Family Medicine Residency, Fargo
Adult Inpatient Care

Introduction

The teaching service of general inpatient medicine at Sanford Health allows residents to refine history and physical exam skills, develop experience in selection of diagnostic tests, and to learn the management of a wide variety of diseases. This rotation provides exposure to common medical problems of hospitalized patients and allows residents opportunities to develop discharge/transition care plans. Additionally, residents encounter uncommon medical conditions and have the opportunity to interact with subspecialists while managing patients with complex conditions.

Goals

<table>
<thead>
<tr>
<th>PGY1</th>
<th>PGY2</th>
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<tr>
<td>Collect a comprehensive medical history, including occupational, behavioral, and sexual history, by soliciting patient information and by consulting other sources of primary data in a logical and organized fashion.</td>
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<td>Record data in a legible, thorough, systematic manner in the EHR (Epic)</td>
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<td>Identify patients’ problems and develop a prioritized differential diagnosis.</td>
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<td>Establish an orderly succession of testing based on patients’ history and exam findings</td>
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<td>Begin to develop therapeutic plans that are evidence and guideline based.</td>
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<td>Communicate in a sensitive and respectful manner with the patient, and others involved in the patient’s care, regarding diagnosis and treatment options</td>
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<td>Critically appraise medical literature and apply evidence to patient care.</td>
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<tr>
<td>Strive to provide</td>
<td>Strive to provide quality</td>
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## Family Medicine Residency, Fargo

### Adult Inpatient Care

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<td>care while being sensitive to health care costs. Effectively coordinate care with other health care professionals. Work with patient care managers, discharge coordinators and social workers to coordinate and improve patient care and outcomes. Identify local resources that are available to assist in ensuring patients receive appropriate services.</td>
<td>Systems based Practice</td>
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### Objectives

At the completion of residency, the resident is expected to display the following knowledge, skills, and attitudes:

1. Normal growth and development (Please also see AAFP Curriculum Guideline No. 278 – Adolescent Health)
2. Health promotion and disease prevention
   a. Healthful diet and physical activity
   b. Prevention of sports- and exercise-related injuries
   c. Substance abuse
   d. Safe sexual practices, sexually transmitted infection (STI) prevention, issues affecting men who have sex with men (MSM) (Please also see AAFP Curriculum Guideline No. 289D – Lesbian, Gay, Bisexual, Transgender Health)
   e. Occupational health and injury prevention
   f. Motor vehicle and bicycle safety
   g. Prevention of coronary artery disease (CAD) and stroke
   h. Cancer screening
3. Mental health
   a. Prevention of anxiety and stress
   b. Depression and other mood disorders
   c. Attention deficit/hyperactivity disorders
   d. Suicide risk
   e. Post-traumatic stress disorder
   f. Psychosocial and community issues
g. Domestic violence
h. Disability and unemployment
i. Family stress
j. Bereavement

4. General medical issues
   a. Nephrologic diseases and conditions: Chronic kidney disease (CKD), acute kidney injury (AKI), hypertension
   b. Cardiovascular diseases and conditions: CAD, congestive heart failure (CHF), arrhythmias
   c. Gastrointestinal diseases and conditions: Inflammatory bowel disease (IBD), gastroesophageal reflux disease (GERD), hepatitis, diverticulitis, colitis, hemorrhoids
   d. Pulmonic diseases and conditions: Asthma, chronic obstructive pulmonary disease (COPD)
   e. Rheumatologic diseases and conditions: Arthritis, musculoskeletal disorders
   f. Oncologic diseases and conditions: Cancer, neoplastic disease
   g. Endocrine diseases and conditions: Diabetes, thyroid disorders, dyslipidemia
   h. Neurologic diseases and conditions: Stroke, cognitive impairment, Parkinson disease, multiple sclerosis (MS)
   i. Infectious diseases and conditions: Pneumonia, urinary tract infection (UTI)/pyelonephritis, cellulitis
   j. Urologic diseases and conditions: Prostatitis, erectile dysfunction (ED), hypogonadism, pelvic floor dysfunction, BPH

Skills

In the appropriate setting, the resident should demonstrate the ability to independently perform or appropriately refer:
   1. Male and female specific examination
   2. Procedure skills
      a. Complete urinalysis
      b. Foley catheter placement
      c. Arthrocentesis
   3. Counseling
      a. Anger management/domestic issues
      b. Alcohol/substance/tobacco abuse
      c. STI prevention (Please also see AAFP Curriculum Guideline No. 289D – Lesbian, Gay, Bisexual, Transgender Health)
      d. Exercise/fitness
      e. Motor vehicle/bicycle safety
      f. Parenting issues
Family Medicine Residency, Fargo
Adult Inpatient Care

4. Interpretive skills
   a. serum electrolytes and routine chemistry panel, complete blood count with
      differential, liver function tests, coagulation studies, arthritis panel and other
      rheumatological laboratory studies.
   b. urinalysis and microscopic examinations of urine
   c. arterial blood gases
   d. electrocardiogram
   e. radiological studies (chest x-ray, abdominal flat plate, CT scans, MRI, Pet scan)
   f. peripheral smear
   g. sputum gram stain
   h. spirometry

Implementation

Implementation of this curriculum should take place in a longitudinal experience on the
inpatient hospital service, both the internal medicine teaching service and the continuity clinic
inpatient service. Physician role models should be available to provide support and advice in
these settings. As appropriate, didactic presentations should be provided, and focused
readings/reference materials should be made available and updated on a regular basis. One-on-
one teaching and counseling may be appropriate at times. Each resident’s continuity panel of
patients should include an adequate number of male and female patients from a variety of age
and demographic groups in a variety of settings. Physician role models should be available to
provide support and advice in these settings. As appropriate, didactic presentations should be
provided, and focused readings/reference materials should be made available and updated on
a regular basis. One-on-one teaching and counseling may be appropriate at times. Each
resident’s continuity panel of patients should include an adequate number of male and female
patients from a variety of age and demographic groups in a variety of settings.

Resources:

UND inpatient internal medicine curriculum
Men’s Health AAFP Reprint No. 257
Family Medicine Residency, Fargo
Behavioral Health

Introduction

Family physicians incorporate knowledge of human behavior, mental health and mental disorders into their everyday practice of medicine. This guideline provides suggestions for appropriate curricula in human behavior and mental health for family medicine residents. It is suggested that the relationship between the patient and the patient’s family be considered basic to an understanding of human behavior and mental health throughout the curriculum. The family medicine resident should have sensitivity to, and knowledge of, the emotional aspects of organic illness.

Family physicians must be able to recognize interrelationships among biologic, psychologic, and social factors in all patients. It is important that the ethical dimensions of patient care be considered among these interrelationships. To facilitate learning, attention must be paid to these principles as a continuum throughout the family medicine residency program.

Goals

<table>
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<tr>
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<th>PGY2</th>
<th>PGY3</th>
<th>Competencies</th>
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<tbody>
<tr>
<td>Learning to distinguish normal from abnormal psychosocial growth and development across the life cycle and be able to apply this knowledge to the care of the individual patient.</td>
<td>Understand normal and abnormal psychosocial growth and development across the life cycle and be able to apply this knowledge to the care of the individual patient.</td>
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<td>Medical Knowledge, Patient Care</td>
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<td>Learning to recognize, initiate treatment for, and utilize appropriate referrals for mental health disorders to optimize patient care.</td>
<td>Be able to recognize, initiate treatment for, and learning appropriate referrals for mental health disorders to optimize patient care.</td>
<td>Be able to recognize, initiate treatment for, and utilize appropriate referrals for mental health disorders to optimize patient care.</td>
<td>Systems-based Practice, Practice-based Learning and Improvement</td>
</tr>
<tr>
<td>Learning the skills to effectively interview and evaluate patients</td>
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<td>Interpersonal and Communication Skills, Patient Care</td>
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## Family Medicine Residency, Fargo
### Behavioral Health

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<td>for mental health disorders using appropriate techniques and skills to enhance the doctor-patient relationship.</td>
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<td>Have sensitivity to and knowledge of the emotional aspects of organic illness.</td>
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<td>Patient Care, Professionalism</td>
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<td>Learning of the necessary resources and protocols to intervene effectively and professionally in emergent psychiatric, domestic violence, child abuse, and disaster situations.</td>
<td>Be able to intervene effectively and professionally in emergent psychiatric, domestic violence, child abuse, and disaster situations.</td>
<td>Be able to intervene effectively and professionally in emergent psychiatric, domestic violence, child abuse, and disaster situations.</td>
<td>Professionalism, Systems-based Practice</td>
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<td>Understand the impact of mental health disorders on the family unit.</td>
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<td>Interpersonal and Communication Skills</td>
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### Objectives

