The American College of Obstetricians and Gynecologists

August 2, 1995

The Honorable Newt Gingrich
2428 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Gingrich:

On behalf of the American College of Obstetricians and Gynecologists (ACOG), an organization representing physicians dedicated to improving women's health care, I am writing to urge you to support a motion that will be offered by Representatives Greg Ganske and Nancy Johnson to strike Section 512 of HR 2127, the Labor, Health and Human Services, Education and Related Institutions FY96 Appropriations Act. This section would prohibit the government from recognizing the Accreditation Council on Graduate Medical Education (ACGME) as the accrediting body for residency programs in Obstetrics-Gynecology if the current ACGME standards regarding abortion training are not reversed.

Section 512 was added to HR 2127 during the Appropriations Committee markup by Representative Tom DeLay and is designed to override new ob-gyn residency training requirements adopted by the ACGME. The ACGME is a private medical accreditation body composed of the American Medical Association, the American Hospital Association, the American Association of Medical Colleges, the American Board of Medical Specialties, and the Council of Medical Specialty Societies that is responsible for establishing medical standards for more than 7,400 residency programs. Earlier this year, the ACGME adopted modifications of the requirements that Obstetrics and Gynecology residency programs must meet to be accredited. These modifications include the following:

> Experience with induced abortion must be a part of residency education, except for programs and residents with moral or religious objections. This education can be provided outside the institution. Experience with management of complications of abortion must be provided to all residents. If a residency program has a religious, moral or legal restriction which prohibits the residents from performing abortions within the institution, the program must ensure that the residents receive a satisfactory education and experience managing the complications of abortion. Furthermore, such residency programs 1) must not impede residents in their program who do not have a religious or moral objection from receiving education and experience in performing abortions at another institution; and, 2) must publicize such policy to all applicants to that residency.

409 12th Street, SW, Washington, DC 20024-2188 (202)638-5577

During the Congressional debate on this issue, misconceptions about the ACGME language have arisen that I wish to clarify. First and foremost, under the ACGME requirements, no institution or individual can be required to participate in the training of induced abortion. Thus, Section 512 seeking to override the ACGME language in order to protect institutions and individuals opposed to abortion is unnecessary given that the requirements already guarantee that any program or resident with moral or religious objections are exempted from the training. ACGME has demonstrated its fairness and its commitment to this principle by altering its language when it was argued that the requirement forced more involvement than those opposed to abortion were comfortable with. Now all that is required of a program that chooses not to provide abortion training for moral or religious reasons is that they notify residents that the program does not offer the training and that they not impede residents from getting the training elsewhere. In addition, training in elective abortions is not specified. Rather, the language requires that training in induced abortions take place.

Congressional override of the ACGME training requirements sets a very dangerous precedent. Never before has Congress sought to override educational standards, let alone standards for training in medicine. ACOG is forced to oppose any new involvement of the government in the education of physicians.

Although Section 512 is intended to address the ACGME abortion training requirements, it actually goes much farther by prohibiting federal and state programs that receive federal funds from relying on ACGME accreditation for Ob-Gyn residency programs. This could create havoc in the medical education field.

For example, to assure that federal funds are being provided for quality medical education, the Medicare program requires that to be eligible for federal funds a residency program must be accredited by ACGME. Section 512 states that the Medicare program cannot rely on ACGME accreditation, but fails to provide any indication of what standards should be used as a substitute. If Section 512 becomes law, the Medicare program would be faced with four choices in order to comply: 1) to establish a separate federal accreditation standard and compliance process for Ob-Gyn residencies; 2) to require the states to establish such a standard; 3) to encourage the formation of an alternative private accreditation standard; or 4) to have no standard and allow residency programs to receive federal funding with no quality demonstration.

In ACOG's view, none of these alternatives are desirable and several would create major problems for Ob-Gyn residency programs. The first two options involve government in a field that has traditionally been left to the private sector. No doubt establishing new government standards would be time consuming and duplicative of the work ACGME has done for years. Even if this is accepted as an appropriate role, the fate of Ob-Gyn residencies and those that are enrolled in such programs would be in doubt until such new standards could be put in place. The third option, while not involving the government, would cause the same disruptions and uncertainty, as current laws require that one must have completed an ACGME accredited program in order to become board certified in Obstetrics and Gynecology. If the government chooses any of the above options, programs would have to be accredited twice if they desire to

receive federal funds and to have their residents eligible for board certification. It is unlikely that a program that does not have federal funds or whose residents are not eligible for board certification could survive. The final option removes all protections of quality, which clearly is not the desire of physicians and their patients, nor should it be the intent of the Congress.

Clearly, Section 512 could have many unintended consequences for the federal government, states, the medical education field, physicians, and their patients. Although ACOG is opposed to any federal intervention in the ACGME accreditation process, we recognize that there are those who believe Congress should intervene in this process. For those individuals, ACOG must point out that Section 512 is more far-reaching than necessary, is vague, and non-specific and should be opposed. ACOG urges you to support the Ganske-Johnson motion to strike this provision when the full House considers the Labor, HHS Appropriations bill later this week.

Sincerely,

Ralph W. Hale MD

Ralph W. Hale, MD
Executive Director

RWH/CV

The American College of Obstetricians and Gynecologists

August 2, 1995

Dear Member of Congress:

Earlier today, you received a letter from ACOG regarding Section 512 of the Labor, Health and Humans Services and Education Appropriations Act, which would override the Accreditation Council of Graduate Medical Education (ACGME) training requirements for Ob-Gyn Residency Programs. Since the time of our letter, we have been notified by the ACGME that it has officially approved new language with regard to training in induced abortion. The newly-approved language is the following (new sections underlined):

> No program or resident with a religious or moral objection will be required to provide training in, or to perform, induced abortions. Otherwise, access to experience with induced abortion must be part of residency education. This education can be provided outside the institution. Experience with management of complications of abortion must be provided to all residents. If a residency program has a religious, moral or legal restriction which prohibits the residents from performing abortions within the institution, the program must ensure that the residents receive a satisfactory education and experience managing the complications of abortion. Furthermore, such residency programs 1) must not impede residents in their program who do not have a religious or moral objection from receiving education and experience in performing abortion at another institution; and 2) must publicize such policy to all applicants to that residency.

