REPORT OF THE
EASTERN VIRGINIA MEDICAL SCHOOL, MEDICAL COLLEGE OF VIRGINIA/VIRGINIA COMMONWEALTH UNIVERSITY, AND THE UNIVERSITY OF VIRGINIA SCHOOL OF MEDICINE ON

OBSTETRICAL TRAINING OF FAMILY MEDICINE RESIDENTS IN THE COMMONWEALTH

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 6

COMMONWEALTH OF VIRGINIA
RICHMOND
1997

Eastern Virginia Medical School

Report on Obstetrical Training of Family Medicine Residents at the Eastern Virginia Medical School

Preamble

Approximately thirty percent of family practitioners nationwide practice obstetrics to some degree. The percentage varies widely from state to state, highest in the northwest and west, lowest in the southeast. In Virginia, eleven percent of family practitioners are involved in obstetric care. This is one of the lowest rates in the country. Because of its importance within the discipline of family medicine, the American Academy of Family Practice has recently re-emphasized and mandated obstetrical training for all residents. Recently the requirements were increased to include, at a minimum, two months of obstetrics, forty deliveries, and ten patients followed longitudinally to delivery. For residents anticipating doing obstetrics as a part of their practice, the Academy recommends a total of six months of obstetrics If they intend to do surgical obstetrics, the Academy recommends a six to twelve month obstetric fellowship.

Eastern Virginia Medical School has responsibility for two separate family medicine residency training programs. One of these is located on the main medical campus in Norfolk, the other is housed in a "model" family practice building that was especially constructed for the program in the neighboring city of Portsmouth. The programs are named "Ghent Family Practice" and "Portsmouth Family Medicine" respectively. Historically, both programs have received teaching and support from the school's Department of Obstetrics and Gynecology and the Division of Maternal and Fetal Medicine (both are which are contained within the Jones Institute of the Eastern Virginia Medical School).

In recent years both family medicine residency programs have been adversely affected by a number of factors. First, the number of "clinic" deliveries dropped precipitously because of changes in the state Medicaid program. This made the inpatient obstetric rotation less effective in providing family practice residents the basic skills for prenatal care and routine deliveries during their first-year rotation. The number of deliveries performed by each first-year resident has dropped over the past three years from approximately forty to a current average of fifteen. Inevitably, there has been a corresponding drop in the ability, confidence, and enthusiasm of the residents to practice obstetrics. Second, during the past year, there has been a significant loss of obstetric faculty teaching effort (within the Department of OB/GYN as well as in the Department of Family Medicine) due to the resignation of one individual, and the illness of another.

The status of obstetric teaching and plans for the revitalization of obstetric learning in both programs will now be discussed. Each program will be described independently.

Ghent Family Practice Residency Program.

Historically, the Ghent Family Practice Residency Program has had a varying degree of emphasis on obstetric training. Before the current requirement for a longitudinal experience existed, approximately thirty to fifty percent of residents would choose the obstetric track, with six months obstetrics and five to ten longitudinal patients in the second and third year. The remainder would do the minimum two months of obstetrics in the first year and a combined GYN/OB month in the second year. Family practice faculty support ranged from one to four faculty members doing obstetrics. The Department of Obstetrics and Gynecology provided ten to twenty percent time of one faculty member to support outpatient obstetrics and gynecology.

At the beginning of this academic year, the department recruited a Generalist Family Medicine Clinical Scholar who had received additional fellowship training in obstetrics. New relationships are in the process of being formalized with the Division of Maternal and Fetal Medicine, and extensive review/revision of the obstetric curriculum and training process has been initiated. In the past year, the department supported the efforts of a nurse practitioner to become certified as a nurse midwife, and she is now being integrated into the Outpatient obstetric clinical practice, as well as the residency teaching program. At the present time, residents in the Ghent Family Practice Program are performing approximately 160 deliveries per year (90 during their inpatient obstetric rotation, and 70 as a part of their longitudinal continuity of care practice experience in the family practice center). To meet the new requirements, they will need to expand this practice to a total of approximately 240 deliveries per year.

There is every indication that such expansion is possible. Additionally, the influence of the Generalist Family Medicine Scholar, coupled with the very high level of collaboration that has been shown by faculty at the Jones Institute has sparked a strong sense of enthusiasm among the residents. One hundred percent of the residents are now involved in "longitudinal" obstetrics (compared with only twenty-two percent last year), and all of the residents are actively participating in the planning and implementation of the emerging new program. Therefore, although a recent review of the past graduates of the Ghent Residency indicated that only some fourteen percent are currently providing obstetrical care, there is every reason to believe that this number will increase significantly in the future.