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

1. Basic behavioral knowledge
   a. Normal, abnormal, and variant psychosocial growth and development across the life cycle
   b. Recognition of interrelationships among biologic, psychologic, and social factors in all patients
Family Medicine Residency, Fargo
Behavioral Health

b. Reciprocal effects of acute and chronic illnesses on patients and their families
c. Factors that influence adherence to a treatment plan
d. Family functions and common interactional patterns in coping with stress
e. Awareness of one's own attitudes and values, which influence effectiveness and satisfaction as a physician
f. Stressors on physicians and approaches to effective coping
g. Ethical issues in medical practice, including informed consent, patient autonomy, confidentiality, and quality of life

2. Mental health disorders
   a. Disorders principally diagnosed in infancy, childhood, or adolescence
      a. Mental retardation
      b. Learning disorders
      c. Motor skills disorders
      d. Communication disorders
      e. Pervasive developmental disorders
      f. Attention deficit and disruptive behavior disorders, i.e., Oppositional Defiant Disorder, Conduct Disorder
      g. Feeding and eating disorders of infancy or early childhood
      h. Tic disorders
      i. Elimination disorders

1. Delirium, dementia, amnestic and other cognitive disorders
   a. c. Substance-related disorders
   b. Alcohol
   c. Amphetamines
   d. Caffeine
   e. Cannabis
   f. Cocaine
   g. Hallucinogens
   h. Inhalants
   i. Nicotine
   j. Opioids
   k. Phencyclidine
   l. Sedative-, hypnotic- or anxiolytic-related disorders
   m. Polysubstance-related disorder

3. Psychotic disorders
   a. Schizophrenia
   b. Paranoid
   c. Disorganized
   d. Catatonic
4. Mood disorders
   a. Major depressive disorder
   b. Dysthymic disorder
   c. Bipolar disorders, including hypomanic, manic, mixed and depressed

5. Anxiety disorders
   a. Panic attack
   b. Phobias
   c. Obsessive-compulsive disorder
   d. Post-traumatic stress disorder
   e. Acute stress disorder
   f. Generalized anxiety disorder
   g. Somatoform disorders
   h. Somatization disorder
   i. Conversion disorder
   j. Pain disorder
   k. Hypochondriasis

6. Factitious disorders
   a. Dissociative disorders
   b. Sexual and gender identity disorders
   c. Sexual desire disorder
   d. Sexual aversion disorder
   e. Orgasmic disorders
   f. Sexual pain disorders
   g. Sexual dysfunction related to a general medical condition
   h. Gender identity disorder

7. Eating disorders
   a. Anorexia nervosa
   b. Bulimia nervosa

8. Sleep disorders
   a. Insomnia
   b. Hypersomnia
   c. Narcolepsy
   d. Breathing-related sleep disorder
   e. Circadian-rhythm sleep disorders
   f. Parasomnias

9. Impulse control disorders
   a. Pathological Gambling
b. Trichotillomania

10. Adjustment disorders
   a. Depressed mood
   b. Anxiety
   c. Mixed anxiety and depressed mood
   d. Disturbance of conduct

11. Personality disorders
   a. Paranoid
   b. Schizoid
   c. Schizotypal
   d. Antisocial
   e. Borderline
   f. Histrionic
   g. Narcissistic
   h. Avoidant
   i. Dependent
   j. Obsessive-compulsive

12. Problems related to abuse or neglect
   a. Additional conditions
      i. Nonadherence / noncompliance
   b. Malingering
   c. Borderline intellectual functioning
   d. Age-related cognitive decline
   e. Bereavement
   f. Marital discord
   g. Academic problem
   h. Occupational problem
   i. Identity problem
   j. Religious or spiritual problem
   k. Acculturation problem
   l. Phase-of-life problem

Skills

In the appropriate setting, the resident should demonstrate the ability to independently perform or appropriately refer:

1. Use of evaluation tools and interviewing skills, which enhance data collection in short periods of time and optimize the doctor/patient relationship.
2. Techniques to elicit the context of the visit [BATHE (background, affect, trouble, handling and empathy) or other techniques].

3. Mental status examination

4. Evaluation of indications for special procedures in psychiatric disorder diagnosis, including psychologic testing, laboratory testing and brain imaging

5. Elicit and recognize the common signs and symptoms of the disorders under Knowledge
   a. Teach patients methods for evaluating and selecting reliable websites for medical information

6. Assessment of depression [PHQ-9, Beck, Zung, Hamilton Scales, SIG-E-CAPS mnemonic (sleep, interest, guilt, energy, concentration, appetite, psychomotor and suicidal ideation)]

7. Evaluation of indications for psychiatric consultation

8. Management of emotional aspects of nonpsychiatric disorders

9. Techniques for enhancing compliance with medical treatment regimens

10. Initial management of psychiatric emergencies: the suicidal patient, the acutely psychotic patient

11. Proper use of psychopharmacologic agents
    a. Diagnostic indications and contraindications
    b. Dosage, length of use, monitoring of response, side effects and compliance
    c. Drug interactions
    d. Associated medical problems

12. Family support therapy

13. Behavioral modification techniques
    a. Stress management.
       i. Breathing
       ii. Muscle relaxation
       iii. Imagery
       iv. Cognitive restructuring
    b. Smoking cessation, obesity management and other lifestyle changes
    c. Chronic pain management

14. Utilization of community resources
    a. Community resources
       a. Patient care team of other mental health professionals

15. Crisis-counseling skills

16. Modification of patient environment

17. Variations in treatment based on the patient's personality, lifestyle and family setting

18. Identification of, intervention in and therapy for drug and alcohol dependency and abuse

19. Appropriate care of health disorders listed under psychopathology

20. Appropriate referral procedures to ensure continuity of care, provide optimal information sharing and enhance patient compliance
    a. Indications
Family Medicine Residency, Fargo
Behavioral Health

b. Process
c. Follow-up

Implementation

Training in human behavior and mental health should be accomplished primarily in the outpatient setting through a combination of longitudinal experiences, supervised experiences and didactic teaching. This combination should include experience in diagnostic assessment, psychotherapeutic techniques, and psychopharmacologic management. Learning tools such as Balint Groups, video review, direct observation, and role-playing are useful and recommended. Collaboration with multiple mental health professionals, including psychiatrists, psychologists, and other mental health professionals working as a team, is often useful.

Resources

Human Behavior and Mental Health AAFP Reprint No. 270
Family Medicine Residency, Fargo
Cardiology

Introduction

Cardiovascular disease is a major cause of morbidity and mortality in our society. The family physician should be proficient in the diagnosis and management of a variety of cardiovascular disorders. Family physicians provide comprehensive and continuing care to individuals and families, with particular attention to behavioral and lifestyle factors.

The depth of experience for each resident depends on the expected practice needs of the resident, especially in terms of practice location, available facilities, and accessibility of consultants. At times the family physician may find it appropriate to seek consultation from a cardiologist to either manage or co-manage a patient for optimal care.

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## Objectives

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

1. Normal cardiovascular anatomy and physiology
2. Changes in cardiovascular physiology with age and pregnancy
3. Risk factors
   a. Coronary artery disease
      i. Hyperlipidemia
      ii. Cigarette smoking
      iii. Genetic predisposition
      iv. Sedentary life style
      v. Hypertension
      vi. Diabetes mellitus
      vii. Obesity
      viii. Nutrition
      ix. Hormonal status
      x. Emotional stress
   b. Valvular heart disease
4. Cardiovascular history
5. Cardiovascular physical examination
6. Noninvasive examinations
   a. Electrocardiography
   b. Chest radiography
   c. Stress testing, including treadmill/bicycle or pharmacologic techniques
   d. Echocardiography/Doppler imaging, both rest and stress, using treadmill/bicycle or pharmacologic techniques
   e. Radioisotope imaging, both rest and stress, using treadmill/bicycle or pharmacologic techniques
   f. ECG monitoring, in-hospital and ambulatory
   g. Vascular Doppler and ultrasound examinations
   h. Computerized tomography (CT)
   i. Magnetic resonance imaging (MRI) and Magnetic resonance angiogram (MRA)

7. Invasive examinations
   a. Diagnostic cardiac catheterization and angiography
   b. Diagnostic carotid and peripheral vascular angiography
   c. Intracoronary and peripheral vascular intervention using appropriate devices
   d. Internal monitoring devices
      i. Central venous and peripheral arterial catheter
   e. Electrophysiologic studies
   f. Indications and contraindications of therapeutic interventions
      i. Coronary artery bypass
      ii. Angioplasty techniques and stent placement
      iii. Pacemaker insertion
      iv. Implantable cardioverter-defibrillator
      v. Valve replacement/repair, percutaneous balloon valvotomy
      vi. Electrophysiologic ablation

8. Relevant laboratory interpretation, including serum enzymes, isoenzymes, lipids, and b-type natriuretic peptide (BNP) or pro-BNP.

