, and amnioinfusion, as well as timely consultation, when necessary
- k. Shoulder dystocia: understand risk factors, prevention, recognition, and management using ALSO protocols
- l. Assisted deliveries: understand indications for and appropriate use and application of a vacuum extractor and forceps, with an understanding of ALSO protocols for safe use of vacuum extractor and forceps.
- m. Cesarean section: understand indications, risks/benefits, and need for timely intervention and surgical consultation

n. Stillbirth: understand management options and care for the psychological needs of patients and families experiencing stillbirth or other catastrophic medical complications of pregnancy

o. Neonatal resuscitation: residents should maintain Pediatric Advanced Life Support (PALS) and/or Neonatal Resuscitation Program-Neonatal Advanced Life Support (NRP-NALS) certification and have experience as first responders for neonates requiring resuscitation

E. Postpartum care

1. Routine postpartum care, including understanding of normal lochia patterns, fluid shifts, education on perineal care, support of breastfeeding and maternal-child bonding, and counseling regarding postpartum contraceptive options

2. Recognition and appropriate evaluation and management of postpartum complications in the hospital, including:

a. Delayed postpartum hemorrhage

b. Postpartum fever and endometritis

c. Pain associated with normal uterine involution, episiotomy, or laceration repair; epidural- or spinal anesthesia-related pain or headache; and musculoskeletal injury associated with labor

d. Thromboembolic disease

e. Recognition that preeclampsia may present as a new disorder in the first six weeks postpartum usually with hypertension, severe headache, and visual disturbances, but may present with signs/symptoms of congestive heart failure (CHF).

f. Lactation: addressing difficulties in the newborn period g. Postpartum depression and other mood disorders

3. Later postpartum follow up

a. Normal and abnormal postpartum lochia and bleeding patterns

b. Awareness of and counseling/management for common breastfeeding difficulties, including problems with milk supply, latch, nipple soreness or cracking, blocked milk ducts, engorgement, and mastitis

c. Continued screening, assessment, and management of postpartum mood disorders

d. Postpartum intimate relationships and family dynamics

e. Parenting education and resources

4. Interconception care: counseling regarding child spacing, risks and monitoring related to prior pregnancy outcomes (e.g., gestational diabetes, pregnancy induced hypertension, prior preterm labor or birth, and thromboembolic disease) with specific knowledge of risk reduction for prevention of preterm birth

F. Newborn care (see AAFP Curriculum Guideline No. 260 – Care of Infants and Children)

G. Consultation and referral

1. Understanding of the roles of the obstetrician, gynecologist, and subspecialist

2. Recognition of a variety of resources in women's health care delivery systems (e.g., Special Supplemental Nutrition Program for Women, Infants, and Children [WIC], Planned Parenthood)

3. Regionalized perinatal care for high-risk pregnancies

4. Collaboration with other health care professionals (e.g., childbirth educator, lactation consultant, certified nurse midwife, nutritionist, dietician, parenting educator, social services, U.S. Department of Health and Human Services, mental health and addiction professionals)

II. Gynecology (see AAFP Curriculum Guideline No. 282 – Women’s Health and Gynecologic Care)

Skills

I. Core skills: In the appropriate setting, the resident should demonstrate the ability to independently perform the following skills (when this is not available or appropriate, the resident should have exposure to the opportunity to practice these skills):

A. Pregnancy: independent performance

1. History, physical examination, counseling, and laboratory and clinical monitoring throughout pregnancy
2. Assessment (general impression, not formal measurements) of pelvic adequacy
3. Assessment of estimated fetal weight and position by Leopold maneuvers
4. Performance and interpretation of non-stress tests and stress tests
5. Limited obstetric ultrasound examination (fetal position, amniotic fluid index, placental location, cardiac activity)
6. Management of labor with accurate assessment of cervical progress and fetal presentation and lie
7. Induction and augmentation of labor, including artificial rupture of membranes
8. Placement of fetal scalp electrode
9. Placement of intrauterine pressure catheter
10. Amnioinfusion
11. Local anesthesia
12. Spontaneous cephalic delivery
13. Active management of the third stage of labor
14. Episiotomy
15. Repair of episiotomies and lacerations (including third-degree)
16. Neonatal resuscitation