Portsmouth Family Medicine Residency Program.

Although fully supported by the medical school, both financially as well as administratively, Portsmouth Family Medicine Residency Program has many of the characteristics of a typical community-based program. In addition to a full-time faculty of six family physicians (none of whom are currently practicing inpatient/delivery obstetrics), the Portsmouth program relies heavily on local community physicians for residency teaching and specialized rotations. Historically, the Portsmouth residents were supervised by a full-time member of the EVMS obstetrics department faculty, who

conducted the majority of deliveries at Portsmouth General Hospital. During this past academic year, this individual resigned his academic position, and subsequently the program has had to rely on the supervisory expertise and teaching services of private, community obstetricians. At the present time, although all of the Portsmouth residents are engaged in "longitudinal" obstetrics, the volume is very low and the new requirement will be difficult to meet unless some major changes can be effected. The Jones Institute at Eastern Virginia Medical School is working with the Department of Family and Community Medicine and the Portsmouth Family Medicine Residency Program to address these issues. In addition, an attractive new location for inpatient obstetric training has been identified (and is currently being explored) and the potential for further collaboration and input by private obstetricians in the community is good.

Conclusion

The current full-time family practice faculty in both residency programs have recognized the need for them to become re-involved in the practice and teaching of clinical obstetrics. As certified (and mostly recertified) diplomats of the American Board of Family Practice, all current faculty have a demonstrated knowledge base in the field of Ob-Gyn. Clearly, the application of this knowledge and the re-development of obstetrical clinical skills will require some intensive and ongoing faculty development, and this has been initiated. In addition, the department has established current obstetric skill and practice as a requirement for the recruitment of further teaching faculty. Coupled with the high level of collaboration and support provided by the Jones Institute at EVMS, the future training of family practice residents in obstetrics appears to have a solid foundation.

Virginia Commonwealth University/Medical College of Virginia

Report on Obstetrical Training of Family Medicine Residents at the Virginia Commonwealth University/Medical College of Virginia and its Affiliated Programs

Virginia Commonwealth University/Medical College of Virginia has five family practice residency training programs located in Blackstone, Chesterfield, Fairfax, Hanover and Newport News (Riverside). All five enjoy fill accreditation from the Liaison Committee on Graduate Medical Education. A survey was conducted to ascertain compliance with the present and proposed new requirements of obstetrical training within the essentials for family practice residency accreditation. Compliance with these new essentials should lead to family physicians who can provide obstetrical services for uncomplicated deliveries in rural Virginia.

Present requirements for maternity care require a two month experience where the resident (1) must be provided instruction in the biological and psychosocial aspects of pregnancy, delivery, and care of the newborn of a woman and her family to include the principles and techniques of prenatal care, management of labor and delivery, and post partum care to enable residents to manage a normal pregnancy and delivery; (2) must assume the responsibility of longitudinal provision of antenatal, natal, and postnatal care during their three years of training; and, (3) elective experiences in high-risk maternity care, including the opportunity of residents to develop technical proficiency in appropriate operative procedure that may form a part of their future practice.

In addition to the above, the proposed new requirements in obstetrical care include:

1. Each resident must have direct responsibility for and performance of a minimum of 40 deliveries.

2. At least 10 of those deliveries must be longitudinal within the family practice center.

3. The program must have family physician faculty with hospital privileges in obstetrics who are engaged in providing these services and who can supervise the residents and serve as role models for them.

4. The resident must be trained in the recognition and management of the high-risk prenatal patient, including consultation and reterral as appropriate.

5. Residents must receive training in genetic counseling.

Review of the survey provides the following overview for compliance with accreditation for maternity care present and proposed:

pregnancy. As a result, continuity with patients throughout their pregnancy is difficult to accomplish here. The majority of residents do not have responsibility for providing longitudinal care of antenatal, natal and postnatal care for the same patients during their three year residency.

All first and second year residents are certified in Advanced Life Support in Obstetrics (ALSO) through the American Academy of Family Practice. Arrangements for residents to receive genetic counseling are in progress.