9. Specific diseases/conditions
   a. Coronary artery disease
      i. Stable/unstable angina
      ii. Myocardial infarction, with and without complications
         1. Cardiogenic shock
         2. Dysrhythmias
         3. Papillary muscle dysfunction and rupture
         4. Ventricular rupture
         5. Aneurysm
      iii. Sudden death
   b. Syncope, cardiogenic and non-cardiogenic
   c. Dysrhythmias
      i. Tachyarrhythmia
         1. Supraventricular
         2. Ventricular
3. Reentrant
   ii. Bradyarrhythmia
   iii. Ectopy
      1. Atrial
      2. Ventricular
d. Hypertension
   i. Essential
   ii. Secondary
   iii. Pulmonary
e. Pulmonary heart disease
   i. Cor pulmonale
   ii. Heart failure
   iii. Systolic dysfunction
   iv. Diastolic dysfunction
f. Venous Thromboembolic disease (VTE)
g. Valvular heart disease
   i. Rheumatic
   ii. Congenital
   iii. Degenerative
   iv. Mitral valve prolapse syndrome
h. Congenital heart disease
   i. Common left to right shunts (acyanotic)
   ii. Common right to left shunts (cyanotic)
   iii. Common obstructive problems
i. Dissecting aneurysm
j. Innocent heart murmurs
k. Peripheral vascular disease
   i. Aneurysm
   ii. Carotid atherosclerosis
   iii. Arterial disease
   iv. Arteriosclerosis obliterans
l. Cardiomyopathies
   i. Congestive (dilated)
   ii. Restrictive
   iii. Hypertrophic cardiomyopathy
   iv. Postpartum
m. Pericardial disease
n. Infection-related
   i. Viral myocarditis
   ii. Subacute bacterial endocarditis
   iii. Kawasaki’s disease
o. Other cardiac disorders
   i. Immunologic
Family Medicine Residency, Fargo
Cardiology

1. Acute rheumatic fever
2. Autoimmune disorders
   ii. Psychogenic
   iii. Traumatic
   iv. Nutritional
   v. Myxoma
   vi. Thyroid dysfunction
   vii. Marfan syndrome
   viii. Drug-related such as cocaine, steroids and chemotherapeutic agents
p. Evaluation of cardiac patient for noncardiac surgery
   i. Cardiac risk including preoperative assessment tools
   ii. Preoperative and postoperative management
q. Antibiotic prophylaxis for valvular disease

10. Cardiovascular pharmacology

Skills

In the appropriate setting, the resident should demonstrate the ability to perform or appropriately refer:

1. Diagnostic procedures
   a. Performance of history taking and physical examination
   b. Mechanics and interpretation of ECG
   c. Interpretation of chest radiographs
   d. Treadmill/bicycle stress test monitoring and interpretation
   e. Ambulatory ECG monitoring and interpretation
2. Therapeutic procedures
   a. Risk management
   b. Cardiopulmonary resuscitation (CPR), both basic life support (BLS) and advanced cardiac life support (ACLS)
   c. Treating dysrhythmias and conduction disturbances
   d. Use of external temporary pacemakers
   e. Management of acute myocardial infarction, postinfarction care, and complications
   f. Congestive heart failure
   g. Hypertensive emergencies
   h. Supervision and management of cardiovascular rehabilitation
      i. Psychosocial issues
      ii. Sexual functioning
      iii. Depression
      iv. Family dynamics
   i. Management of patients after an intervention
      i. Lifestyle adjustments
      ii. Coronary artery bypass surgery
Family Medicine Residency, Fargo
Cardiology

iii. Valve surgery
iv. Congenital heart disease surgery
v. Catheter-related interventional procedures

Implementation

Core cognitive ability and skill may be obtained in block rotations or cardiology experiences in intensive care and cardiac care units. Residents will obtain substantial additional cardiology experience throughout the three years of experience in the family medicine center, on their family medicine service, and internal medicine rotations. It would be a reasonable goal during this time to accomplish proficiency in ECG interpretation and cardiopulmonary resuscitation. Family medicine residents electing additional training in cardiology, particularly residents who are planning to practice in communities without readily available consultation resources, may require skills for which additional training in a structured cardiology education program is strongly recommended. Longitudinal experience in the center for family medicine and on the family medicine hospital service should add experiences in ECG interpretation, stress testing, coronary care, and continued follow-up of patients with cardiovascular problems. Additionally, residents should be encouraged to evaluate the fashion in which they provide cardiology care for their patients. Using a Plan-Do-Study-Act cycle, learners should engage in practice-based learning and improvement to ensure that patients receive optimum care founded in evidence-based medicine.

Resource:

Cardiovascular Medicine AAFP Reprint No. 262
Family Medicine Residency, Fargo
Chemical Dependency

Introduction

Family physicians incorporate knowledge of chemical dependency into their everyday practice of medicine. This guideline provides suggestions for appropriate curricula in chemical dependency for family medicine residents. It is suggested that the relationship between the patient and the patient’s family be considered basic to an understanding of chemical dependency throughout the curriculum. The family medicine resident should have sensitivity to, and knowledge of, the emotional aspects of organic illness. Family physicians must be able to recognize interrelationships among biologic, psychologic, and social factors in all patients. It is important that the ethical dimensions of patient care be considered among these interrelationships. To facilitate learning, attention must be paid to these principles as a continuum throughout the family medicine residency program.

Goals

<table>
<thead>
<tr>
<th>PGY2</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand the normal and abnormal use of chemical substances, legal and illegal, prescribed and non-prescribed, and drug-drug interactions across the life cycle and be able to apply this knowledge to the care of the individual patient.</td>
<td>Medical Knowledge, Patient Care</td>
</tr>
<tr>
<td>Be able to recognize, initiate treatment for, and learning appropriate referrals for chemical dependency to optimize patient care.</td>
<td>Systems-based Practice, Practice-based Learning and Improvement</td>
</tr>
<tr>
<td>Demonstrate the ability to effectively interview and evaluate patients for chemical dependency using appropriate techniques and skills to enhance the doctor-patient relationship.</td>
<td>Interpersonal and Communication Skills, Patient Care</td>
</tr>
<tr>
<td>Have sensitivity to and knowledge of the emotional and social aspects of chemical dependency.</td>
<td>Patient Care, Professionalism</td>
</tr>
<tr>
<td>Be able to intervene effectively and professionally in emergent situations, such as acute intoxication, withdrawal, respiratory depression, violence and delirium.</td>
<td>Professionalism, Systems-based Practice</td>
</tr>
<tr>
<td>Understand the impact of chemical dependency on the family unit, employment and society.</td>
<td>Interpersonal and Communication Skills, Professionalism</td>
</tr>
</tbody>
</table>
Family Medicine Residency, Fargo
Chemical Dependency

Objectives

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

1. Basic chemical dependency knowledge
   a. Normal and abnormal use of chemical substances
   b. Recognition of interrelationships among biologic, psychologic, and social factors in all patients
   c. Reciprocal effects of acute and chronic illnesses on patients and their families
   d. Factors that influence adherence to a treatment plan
   e. Family functions and common interactional patterns in coping with stress
   f. Awareness of one’s own attitudes and values, which influence effectiveness and satisfaction as a physician
   g. Stressors on physicians and approaches to effective coping
   h. Ethical issues in medical practice, including informed consent, patient autonomy, confidentiality and quality of life.

2. Substance-related disorders
   a. Alcohol
   b. Amphetamines
   c. Cannabis
   d. Cocaine
   e. Hallucinogens
   f. Inhalants
   g. Nicotine
   h. Opioids
   i. Phencyclidine
   j. Sedative-, hypnotic-, or anxiolytic-related disorders
   k. Polysubstance-related disorder

Skills

In the appropriate setting, the resident should demonstrate the ability to independently perform or appropriately refer:
Family Medicine Residency, Fargo
Chemical Dependency

1. Use of evaluation tools and interviewing skills, which enhance data collection in short periods of time and optimize the doctor/patient relationship.
2. Techniques to elicit the context of the visit.
3. Mental status examination
4. Evaluation of indications for special procedures in chemical dependency disorder, including psychologic testing, laboratory testing and brain imaging
5. Elicit and recognize the common signs of chemical dependency.
7. Techniques for enhancing compliance with medical treatment regimens
8. Initial management of chemical dependency emergencies
9. Proper use of psychopharmacologic agents
10. Utilization of community resources
11. Crisis counseling skills
12. Variations in treatment based on the patient’s personality, lifestyle, and family setting.
13. Appropriate referral procedures to ensure continuity of care, provide optimal information sharing and enhance patient compliance

Implementation

Training in chemical dependency disorder should be accomplished primarily in the outpatient setting through a combination of longitudinal experiences, supervised experiences and didactic teaching. This combination should include experience in diagnostic assessment, psychotherapeutic techniques, and psychopharmacologic management. Collaboration with multiple mental health professionals, including psychiatrists, psychologists, and other chemical dependency disorder professionals working as a team, is often useful.
Introduction

Health promotion has been described by the World Health Organization (WHO) as the process of enabling people to increase control over and improve their health. The concept of optimal health encompasses not merely the absence of disease, but also a level of vitality to maintain enjoyment and contentment with life.