B. Pregnancy: exposure and practice

1. Vacuum extraction
2. Emergency breech delivery
3. Management of common intrapartum problems (e.g., malpresentation, unanticipated shoulder dystocia, manual removal of placenta)
4. Pudendal block anesthesia
5. First assisting at cesarean delivery
6. Vaginal birth after previous cesarean delivery
7. Dilation and curettage for incomplete abortion (may be an “advanced skill” at some programs)

C. Gynecology (see AAFP Curriculum Guideline No. 282 – Women’s Health and Gynecologic Care)

D. Family planning and contraception (see AAFP Curriculum Guideline No. 282 – Women’s Health and Gynecologic Care)

II. Advanced skills: For family medicine residents who are planning to practice in communities without readily available obstetric-gynecologic consultation and who will need to provide a more complete level of obstetric-gynecologic services, additional, intensified experience is recommended. This experience should be agreed on by the maternity operations committee (defined below) 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 procedures listed below in their practices should obtain additional experience taught by appropriately skilled family physicians and (or in collaboration with) OBGYNs as appropriate. Due to variance in availability of training, some of these skills may be considered “core” skills at some residency programs, particularly those offering advanced obstetrical fellowships.

A. Pregnancy

1. Ultrasound-guided amniocentesis during mid-trimester and third trimester
2. Conduction anesthesia and analgesia (not routinely taught by OB-GYNs)
3. Management of early preterm labor or preterm rupture of membranes
4. Management of multiple gestation
5. Management of planned breech delivery
6. External cephalic version
7. Operative vaginal delivery (vacuum and forceps)
8. Fourth-degree laceration repair
9. Management of severe preeclampsia or eclampsia
10. Management of complications of vaginal birth after previous cesarean delivery

B. Surgery

1. Performance of cesarean delivery
2. Performance of dilation and curettage (D&C) for management retained placenta
3. Postpartum tubal ligation with and without cesarean delivery

C. Gynecology (see AAFP Curriculum Guideline No. 282 – Women’s Health and Gynecologic Care)

D. Family planning and contraception (see AAFP Curriculum Guideline No. 282 – Women’s Health and Gynecologic Care)

Implementation

Core knowledge and skills should require a minimum of two months of experience in a structured obstetrics educational program, with an additional one month dedicated to gynecologic care (see AAFP Curriculum Guideline No. 282 – Women’s Health and Gynecologic Care). Adequate emphasis on both ambulatory and hospital care should be provided. Residents will obtain substantial additional experience in maternity care throughout the three years of their continuity practices. Ideally, residencies should have several core family medicine faculty members skilled in performing and teaching comprehensive maternity care, in addition to OB-GYN specialists in a supportive role.

Programs for family medicine residents should have a collaborative relationship between family medicine faculty and OB-GYNs at the training institution. OB-GYNs may be a formal part of the faculty or be collaborative consultants. Depending on the setting, challenges may exist if the training of OB-GYN residents is privileged over that of family physicians or if practice styles differ among the physicians involved in training residents. Therefore, it is recommended that an operational committee be established for the practice of maternity care at any institution involved in graduate medical education. Part of its mission should be the training of family medicine residents. Members of the committee should represent both family medicine and OB-GYN departments, as well as involving community family physicians who practice maternity care (in communities where they exist). Members should be approved by chairs of the respective departments of the sponsoring educational institution.

These physicians should collaborate in the design, implementation, and evaluation of the training of family medicine residents in OB-GYN care. It should be the responsibility of this operational committee to develop objectives that align 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 responsibility for the overall program. A curriculum in OB-GYN 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 AAFP 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.