We believe that this language change makes Section 512 even more unnecessary than our original letter stated.

Sincerely,

Ralph W. Hale MD

Ralph W. Hale, MD
Executive Director

409 12th Street, SW Washington, DC 20024-2188 (202)638-5577

THE WHITE HOUSE

WASHINGTON

March 9, 1995

MEMORANDUM TO THE PRESIDENT

FROM: CAROL H. RASCO

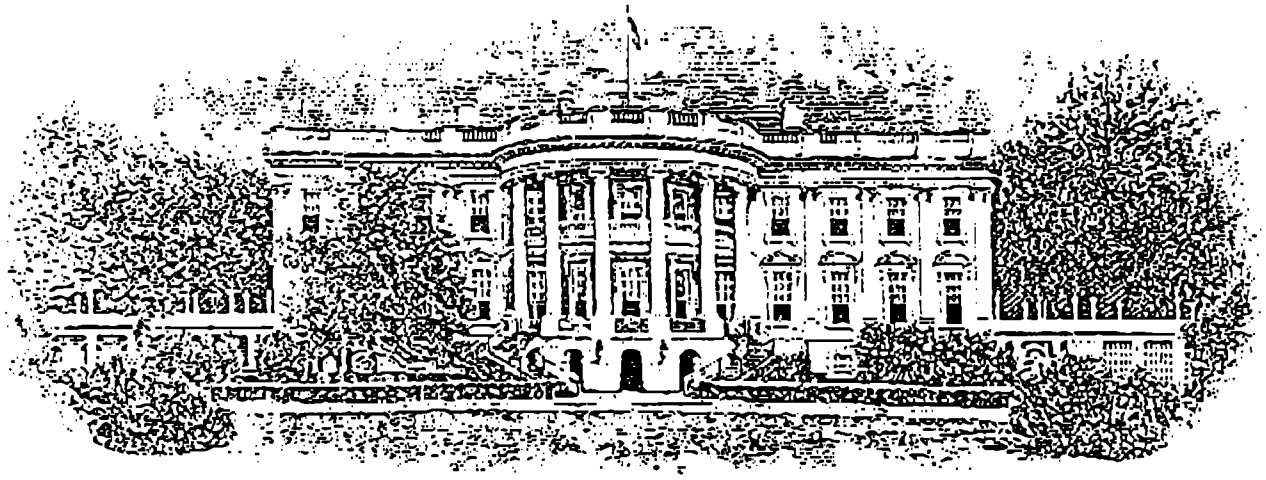
SUBJECT: Accreditation Council for Graduate Medical Education -- Guidelines on Abortion Training

You asked for more information about the report in last week's *Washington Post* that the Accreditation Council for Graduate Medical Education (ACGME) will now require all obstetrics and gynecology residency programs to teach abortion skills.

ACGME is an independent agency that must accredit teaching hospitals before they can receive Federal reimbursement for care provided by resident physicians. On February 14, the agency voted unanimously to require that obstetricians be taught how to perform abortions. Under the new standards, any resident with moral or religious objections may choose not to receive abortion training. Any residency program with moral, religious or legal restrictions can arrange to provide this training at another institution (but must ensure that the residents in their program receive the training).

The new standard is, of course, controversial. Pro-life groups claim that the requirement forces doctors and hospitals to become abortionists. Pro-choice groups argue that residents should learn all procedures that are consistent with current practice standards, and that any doctor who chooses not to perform abortions during training or later practice can do so.

The White House



DOMESTIC POLICY

FACSIMILE TRANSMISSION COVER SHEET

TO: Jennifer Klein

FAX NUMBER: 62878

TELEPHONE NUMBER: 62599

FROM: Karen Guss

TELEPHONE NUMBER:

PAGES (INCLUDING COVER): 5

COMMENTS: Our printer is screwed up so the fonts on the repro sts things pts didn't print correctly. They are OK on the disk.

K

NARAL *Promoting Reproductive Choices*

MEMORANDUM

To: Karen Guss
From: Emma Ketteringham
Date: March 8, 1995
Re: ACGME Abortion Training Requirements

Passage of Recommendation J:

On February 14, 1995, the Accreditation Council for the Graduate Medical Education (ACGME) voted unanimously to require that prospective obstetricians be taught abortion skills. The new requirement applies only to programs that train obstetricians and gynecologists. These are the first standards specifically mentioning abortion. Before this vote, the standards said that residents were to receive clinical experience is family planning, but did not mention abortion specifically.

The new standard to require that resident programs provide instruction in abortion to prospective obstetricians takes effect January 1, 1996. If institutions refuse to provide the new abortion training, they could be stripped of their accreditation, which teaching hospitals need to qualify for federal reimbursements for the services medical residents provide to patients.

Moral/Religious Objection (Conscience Clause):

Under the revised standards, a resident with moral or religious objections to abortion, can be excluded from the training.

Also under the revised standards is a provision that institutions with moral or religious objections can contract to have the abortion training done at another institution. Dr. Gienapp, executive director of ACGME explains, "The ACGME's recent recommendation in no way forces or coerces any individual or institution to perform abortion. Any resident who holds any moral or religious objection to abortion is allowed to be excused from the training requirement. Of equal importance, any residency training program with moral objections to providing abortion training is not required to offer the training at their institution, but must allow residents in their program access to training at another facility."