Disease prevention encompasses activities focused on health risk profiling of asymptomatic persons and the appropriate use of screening and surveillance tests for early detection of disease. Patient education and therapeutic intervention, when indicated, are imperative. Principles of disease prevention applied to individual patients are based on scientific evidence derived from population studies. Screening protocols should consider age, gender, family history, and lifestyle risk factors. Protocols must be dynamic, with regular reevaluation and revision based on new scientific evidence and local community factors.

The patient-centered medical home (PCMH) is an appropriate setting in which to focus on health promotion and disease prevention. By offering continuous, coordinated, and comprehensive care throughout the patient’s family, community, and lifespan, family physicians can be catalysts for health promotion and prevention for their patients. As the cornerstone of the medical home for each patient, the family physician impacts the lives of patients by recommending and supporting positive lifestyle changes and appropriate screening examinations, thus improving health and preventing disease.

Goal

<table>
<thead>
<tr>
<th>PGY1</th>
<th>PGY2</th>
<th>PGY3</th>
<th>Competencies</th>
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</thead>
<tbody>
<tr>
<td>Recognize connections with practice and community data to improve population health</td>
<td>Learning to integrate practice and community data to improve population health</td>
<td>Integrate practice and community data to improve population health, and partner with the community to improve population health</td>
<td>Patient Care, Systems-based Practice</td>
</tr>
<tr>
<td>Work on the skills of teaching patients and families effectively in disease management, disease prevention, and health promotion skills</td>
<td>Educate and counsel patients and families effectively in disease management, disease prevention, and health promotion skills</td>
<td>Educate and counsel patients and families effectively in disease management, disease prevention, and health promotion skills with</td>
<td>Patient Care, Interpersonal and Communication Skills</td>
</tr>
</tbody>
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Family Medicine Residency, Fargo
Community Health
# Family Medicine Residency, Fargo Community Health

<table>
<thead>
<tr>
<th>Competencies</th>
<th>PGY1</th>
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<th>PGY3</th>
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<tbody>
<tr>
<td>while being an active listener</td>
<td>Identify recommendations for health maintenance and screening guidelines for patients of all ages from evidence-based organizational resources</td>
<td>Identify and reconcile recommendations for health maintenance and screening guidelines for patients of all ages from evidence-based organizational resources</td>
<td>Identify and reconcile recommendations for health maintenance and screening guidelines for patients of all ages from evidence-based organizational resources</td>
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<tr>
<td>Systems-based Practice</td>
<td>Apply basic principles of physician wellness and balance in life to adequately manage personal, emotional, physical, and mental health, and apply these principles to the practice of medicine</td>
<td>Apply basic principles of physician wellness and balance in life to adequately manage personal, emotional, physical, and mental health, and apply these principles to the practice of medicine</td>
<td>Apply basic principles of physician wellness and balance in life to adequately manage personal, emotional, physical, and mental health, and apply these principles to the practice of medicine</td>
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<tr>
<td>Professionalism, Medical Knowledge</td>
<td>Perform a detailed history and physical examination, with attention to family, social, and behavioral factors, and identify the role of behavior, social determinants of health, and genetics as factors in health promotion and disease prevention</td>
<td>Perform a detailed history and physical examination, with attention to family, social, and behavioral factors, and identify the role of behavior, social determinants of health, and genetics as factors in health promotion and disease prevention</td>
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<td>Patient Care</td>
<td>Track and monitor disease prevention and health promotion for the patient population and use a system to</td>
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Family Medicine Residency, Fargo
Community Health

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<th>PGY1</th>
<th>PGY2</th>
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Objectives

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

1. Four categories of prevention: primary, secondary, tertiary, and quaternary
2. Current age-specific dietary recommendations for nutrition and weight management
3. Exercise guidelines for fitness, injury prevention, and weight management
4. Influences on psychosocial well-being, including internal perceptions, external stressors, and significant life events
5. Prevention of injuries at home, during recreation, and while driving
6. Safe sexual practices regarding sexually transmitted infections (STIs) and pregnancy planning
7. Pharmacologic prevention of diseases through the use of aspirin, sunscreen, fluoride, and folic acid and other vitamin supplements, as supported by scientific evidence
8. Prevention of diseases at all ages through the use of immunizations
9. Environmental issues that influence personal health, such as secondhand smoke, pollution, sanitation, exposure to lead or other toxic substances, safe housing, and occupational exposures
10. Risk stratification based on age, gender, family history, socioeconomic status, lifestyle choices, environmental factors, and medical issues
11. Criteria used for screening tests, such as sensitivity, specificity, predictive values, bias, safety, cost, and prevalence
12. Periodic health screening guidelines from the U.S. Preventive Services Task Force (USPSTF), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Centers for Disease Control and Prevention (CDC), and the American Cancer Society (ACS)
13. Local, regional, and national resources to assist patients and their families in the development and maintenance of healthy lifestyles and disease prevention
14. Psychological determinants of patient behavior and action choices, including the concept of health literacy and its implications for communicating with local populations of patients
Family Medicine Residency, Fargo
Community Health

15. Communication strategies to effect behavioral changes in patients, including motivational interviewing techniques and assessment of patients’ readiness to change
16. Fundamental understanding of the natural history of chronic disease in order to be able to educate patients about potential complications and outcomes
17. A family systems-oriented approach that considers the influence that factors such as support, relationship distress, intimate partner violence, caretaker fatigue, and critical transition points in family life have on health and happiness
18. Resources that promote the evaluation of the medical literature from an evidence-based medicine perspective
19. Understanding the basic clinical and preventive medicine guidelines and how they apply to a clinical practice

Skills

In the appropriate setting, the resident should demonstrate the ability to independently perform or appropriately refer the following:

1. Gather information on personal history, including family history, vaccination history, diet, chemical substance use, exercise, stress management, socioeconomic status, health literacy, occupation and recreational activities, health and spiritual beliefs, and safety practices
2. Perform physical assessment of fitness, body mass index (BMI), and blood pressure
3. Model a healthy lifestyle
4. Stimulate change through behavior change counseling, motivational techniques, and exercise and nutrition prescriptions
5. Utilize a reminder system for patient follow-up for health maintenance
6. Mobilize community resources, the local health department, and local mental health professionals
7. Approach preventive care systematically, using risk assessment, risk reduction, screening, immunization, and chemoprophylaxis
8. Explain the natural history and course of chronic diseases to patients in order to reinforce preventive strategies
9. Access smartphone applications and online medical databases to research evidenced-based guidelines for disease prevention and health promotion and apply them to patient care
10. Assess basic family and relationship dynamics to identify health-promoting influences and health-hampering influences
11. Interpret the health promotion and prevention literature utilizing evidence-based medicine skills

Implementation
This curriculum should be taught longitudinally, with learning experiences offered throughout the residency program. Curricular content should traverse learning formats that include didactic conferences, journal clubs, small group discussions, preceptor room discussions, and patient care in all settings. The curriculum should include content that teaches residents to critically evaluate clinical prevention recommendations and approaches to motivating healthy behavior change for patients. Reference materials should be available to support these endeavors.

Preventive medicine and health promotion lessons should occur in settings consistent with the PCMH (www.aafp.org/about/policies/all/pcmh.html). Residents should have the opportunity to observe and partner with other health care professionals. Residents should engage in preceptor-supervised interactions with patients in lifestyle and mental health counseling contexts. The family medicine residency clinic should function as a medical home such that health promotion and preventive medicine become part of patients’ active care plans. Residents should actively participate in group determination of clinic policy and procedures regarding preventive medicine and health promotion. Electronic health records should be structured to efficiently support this model of care. Resident records of contact with patients should be reviewed for appropriate inclusion of notes regarding health promotion and disease prevention.