Residents have overall direct responsibility for 30-300 deliveries during their three years of training. However, there are residents who do not get the minimum of 40 deliveries per resident because of scheduling and the delivery time of the mother. Additional elective experience in maternity care is offered, including high-risk maternity care. There is no opportunity for residents to develop technical proficiency in operative procedures. Since there are many obstetricians practicing in the South Richmond area, very few obstetrical patients are available for family practitioners to follow. In addition, the hospitals have historically made it very difficult for family practitioners to deliver OB services. Meeting the new training requirements will be difficult.

Fairfax Family Practice Center.

Residents receive two months of obstetrical training in the first year on a busy obstetrical impatient unit at the Fairfax Hospital. This experience also includes time in the obstetrical outpatient clinic at the hospital. The residents then receive ongoing experience over the second and third years, following at least ten patients over the two year span. An obstacle involved in meeting this requirement, however, is Medicaid reimbursement. As more community providers begin to accept Medicaid reimbursement, the number of patients who receive their care through the traditional route of the health department and the obstetrical clinic at the hospital has declined. In fact, while the number of overall deliveries has not changed substantially, the number of "service" deliveries has declined. Another obstacle is that of achieving adequate numbers of deliveries in the second and third year for male residents, due to some patients' preference or cultural requirement for a female provider.

Residents also participate in the care of patients on the High Risk Perinatal Unit during their first year inpatient experience, as well as training high risk patients in the hospitals' outpatient clinic. During the second and third years, residents learn to recognize, manage, and appropriately refer high risk patients through their interactions with and supervision by both family practice faculty and obstetrical consultants. In addition, residents are taught via ddidacticon the complications of pregnancy. These lectures are taught by family practice faculty and by obstetricians. There is a monthly obstetrical case conference in which complicated pregnancies are presented, and many residents avail themselves of the Advanced Life Support Obstetrical (ALSO) course. Residents receive training in genetic counseling. Each resident has direct responsibility for thirty to fifty deliveries over the three year training period. Residents also assume responsibility for six to twelve cases of longtidudinal provision of antenatal, natal and postnatal care during

their three years of training. The residency will meet the new requirement of ten patients through increased recruitment of patients and through sharing of patients with faculty who do obstetrics. Twelve family practice faculty have hospital privileges in obstetrics. Finally, additional elective training in maternity care is available, though it currently does not include high-risk maternity care. Operative training is also available.

Hanover Family Physicians.

Residents presently receive two months of obstetrical training at MCV Hospitals with an additional night call week during the GYN Outpatient experience, plus longitudinal experience during the three years of residency with a concentration in the final two years. Residents receive training in the recognition and management of the high risk prenatal patients at the university center. In addition, all faculty at the residency site have pursued additional obstretical training as well as served as instructors in the AAFP Advance Life Support in Obstetrics course Residents are taught to recognize complications and emergencies thorough the MCVH experience, as well as the family practice faculty-supervised longitudinal care experience. Genetic counseling is taught residents by MCV faculty and consults for patients at the MCV Genetic Counseling Center.

A recent intern who rotated through OB (x 2 months) assisted with 36 deliveries. An upper class resident will assist with a total of 46 deliveries, in addition to five deliveries performed during an additional week in Labor and Delivery.
These deliveries are down from the class of 1992 because of the drop in total delivery counts for the hospital.

Residents assume responsibility for the longitudinal provision of antenatal, natal, and postnatal care for at least five to fifty patients during their three years training experience. To meet the new minimum requirement of ten patients, the residency has already undertaken a 14-step plan to increase the number of longitudinal patients for resident involvement. Liaisons regardless of payor mix are being investigated with the local health department.

Six family practice faculty currently have hospital privileges in obstetrics. Additional elective training in obstetric care is provided in off-sites at Fort Belvoir, Mary Washington Hospital and Newport News. An unfortunate downside to this away experience is the educational costs that are not covered by state funds. The Rappahanock Area Health Education Center has assisted on a temporary basis with partial support.

Riverside Family Practice Center.

Residents currently do two months training in maternity care under supervision of obstetrical colleagues. Additional training is difficult due to the resistance on the part of the obstetrical faculty to allow us to do longitudinal care. Residents are currently trained in the recognition and management of the high risk prenatal patients. Residents are also taught to recognize complications and emergencies in pregnancy through emergency room training with obstetrical consultants. Finally, residents are instructed in genetic

counseling.

Each resident presently does approximately twenty deliveries. For residents to meet the requirement of forty deliveries will necessitate changes in the way the obstetrical department is run to allow our residents to do more. Currently no residents do longitudinal obstetrical care. No family practice faculty has obstetrical hospital privileges so that plans are underway to hire a double-boarded OB/GYN-Family Practice faculty person. Residents are offered elective training in maternity care along with the opportunities to become technically proficient in operative obstetrics.