National Abortion and Reproductive Rights Action League

1156 15th Street, NW
Suite 700
Washington, DC 20005

Phone (202) 973
Fax (202) 973-

Anti-choice Response:

- Roger Cardinal Mahony of Los Angeles, chairman of the National Conference for Pro-Life Activities stated, "Coercing people and institutions to participate in the destruction of innocent life is a great evil."

- Judie Brown, President of American Life League, stated, "This new requirement is a violation of ethics, particularly for those institutions committed to protecting the child who lives in the womb during nine months of pregnancy."

- Wanda Franz, National Right to Live Committee President, stated, "The Residency Review Committee is using strong-arm tactics to force medical schools to become trainers in abortion techniques.... This proposal seeks to make every [ob/gyn] in the country an abortionist like Surgeon General nominee Henry Foster."

According to the NAF membership newsletter, letters commending the ACGME for imposing this training requirement can be sent to: Dr. John C. Glenapp, Executive Director, Accreditation Council for Graduate Medical Education, 515 North State Street, Suite 2000, Chicago, IL 60610.

REPRODUCTIVE RIGHTS

"[C]ertain choices are too personal for politics."
President Clinton and Vice President Gore
Putting People First

The President is committed to making abortion safe, legal and rare. That is why the President has consistently protected the right of American women to make their own reproductive choices. And that is why, at the same time, he has worked to reduce the number of unwanted pregnancies.

Making Abortion Rare

- Teen pregnancy is a national epidemic. This year, more than 1 million women aged 19 and younger -- 10% of all teenaged girls -- will become pregnant. As part of the Administration effort to prevent unwanted teen pregnancies, the President has called upon leaders in all areas of national life to join together to promote individual responsibility and economic opportunity for America's young people. And the President's plan to redesign welfare includes support for community-based initiatives to end teen preganancy.

- The ten percent of women of childbearing age who use no contraception account for more than half of the unintended pregnancies in this country. And most of the remaining unintended pregancies are caused by inconsistent or incorrect use of contraceptives. To help prevent unwanted pregnancies, the President has requested budget increases for the federal Family Planning Program for each year he has been in office. Among other reproductive health and education services, this program makes family planning information and contraception available to millions of women who might not otherwise get reproductive health care.

- In addition, the President signed legislation to improve the adoption process by preventing discrimination against interracial adoptions and reducing the time that children have to wait in foster care.

Keeping Abortion Safe and Legal

- Women faced with unwanted pregnancies must make difficult decisions, but they shouldn't have to make them alone. President Bush instituted a "Gag Rule" that prevented women who go to federally funded clinics -- primarily poor women -- from getting the information they needed to make informed choices. President Clinton put an end to the "Gag Rule" in his first week as President so that women can get appropriate information and counselling.

- Since 1992, five people have been murdered and seven others have been shot and wounded at family planning clinics where abortions are performed. The President

signed the Freedom of Access to Clinic Entrances Act to fight violence and intimidation targeted by anti-choice extremists against women and their doctors.

- RU-486 is a drug that terminates pregnancy without surgery. If available to American women, RU-486 would expand their choices -- giving them options already available in France, the United Kingdom and Sweden -- and make it more difficult to target abortion clinics for violence and harassment. The President revoked the import ban imposed on RU-486 by the Bush Administration. Now RU-486 is being tested at several family planning facilities around the country.

- Women in the military and in military families deserve the finest health care available. The President assured that comprehensive family planning services are available to these women by reversing the ban on abortion services at military hospitals.

- The President reversed 12 years of attacks on reproductive choice for women around the world when he repealed the Mexico City policy that banned funding to international organizations that promoted comprehensive family planning. And at the International Conference on Population and Development in Cairo, the United States forged a partnership with more than 150 nations around a platform of action to promote gender equality and reproductive health. The platform also recognizes the importance of addressing the threat posed to women's health by unsafe abortions.

- The Department of Health and Human Services implemented a Congressionally ordered change to the Medicaid program to include abortion services for poor women whose pregnancies result from rape or incest as well as to save the life of the women.

- Republicans have already begun a steady assault on the progress we have made. Republicans in Congress have voted an amendment out of committee that would allow states to refuse to fund these abortions -- causing additional suffering for victims of sexual violence. And Republicans have attacked Dr. Henry Foster, the President's highly qualified nominee for Surgeon General, because he had performed the legal medical procedure of abortion as an Ob/Gyn. They have done so despite the facts that Dr. Foster is a good, decent man and a dedicated physician who has delivered thousands of healthy babies and has dedicated his career to preventing unwanted pregnancies and making sure young people don't have to face the choice of abortion.

March 7, 1995
Staff contacts: Jennifer Klein (6-2599)
Karen Guss (6-5603)

The American College of Obstetricians and Gynecologists

DEPARTMENT OF GOVERNMENT RELATIONS

DEPARTMENT FAX NUMBER: (202) 488-3985

DATE: 3/7/95

TO: Jennifer Klein

FROM: Kathy Bryant

RE: RRC Requirements

NUMBER OF PAGES (including this page): 27

RECIPIENT'S FAX NUMBER: 456-2878

COMMENTS:

RRC requirements are attached. Abortion language is on page 15.

IF THERE IS A TRANSMISSION PROBLEM, OR IF YOU WOULD LIKE TO SPEAK WITH SOMEONE AT ACOG, PLEASE CALL (202) 863-2509.

409 12th Street, SW Washington, DC 20024-2188 (202)638-5577

FINAL CHANGES LA

SPECIAL REQUIREMENTS FOR RESIDENCY TRAINING IN OBSTETRICS AND GYNECOLOGY

I. INTRODUCTION

A residency program in obstetrics-gynecology must constitute a structured educational experience, planned in continuity with undergraduate and continuing medical education, in the health care area encompassed by this specialty. While such residency programs contain a patient service component, they must be designed to provide education as a first priority and not function primarily to provide hospital service.