The AAFP would like to recognize the United States Breastfeeding Committee (USBC) for their work in developing Core Competencies in Breastfeeding Care and Services for All Health Professionals. The document provided a framework for this AAFP Curriculum Guideline. The USBC document can be downloaded at: www.usbreastfeeding.org/p/cm/ld/fid=170.

Resources

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Zakrzewski L, Sur D. Immunizations in pregnancy. *Am Fam Physician*. 2013;87(12):828-830. Zolotor AJ, Carlough MC. Update on prenatal care. *Am Fam Physician*. 2014;89(3):199- 208.

Web Sites

Agency for Healthcare Research and Quality. Guidelines and Measures. www.guideline.gov/ American Academy of Pediatrics. www.aap.org/

American Congress of Obstetricians and Gynecologists. www.acog.org/

American Family Physician (AFP): Labor, Delivery, and Postpartum Issues. www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=16

American Family Physician (AFP). Prenatal Care. www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=25

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

Centers for Disease Control and Prevention. Health Equity. Advancing Women's Health and Safety. www.cdc.gov/women

Centers for Disease Control and Prevention. Reproductive Health. Maternal and Infant Health. www.cdc.gov/reproductivehealth/MaternalInfantHealth/

World Health Organization. www.who.int/

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AAFP--ACOG Joint Statement Cooperative Practice and Hospital Privileges

This joint statement 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 a willingness on the part of obstetricians to provide consultation and back-up for family physicians who provide maternity care. The family physician should have 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.

A. 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. 19 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.

B. 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. (1998) (2014 April BOD)

Link to AAFP – ACOG Joint Statement: Cooperative Practice and Hospital Privileges.
<http://www.aafp.org/about/policies/all/aafp-acog.html>

FM OB Fellowship Reading/Didactical Curriculum

- Developed 2020-2021
- Dr. R. Parmar & Dr. H. Hill

Learning objectives

Fellow should be able to:

- Read assignments to prepare for both inpatient service and outpatient clinic;
- Begin by developing a broad base of knowledge and then layer details as the year progresses;
- Review and Evaluate journal articles to support or change published data;
- Lead resident education on labor and delivery after developing evidence-based approach to management and treatment of obstetric related concerns;
- Maintain a continuing checklist of relevant evidence-based articles in obstetrics and women's health to support lifelong learning;

Methods

- Discussion of articles/chapters
- Viewing of selected prerecorded lectures/videos/audio recordings
- Participation in and leading of hands on simulations
- Completion of interactive modules through ACOG

Assessments:

- Weekly didactics time consisting of review of preread topics with fellow and faculty mentor/lead assigned to the week also familiar with topic
- Readings from Gabbe assessed using questions from Gabbe's Obstetrics Study Guide
- Review of didactic sessions every quarter provided in 360 format

Texts:

- Cunningham and Gilstrap's Operative Obstetrics
- Gabbe et al Obstetrics Normal and Problem Pregnancies 8th edition
- Gabbe's Obstetrics Study Guide
- Creasy & Resnik Maternal-Fetal Medicine, 8th edition
- Simpkins The Labor Progress Handbook
- Protocols for High Risk Pregnancy, 6th edition

Websites/Podcasts/Recorded lectures:

- SMFM, ACOG, AAFP
- OBG project
- Dr. Chapa's Clinical Pearls
- CREOGs over coffee
- Baby Doctor Mamas
- UCSF recorded lectures
- AAFP Maternity Care Conference Lectures
- Ultrasound Lectures: <https://www.aium.org/uls/index.htm>

Journals for journal club:

- The Green Journal—ACOG
- The Blue Journal —RCOG British journal
- The Gray Journal—AJOG

Additional GYN/Newborn topics:

- d&c
- Cervical cancer: PAP, colpo, leep
- Contraception
- Menopause?
- NRP topics

