

## Restructuring a Family Practice Obstetrics Curriculum

Thomas C. Peterson, MD, Paul J. Reiss, MD, and William C. Wadland, MD, MS  
Burlington, Vermont

*Maintaining a high-quality curriculum for family practice residency training in obstetrics has become increasingly difficult. In 1984 the faculty of the University of Vermont Department of Family Practice needed to upgrade its obstetric curriculum in a community where family practice obstetrics was nonexistent. The key steps to a new curriculum included the recruitment of family practice faculty with experience in obstetrics, expanded communication with the Department of Obstetrics and Gynecology, the development of baseline attending privileges in family practice obstetrics, the formation of educational tracks for residents, and the promotion of chart audits. Also important were faculty role modeling, intradepartmental meetings, intensive elective rotations, and community education. This case report of program development in family practice obstetrics may serve as a model to help other residency programs.*

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Maintaining an obstetrics curriculum for family practice residents is a challenging task.<sup>1</sup> Comprehensive training guidelines are suggested by the American Academy of Family Practice and the Accreditation Council for Graduate Medical Education.<sup>2,3</sup> External forces nationwide, most prominently liability issues, are resulting in alarming drops in postgraduate obstetrics practice by both family physicians and obstetricians.<sup>4</sup> A recent editorial by Rosenblatt<sup>5</sup> notes that this trend could soon have an impact on the retention of obstetrics training in family practice. In contrast, family practice educators are also aware that the actual source and quality of obstetrics training may influence the choice to perform postgraduate obstetrics.<sup>6</sup> Program curriculum planners struggle in the gap between powerful socioeconomic factors and the requirement to provide comprehensive biosocial and technical training to residents so that they may aspire to provide the entire spectrum of family care. The situation is aggravated by lack of mutual understanding between family practice and obstetrics groups, lack of appropriate family practice faculty role models,<sup>7,8</sup> and, sometimes, lack of patient volume at the training site. Common sense

suggests that relevant and appropriately extensive obstetrics training would improve the family practice residents' comfort in this area and assist interested individuals in filling the void left by obstetricians and family physicians.

This report describes the reorganized curriculum in obstetrics at the University of Vermont Department of Family Practice. The method of reorganization illustrates that successful curriculum changes can occur in this environment; it may serve as a model for other programs.

The 1984 obstetrics curriculum of the Department of Family Practice required a 2-month rotation in the first resident year (PGY-1) and a 1-month night coverage rotation in the second year (PGY-2) on labor and delivery at the Medical Center Hospital of Vermont (MCHV). Prenatal care at the ambulatory family practice site was limited to three to five patients per resident over 3 years of training. Family practice residents did not participate in the delivery; instead, the physicians in the Department of Obstetrics and Gynecology performed the delivery. Family practice resident instruction in obstetrics was provided entirely by obstetricians. The tutelage included a monthly visit to the ambulatory practice by an obstetrics fellow or chief resident. In addition, family physicians had not attended in obstetrics at MCHV for 20 years, although the hospital is the sole provider in the county for inpatient obstetric services. All of the 2700 annual deliveries at MCHV were supervised by obstetricians and nurse midwives.

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*From the Department of Family Practice, University of Vermont College of Medicine, Burlington. Requests for reprints should be addressed to Thomas C. Peterson, MD, University of Vermont College of Medicine, A-111 Given Building, Burlington, VT 05405-0063.*



TABLE 1. DEVELOPMENTAL CHRONOLOGY

Date	Events
3/85	Residents negotiate to deliver their own prenatal patients (with obstetrics back-up)
6/85	Faculty member recruited to lead family practice obstetrics development
10/85	Family practice obstetrics privilege package approved
1/86	Monthly obstetrics chart audit by family practice faculty initiated
5/86	Educational tracks developed
7/86	Two new family practice obstetrics faculty added
9/86	Regular meetings between obstetrics and family practice faculty begin
1/87	Two community (private) family practitioners obtain obstetrics privileges
9/87	Two more family practice obstetrics faculty added
7/88	Family practice faculty cover all family practice obstetric deliveries

Program graduate participation in obstetrics was uncommon; to do so generally required extra training beyond the core curriculum.

Prospective resident candidates, family practice residents, and the department leadership recognized the training inadequacies and were concerned about compliance with accreditation guidelines.<sup>3</sup> These concerns were addressed in a 3-year plan both to develop a progressive, high-quality curriculum and to establish family practice obstetrics firmly in the community. Chronological steps included the recruitment of a faculty member qualified in obstetrics, expansion of peer resident liaisons with the department, definition of family practice provider privileges, opening a dialogue with the Department of Obstetrics and Gynecology to clarify family practice resident education needs, and attention to improving the quality of the prenatal care experience (Table 1).