Health promotion and disease prevention in the residency setting should be taught by example and implied by structure. Faculty should model healthy and balanced lifestyles, demonstrating dedication to family, patients, community, and care of the self through exercise, community service, and other valued activities. The resident’s responsibilities should be structured to ensure opportunities for similar self-care. Consideration should be given to residency policies that ensure active connection between residents and their physicians. Residency-sponsored social activities should be focused on healthy themes, such as exercise and safe recreation. Residency programs should seek opportunities for residents to participate in community outreach and education—which can help residents learn to act as community leaders and experts—and provide other settings for the active promotion of healthy lifestyles and behavior.

Resource

Health Promotion and Disease Prevention AAFP Reprint No. 267
Family Medicine Residency, Fargo  
Critical Adult Care

Introduction

Family physicians are the most broadly trained specialists in the health care profession. Therefore, critical care continues to be part of the training and responsibilities of the family physician. There is a need for family physicians to be able to provide care to the critically ill adult, especially in rural areas and in smaller hospitals. The depth of the critical care experience for each resident will depend upon the expected practice situation of the resident, including the practice location, available facilities, and accessibility of subspecialist consultants. Family physicians caring for hospitalized adult patients require skills and knowledge in ascertaining signs, symptoms, and laboratory abnormalities of the critically ill. They must become masterful in the recognition and diagnosis, competent in the initial resuscitation and management of such cases, as well as acquire the ability to coordinate the chronological flow of care in the hospital (from admission to discharge) and take into consideration the psychosocial issues applicable to each individual patient and his or her caregivers.

Health care expenditure in the U.S. continues to rise, with hospital spending accounting for a significant segment of health care dollars. Hospitals are under continuous demands to provide more efficient care with restricted funds. Managed care capitation, government scrutiny, and health care provider shortages have generated a need in many organizations for physicians to be able to provide high quality critical care. Family physicians must efficiently coordinate care and resources in the hospital setting. Meanwhile, medical advances are being made with regards to technology, e.g., electronic medical records, new imaging studies; diagnostic tests; pharmacotherapy; and invasive as well as non-invasive procedures. This has led to the need for reassessing the quality and safety of health care provision within critical care units.

Preventive medicine, which has traditionally played a key role in ambulatory care, has become an important component in critical care. Strategies have emerged to prevent deep venous thrombosis, maintain euglycemia, and prevent hospital-acquired infections. These infections burden the health care system both economically and in terms of patient outcomes. Inpatient quality and safety measures are being promulgated and evidence-based medicine (EBM) is the ideal approach to management of critically ill patients. With adequate training and preparation, residents can acquire skills to provide best practices from admission through discharge and care transitions, leading to safer, patient-centered, cost-efficient quality care.
# Family Medicine Residency, Fargo
## Critical Adult Care

### Goals

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<thead>
<tr>
<th>PGY1</th>
<th>PGY2</th>
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<th>Competencies</th>
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<tr>
<td><strong>Competencies</strong></td>
<td><strong>Goals</strong></td>
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<tr>
<td><strong>Be able to perform standardized comprehensive critical care assessments and develop acute treatment plans.</strong></td>
<td><strong>Be able to perform standardized comprehensive critical care assessments and develop acute treatment plans.</strong></td>
<td><strong>Be able to perform standardized comprehensive critical care assessments and develop acute treatment plans.</strong></td>
<td><strong>Patient Care, Medical Knowledge</strong></td>
</tr>
<tr>
<td><strong>Learning to develop a systematic approach to medical decision-making and patient care, combining scientific evidence and clinical judgment with patient values and preferences. Knowledge should be evidence-based and from nationally recognized resources.</strong></td>
<td><strong>Be able to optimize treatment plans using a systematic approach to medical decision-making and patient care, combining scientific evidence and clinical judgment with patient values and preferences. Knowledge should be evidence-based and from nationally recognized resources.</strong></td>
<td><strong>Be able to optimize treatment plans using a systematic approach to medical decision-making and patient care, combining scientific evidence and clinical judgment with patient values and preferences. Knowledge should be evidence-based and from nationally recognized resources.</strong></td>
<td><strong>Systems-based Practice, Practice-based Learning and Improvement</strong></td>
</tr>
<tr>
<td><strong>Coordinate admissions, inpatient care, and throughput within the hospital system.</strong></td>
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<td><strong>Coordinate admissions, inpatient care, and throughput within the hospital system.</strong></td>
<td><strong>Systems-based Practice</strong></td>
</tr>
<tr>
<td><strong>Learning to communicate in multiple modalities with patients, families, other health care providers, and administrators. Effective communication is central to the role of the family physician to</strong></td>
<td><strong>Demonstrate the ability to communicate in multiple modalities with patients, families, other health care providers, and administrators. Effective communication is central to the role of the family physician to</strong></td>
<td><strong>Demonstrate the ability to communicate in multiple modalities with patients, families, other health care providers, and administrators. Effective communication is central to the role of the family physician to</strong></td>
<td><strong>Interpersonal and Communication Skills, Professionalism</strong></td>
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# Family Medicine Residency, Fargo
## Critical Adult Care

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<tr>
<td>central to the role of the family physician to promote efficient, safe, and high quality care.</td>
<td>promote efficient, safe, and high quality care.</td>
<td>Medical Knowledge, Practice-based Learning and Improvement</td>
</tr>
<tr>
<td>Recognize self-limitations with regards to practice and seek consultation with other health care providers to provide optimal care. Assess medical information to support self-directed learning</td>
<td>Recognize self-limitations with regards to practice and seek consultation with other health care providers to provide optimal care. Assess medical information to support self-directed learning</td>
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<tr>
<td>Demonstrate compassion, empathy, and sensitivity towards hospitalized patients and appreciate that informed adults with decision-making capacity may refuse recommended medical treatment.</td>
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<td>Professionalism</td>
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<tr>
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<td>Demonstrate compassion, empathy, and sensitivity towards hospitalized patients and appreciate that informed adults with decision-making capacity may refuse recommended medical treatment.</td>
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</table>

## Objectives

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

1. The underlying physiologic changes in the various body systems, including diminished homeostatic abilities, altered metabolism, effects of drugs, and other changes relating to the critically ill patient.
2. The conditions encountered in the hospital setting that are significantly life-threatening or likely to have significant impact in changing care processes leading to quality improvement and efficiency.
Family Medicine Residency, Fargo
Critical Adult Care

3. The unique modes of presentation of critically ill patients, including altered and nonspecific presentations of diseases
4. The financial aspects of critical care and the mechanisms by which medical innovations influence health care patterns and decisions
5. The processes and systems of care that span multiple disease entities and require multidisciplinary input to create quality care and efficiency
6. The processes and communication required for the safe transition of patients from one clinical setting to another
7. The formulation of pretest probability using initial history, physical examination, and preliminary diagnostic information when available, as well as the relevance of sensitivity and specificity in interpreting diagnostic findings
8. The evaluation of benefits, harms, and financial costs of drug therapies for individual patients as well as recognition of risks of adverse drug events at the time of transfer of care. Reconciliation of documentation of medications at the time of discharge
9. Equitable health resources for patients and the recognition that over-utilization of resources may not promote patient safety, quality care, or satisfaction
10. The relationship between value, quality, cost, and incorporating patient wishes into optimal health care
11. The sources for the best available evidence to support clinical decisions and process improvements at the individual and institutional level
12. Advocacy for provision of high quality point-of-care EBM information resources within the institution
13. The role played by an assisting subspecialist consultant in promoting improved care, optimized resource utilization, and enhanced patient safety
14. The access and interpretation of data, images, and other information from available clinical information systems
15. The use of methods and materials to educate, reassure, and empower patients and families to participate in the creation and implementation of a care plan
16. The clinical practices and interventions that improve patient safety and the effects of recommended interventions across the continuum of care
17. The common types of health care-associated infections, including the risk factors
18. The use of hospital antibiogram in delineating antimicrobial resistance patterns and the major resources for infection control information
19. Medical practice conduct to ensure risk management
20. Incorporation of palliative care teams when appropriate during the continuum of critical care illness
21. The following clinical conditions that are relevant to management of the critically ill adult:
   a. Basic science review:
      i. Circulation
      ii. Respiration
b. Renal disease and metabolic disorders:
   i. Acute Kidney Injury
   ii. Acid-base
   iii. Electrolyte abnormalities

c. Cardiovascular conditions:
   i. Acute coronary syndromes
   ii. Cardiopulmonary arrest
   iii. Dysrhythmias
      1. Tachycardias
      2. Bradycardias
   iv. Hypertensive urgency and emergency
   v. Heart failure
   vi. Cardiogenic pulmonary edema
   vii. Use of vasoactive medications