University of Virginia School of Medicine

Report on Obstetrical Training of Family Practice Residents at the University of Virginia and Its Affiliated Program

The purpose of this report is to respond to Senate Joint Resolution #72 which is to look at the evaluation and training of family medicine residents in obstetrics within the state of Virginia. This particular response focuses on the training of family practice residents at the University of Virginia and its affiliated programs in Roanoke and Lynchburg.

Over the last several years the University of Virginia Department of Family Medicine which includes the Charlottesville, Lynchburg and Roanoke locations, has made considerable strides to enhance obstetrical education at their respective sites. This has been supported by the fact that a greater number of family practice residency graduates are choosing to do obstetrics in their practice but the mechanism to obtain adequate obstetrical training within the residency varies from site to site. It is a known premise that the residency review committee for family practice residency training in the United States requires basic obstetric training for a minimum of 2 months rotation. Most all involved in primary practice education realize that family physicians need more experience than just the basic 2 months rotations such as extra rotations at the same or remote sites with further obstetric education enhanced by longitudinal patient care within the training practice themselves. The following summary of each program will look at the individual residency sites within the University of Virginia system to evaluate the efforts within the residencies themselves and whether or not appropriate back up is provided by obstetrical service and whether or not obstetrical service is provided within the parent department of the family practice residency.

Executive Summary

Within the University of Virginia Department of Family Medicine three residency training sites, the issue of obstetrical care has been a concern since the institution of each of these programs. The advancement of the training at these locations have site specific strengths, concerns and complications. Serious threats are present including inadequate volumes, challenge in recruiting Family Practice faculty who do OB and variable support by the OB community.

There is no doubt that in several areas within the state of Virginia the numbers of family practitioners providing obstetrical care have increased but are fairly well localized. For example, in 1979, there were no family physicians in the entire Charlottesville central Virginia area providing obstetrical care. Presently within Charlottesville alone, seven family practitioners provide obstetrical care within the private community. Within the Roanoke area the addition of just four family practitioners to the faculty has definitely enhanced obstetrical care provided by family physicians in the immediate Roanke area along with the well established obstetrical care provided in Rocky Mount and the Moneta area for several years. But as reflected in the problems noted in the Lynchburg area, there are no family physicians at the present time providing obstetrical care within the

Lynchburg area and this has greatly been reflected in the difficulties Lynchburg has noted in getting the adequate support for their own training.

Lynchburg Family Practice Residency (LFP)

The Lynchburg Family Practice Residency has been successfully graduating family practitioners over the last 22 years. Approximately 65% of their graduates practice in small towns or rural areas where the need of obstetrical care is great. Unfortunately, less than 10% of the resident graduates provide obstetrical care in practice.
LFP has met the basic requirements to provide obstetrical training within their residency although none of the family practice faculty provide obstetrical care. This sets the stage for full dependence on the local obstetrical community to provide the training.

Since the institution of the LFP, the obstetrical back up and training within the program has been the single most disconcerting aspect at this training site. The faculty at LFP has spent many hours over these 22 years trying to negotiate and accommodate the concerns of the local obstetrical department so that they could have an excellent learning experience for the residents. They have failed to reach anything more than a minimally acceptable situation. Because of these local conflicts, the difficulties with the obstetrical training has significantly contributed to the loss of two excellent residency directors.

At this time, the LFP is very dependent on the local nurse midwives to provide supervision and training for the residents. The local nurse midwives have done an excellent job in their training. Ideally, if the local obstetrical community could provide back-up support, the family practice faculty should also be providing obstetrical care within their department. A possible alternative is to hire an obstetrician on the faculty at the family practice residency.

Roanoke Family Practice Residency (RFP)

The Family Practice Residency of the Carillon Health System in Roanoke, VA has been providing training for family practice residents for over 25 years. Over those years, significant numbers of graduates practice or have practiced obstetrics within their community. Within the last four to five years RFP has greatly accelerated their efforts to provide outstanding role modeling and obstetrical education within their department by enhancing their faculty with four family physicians who provide obstetrical care. These faculty provide care for routine vaginal deliveries, forceps and vacuum assisted deliveries but do not provide cesarean sections.