An educational program in obstetrics-gynecology must provide an opportunity for resident physicians to achieve the knowledge, skills and attitudes essential to the practice of obstetrics and gynecology and must also be geared toward the development of competence in the provision of ambulatory primary health care for women. ~~and~~ The program must provide opportunity for increasing responsibility, appropriate supervision, formal instruction, critical evaluation and counseling for the resident.

II. INSTITUTIONS

A. Administration

The administration of the sponsoring institution must demonstrate a commitment to educational and scholarly activities by meeting all provisions of the "~~General~~ Institutional Requirements for Accredited Residencies" for approval of a residency program.

B. Participating Institutions

The Residency Review Committee for Obstetrics-Gynecology, for the purpose of

monitoring the structure of residencies, uses the following categories. In all cases, where more than one institution is involved, a formal written agreement must be developed between the responsible administrative bodies of those institutions.

1. Independent - An independent program is conducted within a single educational institution under a single program director. Extramural rotations for a total of no more than six months are permitted under the regulations applied to all programs (see below).

2. Integrated - An integrated program is conducted within multiple educational institutions but under a single program director. Each educational institution involved in an integrated program must provide the same quality of education and level of supervision required of an independent program and must formally acknowledge the authority of the program director and the role that the institution will play in the overall program. Residents may rotate at any level including the final year of the program. ~~must have the overall quality and level of supervision and the educational requirements demanded of an independent program. The residents may rotate at any level, including the final senior resident year.~~ The program director must have authority over the educational program in each hospital, including the teaching appointments and assignments of all ~~teaching staff~~ faculty and all residents and must assure ensure the ~~uniformity~~ adequacy of the educational experience for each resident. Additional extramural rotations for a total of no more than six months are permitted under the regulations applied to all programs (see below). If a program includes rotations for a total of more than six months for any resident, at institutions other than those included in the integrated program, that program becomes an affiliated program. 3. Affiliated - An affiliated program is one in which any resident spends a total of more than six months in extramural rotations outside of the parent

institution (or institutions in the case of integrated programs).

Extramural rotations may be arranged by the program director of either an independent or integrated program in order to enhance the educational experience of the residents. Only under exceptional circumstances, and with written prior approval of the Residency Review Committee, may they be included in the final senior resident year. Residents are appointed by their parent program and assigned by it to the affiliated hospitals, where they spend ~~no more than one-third of the total residency~~ and no more than ~~twelve~~ eighteen months of obstetrics-gynecology and primary care educational experiences. Two types of extramural rotations may be considered:

a. If the total time of extramural rotation from the parent program by any resident during the entire residency exceeds six months, the program is considered to be an affiliated program and the entire program must receive prior approval by the Residency Review Committee.

b. Rotations for a total of less than six months ~~or less~~ will not require that the program be designated as an affiliated program and these rotations may be arranged by the program director without prior Residency Review Committee approval.

C. The Faculty

1. Program Director

a. The program director must be qualified and experienced as a clinician, administrator, and educator in obstetrics and gynecology and must have experience in and commitment to primary health care for women. There must be a minimum of five years experience (post residency/fellowship) in such activities. The program director must be certified by the American Board of Obstetrics and Gynecology or must possess suitable equivalent qualifications.

b. The program director must devote sufficient time and effort to the program to provide day-to-day continuity of leadership, and to fulfill all of the responsibilities inherent in meeting the educational goals of the program.

c. The program director must function within a sound administrative organizational framework, and have an effective teaching staff as essential elements of an approved residency program. Continuity of leadership over a period of years is important to the stability of a residency program. Frequent changes in leadership or long periods of temporary leadership usually have an adverse effect on an educational program.

d. The program director should demonstrate active involvement in: (1) clinical practice, (2) continuing obstetrics/gynecology education, (3) regional or national scientific societies, (4) presentations and publications, and (5) scholarly activities.

e. The program director must have appropriate authority to oversee and to organize the activities of the educational program. The responsibilities of this position should include, but not be limited to the following:

(1). Resident appointments and assignments.

(2). Supervision, direction, and administration of the educational activities; and

(3). Evaluation of the house staff, faculty, and residency program.

f. The program leadership is responsible for notifying the Executive Secretary of the RRC within 30 days, in writing, of any major change in the program that may significantly alter the educational experience for the residents, including:

(1). Changes in leadership of the department or the program;

(2). Changes in administrative structure such as an alteration in the hierarchical status of the program/department within the institution.

(3). Substantial changes in volume and/or variety of the patient population(s).

g. The program director is responsible for communicating to the RRC any change in the use of rotations to participating institutions (including additions or deletions of institutions) and any significant change in the number of patient cases available at the sponsoring and/or participating institutions, if residency education would be adversely affected. The program director must describe the effect of these changes and the corrective action taken to address them.

h. The program director must obtain prior approval for the following changes in the program in order for the RRC to determine if an adequate educational environment exists to support these changes:

(1). For the addition or deletion of any participating institution to which residents rotate for six months or longer;

(2). For the addition or deletion of any rotation of six months or longer;

(3). For any change in the approved resident complement of the program; and

(4). For any change in the length or major change in the educational format of the program.

Upon review of a proposal for a major change in a program, the RRC may determine that a site visit is necessary.