Outline

July

- Evidence based c-section articles
- Clark et al, Prevention of 1st c-section
- Tools and suture
- Sterilization techniques
- GBBS guidelines
- Postpartum hemorrhage
- Operative complications

August

- Hypertensive disorders
- Diabetes
- Hemorrhage chapters and hands on
- Shoulder Dystocia
- Triple I/chorio/endometritis
- Normal and abnormal labor
- Cervical cancer screening
- Maternal mortality; lecture from UCSF or T. Johnson specifics regarding Missouri

September

- Prenatal care
- Postpartum care
- Antepartum fetal evaluation
- Induction of labor
- Breech presentation
- Contraception

October

- Prematurity complications
- PROM/PPROM ch in gabbe
- Post term
- VBAC
- Infant loss/IUFD
- Early pregnancy loss; medication management, surgical management
- Genetic testing

November

- Placental disease
- Fluid disorders
- Alloimmunization
- Breastfeeding
- Depression
- Anemia in pregnancy

December

- Ob us ch
- FGR/IUGR
- Infections in pregnancy
- Pain control in pregnancy

January

- Maternal physiology
- Cardiac disease
- Respiratory disorders
- Skin diseases in pregnancy
- Thyroid
- Multigestation

February

- Infections (bacterial, viral, torch)
- Hepatitis
- Thromboembolism
- Cervical insufficiency

March

April/May

May/June

Chapters in Gabbe

Cesarean delivery ch 19
Preconception and prenatal care ch 6
OB US ch 9
Amniotic fluid disorders ch 35
Preterm labor and birth ch 29
PROM 30
Maternal physiology Ch 3
Genetic screening Ch 10
The neonate ch 22
Normal labor and delivery ch 12
Abnormal labor and induction ch 13
Operative vaginal delivery ch 14
Antepartum fetal evaluation 219
Malpresentation ch 17
Postpartum hemorrhage ch 18
VBAC ch 20
Placenta accreta ch 21
Postpartum care ch 24
Early pregnancy loss and stillborn ch 27
preE and HTN ch 31
FGR/IUGR ch 33
Heart disease in pregnancy ch 37
Respiratory disease in pregnancy ch 39
DM in pregnancy ch 40
Skin diseases in pregnancy ch 51
Lactation and Breastfeeding ch 25
Multiple gestations 32
Cervical insufficiency ch 28
Obesity in pregnancy ch 41
maternal/perinatal infections Ch 52
Viral Infections ch 53
Bacterial Infections ch 54
Thyroid Parathyroid ch 42
Thromboembolic disorders in pregnancy ch 45
OB anesthesia ch 16

Chapters in Protocols for High-Risk Pregnancies

- out of date on several topics but nice guide of different topics

Tobacco/etoh/environment
Depression
Antenatal testing

Maternal disease

Maternal anemia
Sickle cell disease
ITTP
Autoimmune disease

Antiphospholipid antibody syndrome
Inherited thrombophilias
Cardiac disease
Peripartum cardiomyopathy
Thromboembolism
Renal disease
Obesity
DM
Thyroid disorders
acute/chronic hepatitis
Asthma
Epilepsy
cHTN
CMV, herpes, rubella, syphilis, toxo
Flu, west nile, varicella-zoster TB
Malaria
HIV
Parvo B19
GBBS
Acute abdominal pain
Gallbladder, fatty liver & pancreatic disease

OB problems

1st trimester vag bleeding
Cervical insufficiency
Nausea and vomiting
Fetal death and stillbirth
Abnormal amniotic fluid volume
preE
FGR
Rh and other blood group alloimmunizations
Preterm labor
PROM
Indicated late preterm and early preterm deliveries
Prevention of CP
Amnionitis
3rd tri bleeding
AFE

Labor & Delivery

IOL
Intrapartum fetal heart rate monitoring
Breech delivery
VBAC
Placenta accreta
Shoulder dystocia
Twins, triplets, and beyond
Postpartum hemorrhage
Appendix eval of fetal health and defects