Within the residency program, due to the growing demand for enhanced obstetrical training for some residents, Roanoke has devised a two track program, one of which emphasizes more obstetrical exposure within the three year training. This track provides two months in the first year, one month in the second year and two months again in the third year. Part of the time in the third year is spent working with practicing family physicians in Rocky Mount, VA or Moneta, VA which further enhances the residents exposure to needs of the community and thus sets up a good line for future recruitment.

The one difficulty in the obstetrical education is the variable support within the parent hospital itself. Rarely, a family practice resident will be allowed to perform a vacuum assisted delivery and never a forceps delivery. Occasionally they will be allowed to scrub in on a cesarean section but this fluctuates and requires a good bit of assertiveness from the resident themselves. While there is close supervision of the family practice residents by the obstetrical residents, there is little formal teaching by the residents or faculty. Most of the teaching occurs on the rounds themselves.

The other concern is the lack of adequate volume of obstetrical patients on their primary rotation. The number of actual deliveries per month performed by the family practice service while on OB rotation varies but in general is less than 15. It is important to note that these deliveries are usually very low risk, usually simple spontaneous vaginal deliveries. And while on the OB service they are not permitted to perform vacuum or forceps assisted delivery. Any other training they receive in assisted delivery techniques comes from the family practice faculty.

The best training and experience for the family practice residents occurs during the longitudinal care of their own residency practice patients. The RFP residents are given opportunities to manage more complicated patients rather than having to transfer them to the OB residency clinic. Unfortunately, the number of OB patients available for residents to follow are also inadequate. In general, the OB track family practice resident graduate will have performed only 15 to 20 deliveries through their longitudinal clinic in the family practice center.

The RFP faculty have developed an outstanding structured didactic educational program for the family practice residents but are unable to provide a sufficient volume of patients to uniformly insure that the family practice graduates are adequately trained for independent practice, particularly practicing in a more rural environment. The presence of the OB residency is probably at best neutral, neither providing significant support or teaching nor creating a significant impediment to our educational efforts.

University of Virginia Family Practice Residency, Charlottesville (UVAFP)

The University of Virginia Family Practice Residency in Charlottesville, VA has been providing active obstetrical emphasis within the department itself since 1979. Approximately 1/3 of the graduates of the residency have, at one time, provided obstetrical care within their practice in their respective communities.

The initial training for the core 2 months of rotation from 1979 to 1981 was provided at Fredericksburg, Virginia, a community hospital setting. By 1981, there was active support by the Department of OB/GYN at the University of Virginia to have the family practice residents acquire their principle training within the University Hospital. There has been adequate in-house support by the OB/GYN department for the family practice residents in conjunction with the OB residents. Family practice residents do their two month core rotation during their second year. Placement in the second year has been

necessary due to logistical issues in the rest of the CFP curriculum. Those residents who desire to continue obstetrical care in their practice will elect one to two months extra obstetrical rotation at a site outside of the University setting and usually out of state of Virginia.

There is a constant effort to enhance obstetrical education within the family practice setting. Presently there are nine family practice faculty who provide obstetrical care within the principle residency at the University Hospital and at two satellite offices. On average, family practice residents complete their training with ten to twelve deliveries of their longitudinal patients and approximately 25 to 40 deliveries on their obstetrical service.

The major concern at the University site is the decreased volume of patients. This is complicated by the fact that during this time the OB/GYN residency has increased by one resident per year. The family practice residency has increased from six to eight residents per year and the new emergency medicine residency has required some obstetrical experience for their residents. During the same time the total volume of deliveries at the University Hospital has decreased. Now there is an active need, in one way or another, to enhance the number of deliveries either locally or by reaching out to other sites within the state of Virginia.

Appendices

1) Senate Joint Resolution 72

2) Synopsis of Related Studies Regarding Access to Obstetric Care

3) **ACGME Program Requirements for Family Practice,** pgs. 188-190.

962023828

SENATE JOINT RESOLUTION NO. 72

Senate Amendments in [ ] —February 9, 1996

Requesting [~~Virginia's academic health centers~~ the Medical College of Virginia of Virginia Commonwealth University, the University of Virginia Health Sciences Center, and the Eastern Virginia Medical School] to evaluate their programs for obstetrical training of family medicine residents.