~~Each program must have a dedicated program director with an interested and competent teaching faculty sufficient in number and quality to be able to supervise and instruct the residents at all levels and in all of the practice areas of specialty.~~

~~The program director must be a highly qualified member of the department with substantial experience in education in obstetrics and gynecology and must be able to provide a significant commitment of time and effort to the residency program, demonstrate the ability to organize and direct the teaching program and maintain a quality teaching staff. The program director is specifically responsible for all communications with the Residency Review Committee, and must report any major change in the residency program. The program director must take responsibility for providing complete and accurate program information forms, including data concerning resident experience, to the Residency Review Committee, so that a proper assessment of the program can be made. Further the program director has the responsibility of verifying that residents have satisfactorily completed the program.~~

~~The program director must be a diplomate of the American Board of Obstetrics and Gynecology, or possess suitable equivalent qualifications. It is desirable that the chief of service of the department be a diplomate of the American Board of Obstetrics and Gynecology.~~

~~Assignment of the responsibilities for resident education should be clearly defined by the program director. To assure continuity of teaching efforts and departmental policy, the program~~

~~director should have a reasonable tenure of office. The Residency Review Committee~~ must be ~~notified of any change of program directors.~~

2. Attending Faculty

An ~~obstetrics-~~gynecology education program must have a sufficient and appropriate number of attending staff with professional ability, enthusiasm, dedication and a sense of responsibility for teaching residents. It would be well for the staff to regard these attributes as a prerequisite to active faculty membership and promotion. The faculty complement should include appropriately educated generalist faculty. The quality of teaching and supervision by ~~teaching performance of~~ the faculty must be reviewed at least annually by the program director, and written feedback provided to the individual faculty member. When deficiencies occur, corrective action should be undertaken. Regular and protected input into this evaluation by the residents must be an integral component of such reviews.

D. Scholarly Environment

1. Documentation of scholarly activity on the part of the program and the faculty must be submitted at the time of program review. The teaching staff must show evidence of ~~one or~~ more all of the following:

a. Participation in regional or national professional societies;

b. Presentation and/or publication of studies;

c. Participation in research.

2. Clinical and/or basic science research must be ongoing by faculty in the department.

B. Facilities

1. Outpatient Facilities

Appropriate facilities and equipment including patient medical and laboratory data retrieval capabilities to manage patients in a timely fashion must be provided so that efficient and effective education in the ambulatory care aspects of the discipline can be accomplished. ~~Since obstetricians-gynecologists function as providers of comprehensive care for women, experience in the care of ambulatory patients is essential in education programs. Since many of the patient problems seen in the hospital outpatient department are comparable to those seen in office practice, it is essential to provide a closely supervised experience in an active ambulatory setting that also ensures continuity of care for patients by the individual resident. Increasing responsibility should be given to the resident under the conscientious supervision of a qualified attending staff member.~~

2. Inpatient Facilities

Appropriate ~~inpatient~~ facilities and equipment including patient medical and laboratory retrieval capabilities must be ~~available for achievement of~~ provided to achieve the educational objectives including the management of critically ill patients and those undergoing obstetric or gynecologic operative procedures.

3. Medical Records

The fundamentals of good medical history taking and thoughtful, meticulous physical examination must be taught. Information gained by these procedures must be carefully recorded in the medical record. A reliable measure of the quality of a program is the quality of hospital records. These records should include daily appropriate progress notes by residents, together

with a discharge summary. The hospital should maintain a record room with adequate cross indexing and ready reference for study of the patients' charts. Periodic summaries of department statistics are essential for the evaluation of results and usually will be requested at the time a program is reviewed by the Residency Review Committee.

4. Medical Library

A medical library is an important resource to the obstetrics-gynecology education program. The library may be sponsored by the hospital or the department, but it should be readily accessible to staff, both during the day and in the evening. The textbooks should be kept up to date, and there should be an ample supply of current journals devoted to obstetrics-gynecology and related subjects. When a comprehensive library is not available in the hospital, an active reference system should be provided through ready access to larger medical libraries. Programs must provide instruction in retrieval and assessment of medical literature.

5. Resident Facilities and Support Services

Adequate facilities for residents to carry out their patient care and personal educational responsibilities are required. These include adequate on-call, lounge and food facilities for residents while on duty and on call. Also required are clinical support services such as pathology and radiology, including laboratory and radiologic information retrieval systems that allow rapid access to results, and intravenous (IV) services, phlebotomy services, and messenger/transporter services in sufficient number to meet reasonable demands at all times.

F. Other Graduate Medical Education Programs

The program must exist in an educational environment which includes at least two other relevant graduate medical education programs such as internal medicine, pediatrics, surgery, and family

practice. The program director must obtain teaching commitments from the other departments involved in the education of obstetrics-gynecology residents.

III. CURRICULUM

A. General

1. Organization and Structure

a. Resident education in obstetrics-gynecology must include ~~is~~ four years of accredited, clinically oriented graduate medical education, of which ~~at least~~ three years must be focused upon reproductive health care and ambulatory primary health care for women, including health maintenance, disease prevention, diagnosis, treatment, consultation and referral. ~~entirely in the specialty of obstetrics-gynecology.~~ Residency programs may with prior RRC approval ~~preceded by a year of education sponsored by the program may~~ contain more residents in ~~that year~~ the first year than the number approved for subsequent years, ~~each year~~ or may have no residents in the first year. ~~of specialty education. Residency programs may, therefore, be of three or four years duration, but programs of different lengths or quality in the same institution will not be approved.~~

b. The Residency Review Committee has the responsibility for the review of all graduate medical education programs in obstetrics-gynecology seeking accreditation. If a program includes sponsorship of a first graduate year experience, then the Residency Review Committee has the responsibility for review of that first graduate year.

c. A program director, under suitable circumstances, may elect to credit a resident with a period of graduate education in obstetrics and gynecology gained by the resident before entering

the program. The period of education must have been of four or more months in duration and must have been received in a hospital conducting a currently accredited residency in obstetrics-gynecology. This time may then be used to provide time, within the thirty-six months of obstetrics-gynecology, for appropriate electives on other clinical services. It may not be used to shorten the total length of the residency program.

d. The majority of residents are preparing for a practice which provides reproductive health care and ambulatory primary and preventive health care for women, and residency programs may vary as to when and how these requirements are met. The ambulatory primary care component of residency, with the exception of the continuity clinics, may be obtained in an approved family medicine or internal medicine graduate medical education program prior to entering an obstetrics and gynecology residency.