d. Endocrine:
   i. DKA
   ii. Thyroid storm and myxedema coma
   iii. Hyperosmolar nonketotic syndromes
   iv. Adrenal dysfunctions
   v. Other endocrine emergencies

e. Hematologic:
   i. Bleeding disorders
   ii. Coagulopathies
   iii. Transfusion therapy and reactions
   iv. Venous thromboembolic disease

f. Gastrointestinal:
   i. Acute abdomen
   ii. Gastrointestinal bleeding
   iii. Hepatic failure
   iv. Pancreatitis

g. Pulmonary:
   i. Respiratory failure
      1. Hypoxemia
      2. Hypercapnia
   ii. ARDS
   iii. Pulmonary embolism
   iv. Pneumonia
   v. Pulmonary hypertension
   vi. Severe airflow obstruction
   vii. Obesity Hypoventilation Syndromes and Obstructive Sleep Apnea

h. Neurological:
   i. Coma and Delirium
Family Medicine Residency, Fargo
Critical Adult Care

ii. Cerebral vascular accidents
   iii. Hemorrhagic
       1. Ischemic
           a. Thrombolytic therapy
       2. Subarachnoid
   iv. CNS Infections
       1. Meningitis
       2. Encephalitis
   v. Brain and spinal cord trauma and disease
   vi. Seizures and Status Epilepticus
   vii. Neuroleptic Malignant syndrome
   viii. Serotonin Syndrome
   ix. Movement disorders
   x. Neurological emergencies
   xi. Analgesia
   xii. Sedation
   xiii. Post arrest induced hypothermia cerebral protection strategies

i. Infectious disease:
   i. SIRS, Sepsis, Severe Sepsis, Septic Shock
   ii. Early Goal Directed Therapy
   iii. Antimicrobial therapy
   iv. Immunocompromised patients
   v. Clostridium difficile and pseudomembranous colitis

j. Multisystem:
   i. Shock States
      1. Septic
      2. Cardiogenic
   ii. Hypothermia
   iii. Hyperthermia
   iv. Rhabdomyolysis
   v. Multisystem organ failure
   vi. Overdose and poisonings
   vii. Alcohol and drug withdrawal
   viii. Trauma
   ix. Thermal injury

k. Perioperative care:
   i. preoperative clearance
   ii. Preoperative antibiotic therapy
   iii. Postoperative management (pain, glycemic control, antibiotics)
   iv. Postoperative crisis

l. Preventative practices:
   i. Alimentary
Family Medicine Residency, Fargo
Critical Adult Care

ii. Nosocomial infections including:
   1. Central line infections
   2. Ventilator acquired pneumonia
iii. Venous thromboembolism
iv. Decubitus ulcers
m. Nutrition and metabolism:
   i. Metabolic requirements
   ii. Enteral and parenteral feeding
n. Coexisting conditions:
   i. Obesity
   ii. Pregnancy
   iii. Elderly
o. End-of-life:
   i. Palliative care team incorporation
   ii. Hospice evaluation
   iii. Advanced life support utilization
   iv. Organ donation and transplantation
   v. Pronouncement of death

Skills
In the appropriate setting, the resident should demonstrate the ability to independently perform or appropriately refer:

1. Obtaining a comprehensive history and physical examination in the hospital setting
2. Appropriate selection, interpretation, and performance of diagnostic procedures
3. Developing problem lists in practical, clinical, functional, psychological, and social terms
4. Setting appropriate priorities and limitations for investigation and treatment
5. Performing the basic elements of the ACLS protocol and procedures:
   a. Cardioversion
   b. Electrical and chemical
   c. External temporary pacemaker application
   d. Electrocardiogram interpretation
   e. Obtaining vascular access
6. Performing ATLS as needed, including:
   a. Tube thoracostomy
   b. Needle decompression
   c. Paracentesis
   d. Arterial blood gas
   e. Central venous access via jugular, subclavian and femoral veins
7. Ventilator management, including:
   a. Chest X-ray interpretation
   b. Non-invasive and invasive ventilation
   c. Issues in sedation, analgesia, and paralytic agents usage
   d. Airway management
Family Medicine Residency, Fargo
Critical Adult Care

e. Ventilator crisis
f. Weaning from ventilator support
g. Recognition and management of the difficult airway

8. Early goal directed therapy in sepsis recognition and management
   a. Code sepsis team leadership
9. Moderate Sedation and Conscious Sedation
10. Diagnostic and therapeutic procedures:
    a. ABGs
    b. Lumbar puncture
    c. Thoracentesis
    d. Arthrocentesis
    e. Paracentesis
    f. Catheter placement (arterial line or central venous access)
    g. Medical ultrasonography i. Central line placement guidance
       i. Resuscitation

11. Glasgow Coma Scale assessment, CIWA scale (alcohol withdrawal)
12. Management of patient monitoring information and technology
13. Utilizing the multidisciplinary approach with regards to patient education, quality improvement, transition of care
14. Coordinating a range of services appropriate to the patient’s needs and support systems
15. Appropriate communication with patients and / or caregivers regarding the proposed investigation and treatment plans in such a way as to promote understanding, compliance, and appropriate attitudes
16. Dealing with ethical issues in the terminally ill to include:
    a. Decision-making capacity
    b. Euthanasia
    c. Health care rationing
    d. Palliative and end-of-life care

Implementation

Implementation of this curriculum should be obtained in block rotations in the medical intensive care unit. Experiences may also be obtained in critical care units such as surgical intensive care, coronary care, neurologic intensive care, as well as in related rotations such as cardiology, nephrology, pulmonary, neurology, gastroenterology, and surgery. Residents will obtain substantial additional experiences throughout the three years by way of longitudinal experience. Residents should complete the Fundamental Critical Care Support course sponsored by the Society of Critical Care. Physicians who have demonstrated skills in caring for critically ill adults and who are proficient in hospital medicine should be available to act as role models and consultants for the residents. These physicians should be available to give support and advice to residents in the management of their own patients. A multidisciplinary approach is an appropriate way of structuring teaching experience in this area.
Family Medicine Residency, Fargo

Critical Adult Care

The resident must have responsibility for critically ill adult patients and be active in the decision making process. A significant number of intensive care and critical care patients should be a part of each resident’s panel of patients. It should be required that the resident have the experience of continuing the care of these patients upon discharge to either home, subacute rehabilitation facilities, long-term care facilities, assisted living facilities, and / or the ambulatory setting, i.e., the family medicine center).

Resources:

Care of the Critically Ill Adult AAFP Reprint No. 291
Family Medicine Residency, Fargo  
Dermatology

Introduction

Family physicians are on the front line of managing skin conditions. According to the 2010 National Ambulatory Medical Care Survey, disorders of the skin accounted for more than 11.5 million visits, resulting in more than 50 million billed diagnoses. Skin conditions are the 18th most common reason for presenting at a primary care physician’s office. Relatively innocuous skin conditions create a major concern to patients due to their visibility. Pattern recognition is extremely important with skin complaints. Family physicians must develop keen observational skills and consistently use appropriate terminology to characterize skin lesions. The adage “a picture is worth a thousand words” remains key to dermatologic care.

The attitude of the physician in taking all complaints seriously and doing a methodical workup will lead to proper care and ease patient anxiety. A family physician must have knowledge of different diagnoses associated with different lesion types and must know where to access appropriate, reliable information in a timely manner using textbook or online resources. Family physicians are experts at holistically treating patients and are well suited to detecting systemic disease that may have dermatologic manifestations. Early diagnostic biopsy and definitive surgical or medical treatment are well within the scope of a family physician’s skills. Family physicians must be proficient on a systems level in providing timely, cost-effective, and cosmetically excellent skin surgery. Patients should be given realistic expectations on wound healing, cosmetic results, and possible complications.

Timely referral is key in challenging cases that require specialized treatment modalities more commonly performed by a dermatologist. Family physicians play a key role in promoting behaviors to prevent skin cancers and other skin diseases while ensuring the future health of the skin, our body’s largest organ.