Patrons—Lambert, Walker and Woods; Delegates: Baker, Brickley, Connally, DeBoer, Heilig, Melvin, Morgan and Moss

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Referred to the Committee on Rules

WHEREAS, measures such as infant mortality rates and low-weight birth rates indicate that Virginia needs to improve its maternal and child health care system; and

WHEREAS, quality obstetrical care is an essential element of an effective maternal and child health care system; and

WHEREAS, many rural areas are experiencing a shortage of obstetricians; and

WHEREAS, family physicians who provide obstetrical care are a vital resource for rural Virginia; and

WHEREAS, rural family physicians who practice obstetrics must be supported by appropriate referral and consultative arrangements with obstetricians; and

WHEREAS, obstetricians must be assured that referring family physicians are able to provide state-of-the-art prenatal care, detect high-risk pregnancies, and make appropriate referrals and requests for consultation; and

WHEREAS, family physicians and obstetricians must have a clear and mutually supportive relationship if Virginia is to make progress in assuring adequate access to obstetrical care in rural areas; and

WHEREAS, such supportive relationships should be formed during the obstetrical training of family physicians; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Medical College of Virginia of Virginia Commonwealth University, the University of Virginia Health Sciences Center, and the Eastern Virginia Medical School be requested to evaluate their programs for obstetrical training of family medicine residents to ensure that graduates are adequately trained to meet the demands of rural obstetrical practice within a collaborative environment with obstetricians. Each institution shall consult with representatives of community-based residency programs in conducting the study.

Each institution shall provide staff support for its study.

Each institution shall report on its progress to the Governor and the General Assembly by October 1, 1996, as provided in the procedures of the Division of Legislative Automated Systems for processing legislative documents.

Official Use By Clerks

Passed By The Senate		**Passed By The House of Delegates**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

Clerk of the Senate | Clerk of the House of Delegates

SYNOPSIS OF RELATED STUDIES REGARDING ACCESS TO OBSTETRIC CARE

1989 **Medical Society of Virginia. Problems and Solutions to Access to Obstetrical Care Virginia Physicians Respond.** The Medical Society conducted a comprehensive survey of family physicians and obstetrician/gynecologists throughout the state regarding their views of potential solutions in improving accessibility to obstetrical services. The conclusion of that study was there was a moderate to serious access to care problem in Virginia, particularly for the Medicaid and indigent populations, and that there are relatively few obstetricians currently located in sparsely populated areas of the state. Resolutions included: (1) Stemming the flow of physicians leaving the practice of obstetrics. (2) Enlarging the pool of physicians willing to provide obstetrical services. (3) Attract physicians willing to provide obstetrical services to underserved areas. (4) Remove barriers to participation in programs serving the financially needy obstetrical patient. (Increase reimbursement, reduce paperwork and provide financial assistance with malpractice premiums). (5) Encouraging a systems approach to the delivery of obstetrical care in underserved areas.

1990 **Virginia Health Planning Board Senate Document No. 27. (SJR 168) Access to Obstetrical Care.** This study identifies general barriers that exist within many parts of Virginia which must be eliminated or significantly reduced if access to obstetrical care is to be improved. Selected recommendations include: (1) Empower the Boards of Medicine, Nursing, and Pharmacy to pursue the changes necessary to allow for broader participation by nurse practitioners, including nurse midwives in the delivery of obstetrical care services. (2) Provide greater access to quality prenatal care regardless of the patient's payment source. (3) Focus existing resources and efforts to increase the availability of transportation for women to obstetrical care providers. (4) Pay part of the medical liability insurance premiums for medical providers of obstetrical care for medically underserved communities. (5) Endorse efforts to enhance utilization of the Birth-Related Neurological Injury Compensation Act. (6) Support funding needed to provide the manpower necessary to implement initiatives such as case management for high-risk women.

1990 **Task Force on the Practice of Nurse Practitioners, Virginia Department of Health Professions. A Survey of Physicians in Virginia and A Survey of Nurse Practitioners in Virginia.** This report summarizes results obtained from nurse practitioners and physicians surveys. Some of the relevant findings from the physician survey: (1) Most physicians had some experience working with nurse practitioners. (2) Physicians reported that the most important disincentives for practicing in collaboration with nurse practitioners were potential malpractice liability and the time required for supervision. (3) Most physicians were opposed to extending eligibility for direct third party reimbursement to nurse practitioners. (4) Most physicians were supportive of extending prescriptive authority to nurse practitioners with certain limitations. (5) Most physicians

support extending hospital privileges to nurse anesthetists but are opposed to extending the same privileges to primary care nurse practitioners and nurse midwives. Some of the relevant findings from the nurse practitioners survey: (1) Hospitals provide the main practice setting for close to one-half of the nurse practitioners; only 23% indicated that their practice areas were rural. (2) One-half of the practicing nurse practitioners noted that they currently had hospital privileges. (3) Fully one-half of the nurse practitioners noted that extending prescriptive authority would greatly enhance their ability to care for patients. (4) The majority of nurse practitioners indicated that it would be personally important to have direct reimbursement. (5) Very few nurse practitioners indicated that they had ever been named in a lawsuit.