e. Growth in knowledge and experience in the primary and preventive care role is best provided to residents by maximizing their participation in an ambulatory environment designed to enable continuity of care over an extended period of time. It is required that continuity clinics be provided and be attended by residents throughout three years of the residency.

f. Specific educational experiences for the primary and preventive care role should occupy the equivalent of at least six months of the four years of residency and may be addressed in any of the four years. The emphasis should be on ambulatory care of the patient, which requires both knowledge and skills in the areas of health maintenance, disease prevention, risk assessment, counseling and the use of consultants and community resources. These experiences should be evident in the residents' exposure to continuity of care, general gynecology, general obstetrics, prevention or control of disease, e.g. sexually transmitted disease, substance abuse,

or for prevention of pregnancy. In addition to rotations in obstetrics-gynecology, general medical management experience should also be obtained during rotations in internal medicine and/or family practice, emergency medicine and geriatric medicine. The individual's role and experience in these rotations should be equivalent to those of residents on these services and should be relevant to the health care of women. They should be strongly oriented towards ambulatory care and must include at a minimum a four month rotation in general medicine or Family Practice medicine and a one month rotation in Emergency Medicine. In addition, residents must have a structured experience in Geriatric Medicine that is the equivalent of at least one month of a block rotation.

~~Programs differ widely in the types of experience they offer to physicians entering the first year of graduate education. Many programs include rotations to other clinical services, such as medicine, surgery or neonatology. Other programs, however, offer predominantly experience in obstetrics gynecology but may provide elective time later in the residency for rotations to other clinical services.~~

g. The patient population upon which ~~available to~~ the educational program is based should be sufficient in size and composition so that the broad spectrum of experiences necessary to meet the educational objectives will be provided, ~~should provide a variety of operative experience in obstetrics gynecology. While the quality of the surgical experience in a hospital is more important that the actual number of cases, and while there is great value to a resident in acting as an assistant to a skilled and experienced obstetrician gynecologist, it is also essential that the resident gain experience in management of patients by personal evaluation of the signs and symptoms, physical and laboratory findings leading to a diagnosis and decision for therapy as~~

~~well as the performance of technical procedures.~~

h. The ambulatory care experiences of residents preparing for their roles as providers of primary and preventive care require the same attention, supervision and guidance as those experiences in specialty clinics. It is essential to provide a closely supervised experience by appropriately educated generalist faculty that ensures continuity of care for patients by the individual resident. Increasing responsibility should be given to the resident under the supervision of a qualified, on site, attending staff/faculty member. Residents should develop and maintain a continuing physician-patient relationship with a panel of patients, at least one half-day per week, throughout at least three of the four years of education. The use of remote sites or institutions or clinical services must not interrupt continuity of care clinics for longer than two months each year. Residents should be provided opportunity on at least a weekly basis to return to the parent institution for their continuity clinic experience. Alternatively, if the geographic proximity of the remote site or institution permits, the continuity clinic experience may take place at that location. ~~Since obstetrician-gynecologists function as providers of comprehensive care for women, experience in the care of ambulatory patients is essential in education programs. Since many of the patient problems seen in the hospital outpatient department are comparable to those seen in office practice, it is essential to provide a closely supervised experience in an active ambulatory setting that also ensures continuity of care for patients by the individual resident. Increasing responsibility should be given to the resident under the conscientious supervision of qualified attending staff.~~

2. Content of Curriculum

a. The resident's ability to personally evaluate a patient's complaint, provide an accurate examination, employ appropriate diagnostic tests, arrive at a correct diagnosis and recommend the appropriate treatment is of paramount importance.

~~The specific definition given to the first year of graduate education, as described in the General Requirements, depends on the content of the education and the administrative structure developed for implementing~~ and supervising the experience.

b. Formal teaching activities in obstetrics-gynecology should be structured and regularly scheduled. They should generally consist of patient rounds, case conferences, journal clubs and coverage of appropriate basic sciences pertinent to the specialty. In cross-disciplinary conferences such as perinatology, appropriate physicians from other specialties should be invited to participate.

c. Judgment as to the need for a surgical procedure and the recognition and management of complications are as important as the technical aspects of residency education. The program must, therefore, ensure that the resident's clinical experience emphasizes appropriate involvement in the process that leads to selection of the surgical option, the preoperative assessment, and the postoperative care of the patients for whom they share surgical responsibility. Continuity of care of these patients must be documented. ~~An acceptable~~ A residency program in obstetrics-gynecology must be a ble to provide substantial, diverse and appropriate surgical experience after the residents have mastered the basic skills.

d. The program must provide a structured didactic and clinical educational experience in all methods of family planning. Topics must include all reversible methods of contraception,

including natural methods, as well as sterilization. This must include experience in management of complications as well as training in the performance of these procedures. This education can be provided outside the institution, in an appropriate facility, under the supervision of appropriately educated faculty.

e. Experience with induced abortion must be part of residency education, except for residents with moral or religious objections. This education can be provided outside the institution. Experience with management of complications of abortion must be provided to all residents. If a residency program has a religious, moral or legal restriction which prohibits the residents from performing abortions within the institution, the program must ensure that the residents receive a satisfactory education and experience managing the complications of abortion. Furthermore, such residency programs must have mechanisms which ensure that residents in their program who do not have a religious or moral objection receive education and experience in performing abortion at another institution.

f. Since an increasing percentage of women seeking their medical care from obstetrician-gynecologists are postmenopausal, there must be appropriate didactic instruction and sufficient clinical experience in the management of the problems of women in the post-reproductive age.