Goals

<table>
<thead>
<tr>
<th>PGY1</th>
<th>PGY2</th>
<th>PGY3</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning to provide compassionate and culturally appropriate patient care that recognizes the effect of skin problems on the patient and emphasizes the importance of</td>
<td>Provide compassionate and culturally appropriate patient care that recognizes the effect of skin problems on the patient and emphasizes the importance of</td>
<td>Provide compassionate and culturally appropriate patient care that recognizes the effect of skin problems on the patient and emphasizes the importance of</td>
<td>Patient Care</td>
</tr>
</tbody>
</table>
## Family Medicine Residency, Fargo Dermatology

<table>
<thead>
<tr>
<th>PGY1</th>
<th>PGY2</th>
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<tbody>
<tr>
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<tr>
<td>comprehensive preventive care</td>
<td>comprehensive preventive care</td>
<td>comprehensive preventive care</td>
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</tr>
<tr>
<td><strong>Become familiar with common skin diseases and their treatment, and learn to perform common dermatologic procedures</strong></td>
<td><strong>Diagnose and treat common skin diseases proficiently and adeptly perform common dermatologic procedures</strong></td>
<td><strong>Diagnose and treat common skin diseases proficiently and adeptly perform common dermatologic procedures</strong></td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td><strong>Utilize diagnostic and evidence-based treatment guidelines, as well as maintain up-to-date knowledge and usage of evolving dermatologic treatment technology</strong></td>
<td><strong>Utilize diagnostic and evidence-based treatment guidelines, as well as maintain up-to-date knowledge and usage of evolving dermatologic treatment technology</strong></td>
<td><strong>Utilize diagnostic and evidence-based treatment guidelines, as well as maintain up-to-date knowledge and usage of evolving dermatologic treatment technology</strong></td>
<td>Practice-based Learning and Improvement</td>
</tr>
<tr>
<td><strong>Communicate effectively with the patient so that dermatologic diagnosis and treatment is provided in a nonjudgmental, caring manner</strong></td>
<td><strong>Communicate effectively with the patient so that dermatologic diagnosis and treatment is provided in a nonjudgmental, caring manner</strong></td>
<td><strong>Communicate effectively with the patient so that dermatologic diagnosis and treatment is provided in a nonjudgmental, caring manner</strong></td>
<td>Interpersonal and Communication Skills, Professionalism</td>
</tr>
<tr>
<td><strong>Learn to determine which problems can be managed by a family physician and how to coordinate needed referrals to specialty providers</strong></td>
<td><strong>Incorporate knowledge of the dermatology specialty in order to determine which problems can be managed by a family physician and how to coordinate needed referrals to specialty providers</strong></td>
<td><strong>Incorporate knowledge of the dermatology specialty in order to determine which problems can be managed by a family physician and how to coordinate needed referrals to specialty providers</strong></td>
<td>Systems-based Practice</td>
</tr>
</tbody>
</table>
Objectives

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

1. Classification and terminology of skin disorders
   a. Description of primary and secondary lesions
2. Diagnosis of common dermatologic disorders based on history, topography, and morphology
3. Management of common skin disorders
   a. Acne
   b. Actinic keratosis
   c. Alopecia and hair disorders
   d. Bacterial infections
   e. Bites and stings (mammals, spiders, reptiles, ticks, and insects)
   f. Infestations (lice, scabies, bedbugs, schistosome cercarial dermatitis, myiasis)
   g. Contact dermatitis
   h. Cutaneous viral infections and exanthems
   i. Eczema and atopic dermatitis
   j. Fungal skin infections
   k. Hyperpigmentation and hypopigmentation
   l. Lichen planus and bullous/vesicular diseases
   m. Nail disorders
   n. Nevi
   o. Rosacea
   p. Skin ulcers and pressure sores
   q. Dermatologic manifestations of sexually transmitted infections (STIs)
   r. Seborrheic dermatitis
   s. Psoriasis
   t. Urticaria and drug eruptions
4. Prevention of skin diseases
5. Skin manifestations of systemic diseases
6. Prevention, recognition, and management of common skin cancers (including basal cell carcinoma, squamous cell carcinoma, Kaposi sarcoma, and melanoma)
7. Pharmacology of skin medications

Skills

In the appropriate setting, the resident should demonstrate the ability to independently perform:

1. History and physical examination appropriate for skin conditions
2. Preventive skin examination
3. Biopsy of skin lesions
   a. Punch biopsy
b. Shave biopsy
c. Excisional biopsy

4. Scraping and microscopic examination
5. Use of dermoscopy to complement physical examination

6. Injection
   a. Local anesthesia
   b. Steroids

7. Incision and drainage

8. Destruction of lesions
   a. Cryosurgery
   b. Electrodesiccation
   c. Curettage

9. Choice of suturing materials and skin surgery instruments
10. Skin closure techniques including: non-suturing techniques (e.g., benzoin and Steri-Strips, skin glues); simple interrupted; simple continuous; vertical and horizontal mattress; layered closures; and subcuticular suturing

11. Principles and practice of wound care, including use of occlusive dressings
12. Counseling and anticipatory guidance for dermatologic disorders

Implementation
Implementation of this curriculum should include structured experience (both focused and longitudinal) throughout the residency program. Completion of online module “Basic Dermatology” from American Academy of Dermatology. Physicians who have demonstrated skill in caring for skin conditions should act as teachers and role models by advising residents to manage their own patients. Attendings should demonstrate proper technique while allowing residents to actively participate in procedures in order to achieve competency.

Resource

Conditions of the Skin AAFP Reprint No. 271
Family Medicine Residency, Fargo
Diagnostic Imaging

Addendum to all areas of Pediatric and Adult Care

Introduction

Imaging is an important diagnostic tool in all areas of patient care. Additionally, imaging has increasingly become an integral part of treatment of many conditions. With the rising costs of care and the increased availability of sophisticated imaging tools, it is necessary to balance many competing factors in ordering the “best” image.

Goals

<table>
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<tr>
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<th>PGY2</th>
<th>PGY3</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Be able to order the appropriate imaging tool for symptoms of concern, with consideration for availability and time constraints</td>
<td>Be able to order the appropriate imaging tool for symptoms of concern, with consideration for availability and time constraints, and interpret results to formulate a treatment plan.</td>
<td>Be able to order the appropriate imaging tool for symptoms of concern, with consideration for availability and time constraints, and interpret results to formulate a treatment plan.</td>
<td>Patient Care, Medical Knowledge</td>
</tr>
<tr>
<td>Be familiar with the “costs” of an imaging tool which includes monetary, radiation exposure, and discomfort for the patient</td>
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<td>Be familiar with the “costs” of an imaging tool which includes monetary, radiation exposure, and discomfort for the patient</td>
<td>Patient Care</td>
</tr>
<tr>
<td>Develop the skill of reviewing the image/report with the patient and their family</td>
<td>Develop the skill of reviewing the image/report with the patient and their family</td>
<td>Being skilled in reviewing the image/report with the patient and their family</td>
<td>Interpersonal and Communication Skills</td>
</tr>
<tr>
<td>Develop the ability to describe and discuss the findings on imaging with colleagues and other specialists</td>
<td>Develop the ability to describe and discuss the findings on imaging with colleagues and other specialists</td>
<td>Be able to describe and discuss the findings on imaging with colleagues and other specialists</td>
<td>Patient Care</td>
</tr>
</tbody>
</table>
Family Medicine Residency, Fargo
Diagnostic Imaging

Addendum to all areas of Pediatric and Adult Care

Objectives

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

1. Knowledge of the scientific basis for each type of imaging, i.e. radiation, Doppler, magnetism, radioactive isotopes.
2. Knowledge of various views of flat plate x-rays for different part of the skeletal body, and accurate interpretation of the image.
3. Acquaintance with various methods of imaging, biopsy, tapping and treatment accomplished with interventional radiology.
4. Interpretation of CT scan and MRI images.
5. Able to distinguish conditions that are best evaluated with ultrasound vs CT scan vs MRI.
6. Point of care ultrasound

Skills

Interpretation of:

1. Chest x-ray
2. Abdominal flat and upright x-ray
3. Skeletal x-rays
4. Head CT scan
5. Spinal CT scans
6. Chest, abdominal and pelvic CT scans
7. Limited OB ultrasound- FHR, fetal presenting part, AFI

Resource

Debra Walker, MD FAAFP
Family Medicine Residency, Fargo
Emergent Care

Introduction

The family physician is the most broadly trained specialist in the health care profession. There is considerable overlap in the patient populations served by the family physician and the emergency physician, with a natural overlap in the competencies, knowledge, skills, and attitudes necessary to succeed in each setting. This guideline seeks to identify the unique and critical elements that might not be adequately addressed in other curricular areas (e.g., medicine, pediatrics, surgery, obstetrics, orthopedics, ophthalmology). It is assumed that management of acute emergent conditions in each required specialty rotation is adequately addressed within those curricula. Residents’ future unique practice settings (e.g., solo emergency practice, rural/remote settings that require significant stabilization for distant transport) will determine the need for additional knowledge, procedural skills, and mastery of these elements.

Prompt assessment, intervention, and disposition are critical elements of the emergency medicine experience and are frequently performed in the face of multiple simultaneous patient encounters. The resident will need to become more comfortable as a member of a health care team that treats patients in urgent and emergent situations, as well as learning the appropriate use of consultants in patient care.