1990 **Virginia Health Planning Board.** Alternative Providers in Medically Underserved Areas This study focuses on the utilization of primary care nurse practitioners and certified nurse midwives to improve access to primary care services. Selected recommendations: (1) Increase the level of Medicaid reimbursement to primary care physicians. (2) Remove barriers to third party reimbursement for midlevel provider services. (3) Increase use of telecommunications technology in baccalaureate level degree and nurse practitioner educational opportunities to rural areas. (4) Expand clinical experiences in medically underserved areas for midlevel educational programs. (5) Establish a scholarship program for the education of midlevel providers. (6) Increase funding for the Virginia Physician Loan Repayment Program. (7) Encourage professional groups, educational institutions, and local health planning boards to present programs for physicians that explain the roles, functions, and benefits of utilizing midlevel providers in primary care medical practices. (8) Authorize limited prescriptive authority to nurse practitioners throughout the Commonwealth.

1991 **Task Force on Access to Obstetric Care.** Issues and Recommendations Relating to Obstetrical Care in Virginia. The Virginia Hospital Association in collaboration with the Virginia Obstetrical and Gynecological Society created a task force in September of 1989 to look at the various issues relating to access to obstetrical care in the Commonwealth. The Health Planning Board's Report on Access to Obstetrical Care and the Medical Society of Virginia's survey, Problems and Solutions to Access to Obstetrical Care: Virginia Physicians Respond were reviewed. Recommendations: (1) State health officials must develop a fundamental, statewide policy which commits Virginia to ensuring that adequate obstetrical care is available to all women regardless of where they live in Virginia or their ability to pay. (2) Because the problems with access are so unique to each locality, localized efforts will be necessary to determine the needs of that particular population. One suggestion is the creation of local advisory boards to health departments. (3) Reimbursement to providers caring for Medicaid patients should continue to be increased and maintained at a level which is reflective of the costs incurred by providers for the care they give. (4) Local health departments must be given more autonomy and flexibility in order to meet the locality's special needs.

1992 **HJR 235 Requesting the Commission on Health Care for All Virginians to study the actuarial basis for the costs of malpractice insurance for obstetricians and for others who offer obstetric services**

1992 **Report of the Department of Health Professions and the Virginia Health Planning Board. The Potential for Expansion of the Practice of Nurse Midwives** (HJR 431 Requesting the Health Planning Board in conjunction with the Department of Health Professions to study the potential expansion of the practice of nurse midwives). Recommendations included: (1) Endorse the collaborative practice concept of physicians and nurse-midwives. (2) Directed the General Assembly to provide funding and determine the site for an accredited nurse-midwife education program to be established. (3) Provide incentives for prenatal and obstetric care for the underserved. (4) Establish a scholarship program for nurse-midwifery students based upon the student's agreement to practice in medically underserved areas of the Commonwealth for a minimum time period. (5) Appropriate state agencies develop financial incentives for health care practitioners, hospitals, and local health departments who agree to work with certified nurse-midwives to provide perinatal services in medically underserved areas or for medically underserved populations. (6) The Department of Medical Assistance Services consider providing incentive payments for prenatal and obstetric services to Medicaid recipients provided by collaborative physician/nurse-midwife practices. (7) The Commission on Health Care for all Virginians initiate and support legislative proposals to amend open staff provisions of current hospital licensing statutes to include certified nurse-midwives whose collaborating physicians have privileges. (8) Endorses the concept of perinatal regional care practiced in a manner systematically related to the essential perinatal care needs of individual communities and the regions. To assess local needs and priorities and to develop strategies to meet these needs at a local level, community advisory panels should be developed to include local health department representatives, hospital officials, family practitioners, obstetricians, certified nurse-midwives, and citizens. (9) The Virginia Health Planning Board study the efficacy of birthing centers in extending access to obstetric care.

1995 **Report of the Secretary of Health and Human Resources. House Document No. 24: An Initial Evaluation of Precedent, Need, Support and Desirability of Including Obstetrician/Gynecologist in Legislative Definitions of Primary Care Provider.** Legislative action for the purpose of categorizing obstetricians and gynecologists as primary care physicians was not recommended.