## REORGANIZATION OF OBSTETRICS CURRICULUM

### Attending Privileges

The recognition of family physician obstetric skills was a critical step. In August 1985 an experienced family physician with residency training in obstetrics was recruited

TABLE 2. BASELINE PRIVILEGES FOR FAMILY PRACTICE OBSTETRICS

Requirement	Privileges
Without consultation	Delivery (normal vertex, outlet forceps) Management of bleeding (first trimester) Fetal distress (transient, intermittent) Circumcision of newborn Episiotomy Lacerations (vaginal, perineal, cervical) Amniotomy Fetal monitoring (external, internal) Premature rupture of membranes (term)
Consultation	Induction Toxemia (mild, moderate) Retained placenta (manual removal) Prolonged labor (prolonged latent phase, protracted active phase, arrest of dilatation, and/or descent) Fetal monitoring with internal pressure catheter Premature rupture of membranes (with induction, less than 38 wk)
Transfer of care	Delivery (breech, mid-forceps) Management of bleeding (second and third trimester) Toxemia (severe) Fetal distress (continuing) Cesarean section Dilation and curettage Other medical problems on recommendation of consultant

NOTE: Consultation is required for all antepartum admissions

to lead the development. An immediate issue was the lack of MCHV privilege guidelines in obstetrics for family physicians. The new faculty member was familiar with baseline family practice privileges and their value in enhancing understanding between departments.<sup>9</sup> The closest regional academic center, The Dartmouth Medical Center, had clear guidelines for family practice obstetric care. Thus, the baseline privileges for family physicians at MCHV were modeled after the AAFP guidelines on hospitals,<sup>10</sup> the Dartmouth guidelines, and the community hospital experience of the new faculty member (Table 2). Once the baseline privileges were established, there was no difficulty in obtaining the privileges for other qualified family physicians.

The only area of concern with regard to the baseline privileges was the need for consultation for all labor inductions and use of internal pressure catheters. The consultations were soon discovered to be supportive, however, and function as a means to keep the obstetric resident service aware of any potential difficulties. The consultations have not interfered with patient manage-



**TABLE 3. OBSTETRICS EDUCATION AND PROCEDURE TRAINING TRACKS**

Track	Education or Procedure
Track 1 (PGY-1 through PGY-3)	Initial prenatal examination Labor evaluation Normal vaginal delivery Artificial rupture of membranes Anesthesia (local) Fetal monitoring (external, internal, pressure catheter) Supervision of oxytocin administration Second assist, cesarean section, tubal ligation Circumcision Episiotomy repair
Track 2 (PGY-2 through PGY-3)	Vaginal delivery (repeat cesarean section) Low forceps/vacuum assist pH sampling technique Fourth-degree episiotomy repair Anesthesia (pudendal) Oxytocin challenge test/nonstress testing Basic ultrasound evaluation Laceration repair (cervical, fourth degree) First assist at cesarean section/tubal ligation Manual removal of placenta
Track 3 (PGY-3)	Suction curettage for first trimester abortion Amniocentesis Breech delivery Twin delivery Cesarean section Tubal ligation Ectopic pregnancy Uterine exploration
<i>PGY-1, PGY-2, PGY-3 refer to family practice residency years 1, 2, 3, respectively</i>	

ment or the performance of procedures by the family physicians.

**Faculty Development**

The development of a faculty who performed obstetrics was critically important in establishing a viable curriculum. Currently six family physicians with interests in obstetrics facilitate the training. The backgrounds of these physicians range from solo rural obstetric care to academic university practice. They supervise all family practice resident and faculty patient deliveries as well as the prenatal care provided by residents at the model practice site. In addition, they serve as role models for the residents by maintaining their own obstetrics practices. Faculty communicate frequently with the university obstetricians and the obstetric residents. This dialogue is essential and assures continued development of the educational experience.

**Educational Tracks**

In the new University of Vermont family practice obstetrics curriculum, each resident chooses one of three levels of obstetric training with the understanding that his or her choice may influence later career decisions regarding obstetric practice.<sup>5</sup> The new curriculum is structured on a track system that allows the residents to examine educational options early in their training (Tables 3 and 4). The tracks also guide the evaluation process and serve as a documentation tool for privileges.

Track 1 includes the essential core of skills and knowledge needed to practice family medicine, but not obstetrics. Track 2 is designed for residents who are planning to perform routine nonoperative obstetrics and includes both fundamental and advanced skills. The majority of the residents complete this track. Track 3 outlines the essential training for a family physician to practice competent operative obstetrics. To achieve the completion of Track 3, an individual would need to invest additional postresidency training in an extended elective or a fellowship.

Formal residency review occurred after the initiation of this curriculum. The review was most favorable, identifying no deficiencies in obstetrics training. Full accreditation was granted.

**Ambulatory Care**

The focus of the obstetrics experience is the resident's own primary care practice. Residents have the opportunity to provide both antepartum and intrapartum care for multiple patients from their practices. An organized approach to prenatal care is available to guide the resident. A risk-assessment tool and problem list are utilized. The faculty has developed a series of screening and management cues. A faculty member audits each chart monthly

**TABLE 4. PROBLEM MANAGEMENT RECOMMENDED FOR COMPLETION OF TRACK 2**

- Postmature pregnancy
- Premature rupture of membranes
- Mild and moderate toxemia
- Gestational diabetes, non-insulin-dependent
- Herpes screening
- Human immunodeficiency virus issues
- Management of bleeding
- Prolonged labor
- Fetal distress
- Neonatal resuscitation
- Meconium staining
- Premature labor
- Selective induction

*NOTE: The family practice resident should develop an understanding of the above management areas and the appropriate timing to obtain specialist consultation*