3. Educational Objectives

a. Every program, in order to be accredited, must have a written statement of the educational objectives for the residents in that program and a list of those objectives must be given to each resident. One example of such objectives is set forth in the current "Educational Objectives for Residents in Obstetrics and Gynecology," produced under the auspices of The

Council on Residency Education in Obstetrics and Gynecology. Directors of the programs must be able to document that they are reviewing the implementation of the educational objectives and that the residents are indeed accomplishing what is anticipated of them. Any program which does not establish a system which clearly demonstrates that each resident has or has not successfully accomplished each of the items indicated in the program's statement of educational aims and objectives cannot be considered to be an adequate program.

b. It is ~~not~~ neither essential nor desirable that all educational programs or individual resident experiences be identical in structure or function. Variations that provide creative solutions and opportunities, or allow greater efficiency in the educational program may be implemented with the prior written approval of the RRC. It is, however, mandatory that each residency program provide quality education and experience for each of the residents completing the program.

4. Resident Numbers

a. The number of residents that can be adequately and responsibly educated depends on several interrelated factors. Clinical involvement alone does not constitute an educational experience. The provision of adequate supervision, education, individual evaluation and administrative support is critical. With this, it is of utmost importance that each resident have sufficient independent operative and clinical responsibilities to prepare for practice in the specialty.

b. The maximum number of residents in a program is linked to the number that can be accommodated within the framework of these requirements. Since one of the most important considerations is the clinical experience available to give each resident adequate primary responsibility, and since this usually centers upon the senior resident year, the maximum number

of residents in a program depends upon how many senior residents the program can educate. Usually the maximum number of residents in a program is the number of senior residents the program can accommodate multiplied by three or four, depending upon the length of the program.

c. The minimum number of residents in an accreditable program is two (2) per year. Accreditation is granted on the basis of a balance between the educational resources and the number of residents in the program. The appointment of residents in excess of the approved number may adversely affect the quality of the total experience of each resident. Therefore, changes in the educational resources should be reported to the Residency Review Committee and proposed increases in the number of residents must first be approved in writing by the Residency Review Committee.

d. All requests for a change in the number of residents must demonstrate a distinct and substantial improvement in the educational opportunities for all residents in the program. Such requests must be based not only on the availability of an adequate patient population but also on adequate resources for supervision, education and evaluation. A request for a change in the number of residents must describe the impact of total experience upon each of the senior residents under the new circumstances. The request will be considered incomplete if it lists only expansion in beds, hospitals, or overall clinical experience and does not address the question of expansion of faculty and administrative support necessary to teach, supervise and evaluate the additional residents. Conversely, a reduction in beds, hospitals or other changes in the program which may lead to an anticipated decrease in total experience for the residents must be promptly called to the attention of the Residency Review Committee to determine if a reduction in the

number of resident positions in a given graduate medical program is necessary.

5. Other Residents and Trainees

a. The number of residents from other graduate medical education programs in any specialty who are assigned to the obstetrics-gynecology residency should not be so large as to compromise the educational resources of the obstetrics-gynecology residency.

b. For those residency programs associated with post-residency fellowships, the education of fellows must not compromise the experience of residents.

6. Patient Responsibility/Supervision

a. Supervision of residents in obstetrics and gynecology is required to ensure proper (1) education, (2) quality of care, (3) patient safety, and (4) fulfillment of responsibility of the attending physicians to their patients. These considerations must be integrated with the goal of independent competence in the full range of obstetrics and gynecology at the completion of residency. This implies a graduated and increasing level of independent resident action ~~which is complete at the end of residency~~. Each program director must balance quality assurance for patient care, resident education, and independent resident action. The level of resident supervision should be commensurate with the amount of independent function that is designated at each resident level. Residents, as well as faculty, may provide supervision.

b. On an obstetrics and gynecology service, adequate supervision requires the 24-hour presence of faculty in the hospital except when residents are not assigned in-house call responsibilities. Faculty must be immediately available to the resident if clinical activity is taking place in the operating rooms and/or labor and delivery areas. Faculty must be within easy walking distance of patient care units. Clinical services provided in ambulatory (office)

locations require on site supervision. Open and generously used lines of two-way communication are important and should be encouraged.

c. If it is judged by the program director that the size and nature of the patient population does not require the 24-hour presence of residents and faculty, this situation must be carefully defined and reviewed and should include information about the nature of the hospital, the patient population, the nature of attending staff, the geographic and climatic situations. Exceptions require prior written approval from the RRC.

d. Supervision of residents is a responsibility of the program director and teaching staff. It is the responsibility of the institution sponsoring a residency program to establish oversight to assure that programs meet the supervisory provisions of these Requirements.

7. Graded Responsibility

Complete management of a patient's care under adequate supervision should be considered the highest level of residency education. There are, however, circumstances under which the resident may not assume complete management:

a. When the program director or his/her designee does not believe the resident's expertise or understanding is adequate to ensure the best care of the patient.

b. When the attending physician is unable ~~not willing~~ to delegate the necessary degree of responsibility.

c. When the resident, for religious or moral reasons, does not wish to participate in the proposed procedures.

An essential feature of resident education is that a significant number of staff support the principle of delegation of complete management under supervision.

Increasing responsibility must progress in an orderly fashion, culminating in a senior resident year. The senior resident year consists of twelve months of clinical experience, in the last year of the resident's program. Elective time in the senior resident year requires the prior approval of the Residency Review Committee. The senior resident must have sufficient independent operating experience to become technically competent and have enough total responsibility for management of patients to ensure proficiency in the diagnostic and treatment skills that are required of a specialist in obstetrics-gynecology in office and hospital practice.

8. Duty Hours and Personal Responsibilities

On-call requirements are essential for an optimal educational environment and to assure continuity of patient care. The number of residents and faculty should be adequate to prevent excessive frequency and length of on-call duty. The scheduling of on-call duty should consider that clinical events in obstetrics and gynecology do take place at any time; that safe and effective patient care and a good learning environment both require adequate periods of rest; and that the residency program appointment is the resident's full-time compensated occupation. The frequency of on-call duty for residents should be, on the average, no more often than every third night. Residents should be allowed to spend, on the average, at least one full day out of seven away from program duties. The program director must also ensure adequate backup if sudden and unexpected patient care needs create resident fatigue sufficient to jeopardize patient care during or following on-call periods.