1995 **Joint Commission on Health Care. Obstetrical Care in Rural Areas.** In response to SJR 331 Directing the Joint Commission on Health Care to study access to obstetrical care for the women of rural Virginia. Following options recommended: (1) Consider requesting the Secretary of Health and Human Resources to study the costs and benefits of available options for expanding Virginia Medicaid coverage for pregnant women and infants. (2) Consider requesting the Secretary of Health and Human Resources, in

cooperation with the Bureau of Insurance and the Worker's Compensation Commission, to evaluate the impact of the Virginia Birth-Related Neurological Injury Program in rural areas and recommend policies for improving the utility of the program for rural providers and consumers. (3) The Virginia Academy of Family Practice and the Virginia OB/GYN Society should consider establishing a joint task force to establish standards and protocols for prenatal care, detection of high risk cases, obstetrical referral, and backup. (4) Virginia's academic health centers should evaluate their programs for obstetrical training of family medicine residents to ensure that they produce graduates who are adequately trained to meet the demands of rural obstetrical practice within a collaborative environment with obstetricians. (5) Consider state funding to establish a nurse midwifery program at VCU-MCV.

There must be education in the prevention and detection of diseases in women. Instruction on women should also cover social issues of concern to women, including domestic violence, rape, sexual abuse, and the changing role of women in our society. Residents should have the opportunity to develop an understanding of the effect of the community on women's health care, including the epidemiology of infant mortality and prevention of teenage pregnancy. Residents must have the opportunity to learn about the mental health issues of women, including problems that are seen predominantly in women, such as the sequelae of sexual abuse and eating disorders.

b. Maternity Care

The resident must be provided instruction in the biological and psychosocial impacts of pregnancy, delivery, and care of the newborn on a woman and her family. There must be a minimum of 2 months of experience in maternity care, including the principles and techniques of prenatal care, management of labor and delivery, and postpartum care. This must involve sufficient instruction and experience to enable residents to manage a normal pregnancy and delivery.

The resident must be trained in the recognition and management of the high-risk prenatal patient, including consultation and referral as appropriate. Additionally, residents must be taught to recognize and manage complications and emergencies in pregnancy, labor, and delivery. Residents also must receive training in genetic counseling.

To ensure that residents have adequate opportunity to achieve appropriate

competencies, each resident must have direct responsibility for and performance of a minimum of 40 deliveries. A portion of the maternity care experience must be derived from the continuity panel of patients. To accomplish the objectives of the curriculum in maternity care, residents must assume the responsibility of longitudinal provision of antenatal, natal, and postnatal care to at least 10 patients during their 3 years of training. Whenever possible, these patients should be derived from the residents' panels of patients in the FPC.

Supervision of labor and delivery care must be immediately available. The program must have family physician faculty with hospital privileges in obstetrics who are engaged in providing these services and who can supervise the residents and serve as role models for them.

The program must make available additional training in maternity care as an elective within the 36-month curriculum. This elective experience must include high-risk maternity care, including the opportunity for residents to develop technical proficiency in appropriate operative procedures that may form a part of their future practice.

c. Gynecological Care of Women

There must be a minimum of 1 month or its equivalent of structured experience in the care of the gynecological system in nonpregnant women. This experience must be in addition to the routine care of continuity patients in the FPC. All residents must be provided instruction in normal growth and

development; diseases of the female reproductive tract; reproductive physiology including fertility, family planning, and sexuality; physiology of menopause; and pelvic floor dysfunction. The program also must provide adequate instruction and clinical experience in managing emergent problems of the female reproductive system. This experience should be predominantly ambulatory, but residents must participate in the management of gynecological/surgical emergencies. The training should include some inpatient care, preoperative care, assisting in surgery, and postoperative care. The residents must have the opportunity to learn to perform appropriate procedures.

Teaching hospitals involved in obstetrical training of family practice residents are encouraged to show evidence that graduates of their family practice residency programs can fairly obtain privileges at that teaching hospital upon graduation.

4. Care of the Surgical Patient

The program must provide instruction with special emphasis on the diagnosis and management of surgical disorders and emergencies and the appropriate and timely referral of surgical cases for specialized care.

Residents must be taught to appreciate the varieties of surgical treatments and the potential risks associated with them to enable them to give proper advice, explanation, and emotional support to patients and their families. The residents should also be taught to recognize conditions that are preferably managed on an elective basis.