B. Specific Educational Experiences

Resident education must include, but not necessarily be limited to the following:

1. Obstetrics

a. The full range of obstetrics, including high-risk obstetrics and medical and surgical complications of pregnancy.

b. Genetics, including the performance of genetic amniocentesis and patient counseling.

c. Learning and performing operative vaginal deliveries, including obstetric forceps and or vacuum extractor.

d. Performing vaginal breech ~~deliveries~~ and vaginal multifetal deliveries.

e. Performing vaginal births after previous cesarean delivery.

f. Obstetric anesthesia. Residents must learn the principles of general and conduction anesthesia, together with the management and the complications of these techniques.

g. Experience in the management of critically ill patients.

h. Immediate care of the newborn. Every resident must have experience in resuscitation of the human newborn, including tracheal intubation. The principles of general neonatal complications must be learned as well.

i. The full range of commonly employed obstetrical diagnostic procedures, including ultrasonography and other relevant imaging techniques.

j. The emotional and psychosocial impact of pregnancy upon an individual and her family, in a variety of circumstances.

k. The counseling of women regarding nutrition, exercise, health maintenance, high-risk behaviors and preparation for pregnancy and childbirth.

l. Obstetric pathology.

2. Gynecology

a. The full range of ~~the content and patient age of~~ medical and surgical gynecology for all age groups.

b. Diagnosis and management of pelvic floor dysfunction including experience with the various operations for its correction.

c. Diagnosis, ~~and~~ medical, and surgical management of urinary incontinence.

d. Oncology, including prevention, diagnosis and treatment. ~~radiation and chemotherapy~~.

e. Diagnosis and non-surgical management of breast disease, including fine needle aspiration.

f. Reproductive endocrinology and infertility.

g. Clinical skills in family planning.

h. Psychosomatic and psychosexual counseling.

i. The full range of commonly employed gynecologic diagnostic procedures, including ultrasonography and other relevant imaging techniques.

j. Experience in the management of critically ill patients.

k. Counseling and educating patients about the normal physiology of the reproductive tract and regarding high-risk behaviors which may compromise reproductive function.

l. Gynecologic pathology.

3. Primary and Preventive Care

a. Comprehensive history taking which includes medical, nutritional, sexual, family, genetic and social behavior data, and the ability to assess health risks.

b. Complete physical examination.

c. Appropriate use of laboratory studies and diagnostic techniques.

d. Patient education and counseling.

e. Screening appropriate to patients of various ages and risk factors.

f. Immunizations needed at specific ages and under specific circumstances.

g. Diagnosis and treatment of the common, non-reproductive illnesses affecting women.

h. Management of the health care of patients in a continuous manner through all the reproductive and post-reproductive years.

i. Appropriate use of community resources and other physicians through consultation when necessary.

j. Appropriate awareness and knowledge of the behavioral and societal factors that influence health among women of differing socio-economic and cultural backgrounds.

k. Behavioral medicine and psychosocial problems, including domestic violence, sexual assault and substance abuse.

l. Emergency care.

m. Geriatric medicine. Ambulatory primary care problems of the geriatric patient.

n. Basics of epidemiology, statistics, data collection and management, and use of medical literature and assessment of its value.

o. Ethics and medical jurisprudence.

p. Community medicine.

q. Health care systems.

r. Information processing and decision making.

~~3. Other~~ *[These items have been moved.]*

~~a. Obstetric and gynecologic pathology.~~

~~b. Emergency medicine.~~

~~c. Basic medical epidemiology and statistics.~~

~~d. Ethics and medical jurisprudence.~~

C. Research

The quality of the educational experience within a department of obstetrics and gynecology is enhanced by an active research environment. It is highly desirable that every program encourage each resident to be involved in a research project.

IV. EVALUATION

A. Resident Performance

The program director must establish methods of periodically and systematically evaluating and documenting the level of performance, experience and technical skills of the residents. One example of an acceptable mechanism helpful in evaluating cognitive knowledge is the CREOG

in-training examination. On at least a semi-annual basis, program directors or their designees must inform the residents of their individual progress, emphasizing strong points and offering guidance with regard to correcting deficiencies. These evaluations, as well as a list of skills which the resident has mastered, must be documented and available (without revealing the specific resident's identity) at the time the program is reviewed for approval.

Physicians must have the welfare of their patients as their primary professional concern. The resident must therefore demonstrate those humanistic qualities which foster the formation of appropriate patient/physician relationships. These include integrity, respect, compassion, professional responsibility, sensitivity to the patient's needs for comfort and encouragement, and an appropriate professional attitude and behavior towards colleagues. These attributes should be emphasized throughout the curriculum, and must be evaluated.

B. Program Review

For the purpose of program review, accurate and complete documentation of each individual resident's experience for each year of the program is mandatory. These records should indicate the level of participation of the resident and skills achieved. The program director must review at least semi-annually the record of operative experience with the individual resident for breadth and depth of experience as well as for evidence of continuing growth in technical achievements. These cumulative data will be reviewed in detail at the time of survey for program approval or continued program approval. For the purposes of these records, there is no distinction between private and service patients.

Annually, the program director must collect, compile and retain the numbers and types of operative procedures performed by residents in the program, together with information

describing the total resident experience in each institution and facility utilized in the clinical education of residents. This information must be provided in the format and form specified by the Residency Review Committee.

One significant measure of the quality of a program is the performance of its graduates on the examinations of the American Board of Obstetrics and Gynecology.

V. BOARD CERTIFICATION

Program directors must notify residents who plan to seek certification by the American Board of Obstetrics and Gynecology that they should communicate with the Executive Director of the Board to obtain the latest information regarding current requirements for certification.

RRC: October, 1994

ACGME: February, 1995

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