Goals

<table>
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<tr>
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<th>PGY3</th>
<th>Competencies</th>
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<tbody>
<tr>
<td>Increasing efficiency in rapidly obtaining the most pertinent</td>
<td>Demonstrate an ability to rapidly gather and assess information</td>
<td>Demonstrate an ability to rapidly gather and assess information</td>
<td>Patient Care, Medical Knowledge</td>
</tr>
<tr>
<td>information to the care of the patient and employing the correct</td>
<td>pertinent to the care of patients in an urgent and emergent situation,</td>
<td>pertinent to the care of patients in an urgent and emergent situation,</td>
<td></td>
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<tr>
<td>emergent protocol for stabilization and disposition of the patient</td>
<td>and develop treatment plans appropriate to the stabilization and</td>
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<td>disposition of these patients</td>
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<tr>
<td>Identify the indication and learn to perform procedures as</td>
<td>Identify the indication and perform procedures as appropriate for</td>
<td>Identify the indication and perform procedures as appropriate for</td>
<td>Patient Care, Medical Knowledge, Practice-</td>
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<td>appropriate for the</td>
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<td>the</td>
<td>based Learning and Improvement</td>
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</table>
## Family Medicine Residency, Fargo
### Emergent Care

<table>
<thead>
<tr>
<th>Competencies</th>
<th>PGY1</th>
<th>PGY2</th>
<th>PGY3</th>
<th>Systems-based Practice</th>
<th>Practice-based Learning and Improvement</th>
<th>Professionalism, Interpersonal and Communication Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquire the requisite skills in appropriate utilization of the resources available in the urgent and emergent care setting, including laboratory, radiology, ancillary services, and consultations with specialists (including transfer to a higher level of care)</td>
<td>stabilization of the patient in an urgent and emergent care setting</td>
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<td>Systems-based Practice</td>
<td>Practice-based Learning and Improvement</td>
<td>Professionalism, Interpersonal and Communication Skills</td>
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</tr>
<tr>
<td>Demonstrate an ability to learn from experience, perform self-analysis of practice patterns</td>
<td>Demonstrate an ability to learn from experience, perform self-analysis of practice patterns, and participate in peer review of practice patterns</td>
<td>Demonstrate an ability to learn from experience, perform self-analysis of practice patterns, and participate in peer review of practice patterns</td>
<td>Systems-based Practice</td>
<td>Practice-based Learning and Improvement</td>
<td>Professionalism, Interpersonal and Communication Skills</td>
<td></td>
</tr>
<tr>
<td>Use a professional and caring manner and sensitivity to cultural and ethnic diversity to appropriately inform and educate the patient and family, and to elicit their participation in medical decision making</td>
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<td>Practice-based Learning and Improvement</td>
<td>Professionalism, Interpersonal and Communication Skills</td>
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</tr>
</tbody>
</table>
Family Medicine Residency, Fargo
Emergent Care

Objectives
At the completion of residency, the resident is expected to display the following knowledge, skills, and attitudes:

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

1. The principles of care through the continuum of medical management
   a. Pre-hospital emergency care and its importance in the initial stabilization of patients
      i. Emergency medical services (EMS)
      ii. Communication systems and protocols (including appropriate implementation on a community- and system-wide basis)
   b. Prioritization and triage
   c. Resuscitation and stabilization
   d. Reassessment and monitoring
   e. Consultation
   f. Disposition
   g. Mass casualty and disaster planning, and coordination of care with appropriate government and private agencies

2. Assessment and management of conditions in the following content areas:
   a. Trauma
      i. Primary and secondary assessment of the traumatically injured patient
      ii. By mechanism of injury
         1. Blunt trauma (e.g., heart, lung, intra-abdominal organ rupture)
         2. Penetrating trauma (e.g., gunshot, stab wounds)
      iii. By site of injury
         1. Head and neck
         2. Spine and spinal cord
         3. Facial
         4. Soft tissue
         5. Chest
         6. Abdomen
         7. Extremities
         8. Genital and urinary
   b. Psychiatric emergencies
      i. Mood disorders
      ii. Homicidal ideation, suicidal ideation and attempt
      iii. Acute mania
      iv. Acute anxiety and panic disorders
      v. Hysterical conversion
      vi. Addictive disorders, overdose syndromes, and drug-seeking behaviors
      vii. Pain management guidelines
Family Medicine Residency, Fargo
Emergent Care

viii. Delirium and altered mental status
ix. Risk assessment and involuntary commitment
x. Management of the combative patient
xi. Acute alcohol withdrawal
xii. Utilization of mental health services in the emergent setting
c. Environmental disorders
   i. Burns (e.g., chemical, thermal, electrical)
   ii. Electrocution and lightning injuries
   iii. Heat and cold injuries
   iv. Bites (human and animal) and stings
   v. Poisonous plants
   vi. Hypersensitivity reactions and anaphylaxis
d. Obstetric and gynecologic emergencies
   i. Sexual assault and rape
   ii. Acute pelvic pain
   iii. Ectopic pregnancy
   iv. Threatened or spontaneous abortion
   v. Precipitous delivery, preeclampsia, and eclampsia
   vi. Vaginal bleeding
   vii. Emergency contraception
e. Victims of violence
   i. Child abuse
   ii. Partner/spousal abuse
   iii. Elder abuse
3. Recognition and management of acute life-threatening conditions in the following organ systems:
   a. Acute neurologic disorders
      i. Altered level of consciousness and coma
      ii. Acute cerebrovascular accidents (CVA)
         1. Hemorrhagic
         2. Embolic, and understanding the indications and management of thrombolysis in acute embolic CVA
         3. Transient ischemic attack (TIA)
      iii. Acute infections of the nervous system, meningitis, and encephalitis
      iv. Seizures
      v. Acute headache management
      vi. Acute spinal cord compression
      vii. Closed head injury (e.g., concussion, contusion)
   b. Acute respiratory disorders
      i. Acute respiratory distress and failure
      ii. Pulmonary embolism
      iii. Pulmonary infections
      iv. Pneumothorax
v. Exacerbation of obstructive and restrictive lung disease (e.g., asthma, chronic obstructive pulmonary disease [COPD])

c. Acute cardiovascular disorders
   i. Acute chest pain
   ii. Cardiac arrest
   iii. Life-threatening dysrhythmias
   iv. Acute coronary syndrome (e.g., unstable angina, non-ST segment elevation myocardial infarction [NSTEMI], STEMI)
   v. Heart failure (acute and exacerbation of chronic heart failure)
   vi. Thoracic and abdominal aortic aneurysm dissection and rupture
   vii. Thrombolytic therapy
   viii. Hypertensive urgencies and emergencies
   ix. Acute vascular obstruction
   x. Thromboembolism (pulmonary embolism and deep vein thrombosis)

d. Acute endocrine disorders
   i. Diabetic ketoacidosis and hyperosmotic nonketotic state
   ii. Thyroid emergencies (thyroid storm and myxedema coma)
   iii. Acute adrenal insufficiency

e. Acute gastrointestinal disorders
   i. Acute gastrointestinal bleeding
   ii. Acute abdomen and its initial surgical evaluation
   iii. Acute cholecystitis
   iv. Acute appendicitis
   v. Acute pancreatitis
   vi. Acute diverticulitis
   vii. Acute bowel obstruction
   viii. Ischemic bowel disease

f. Acute genitourinary system disorders
   i. Sexually transmitted infections
   ii. Acute testicular pain (e.g., testicular torsion, epididymitis)
   iii. Renal colic and nephrolithiasis
   iv. Acute pyelonephritis
   v. Acute urinary retention
   vi. Priapism
   vii. Acute musculoskeletal disorders
   viii. Initial fracture management
   ix. Reduction of acutely dislocated joints
   x. Acute joint sprains and strains
   xi. Compartment syndromes

4. Recognition and management in the following areas:
   a. Toxicologic emergencies, toxidromes, and their treatment
      i. Acute overdose and pharmacokinetics
      ii. Accidental poisonings and ingestion
Family Medicine Residency, Fargo
Emergent Care

iii. Treatments and antidotes
iv. Access to databases and poison control

b. Mass casualty
   i. Bioterrorism
   ii. Environmental/natural disaster
   iii. Nuclear
   iv. Biological and infectious
   v. Chemical

c. Special circumstances
   i. Resuscitations (e.g., coordination, communication, recording)
   ii. Drowning and near-drowning
   iii. Sudden infant death syndrome (SIDS)
   iv. Metabolic disorders and acid-base imbalance
   v. Shock and initial resuscitative measures required for each unique condition
      1. Hypovolemia and dehydration
      2. Acute heat exhaustion and heat stroke
      3. Septic shock
   vi. Acute infectious emergencies

d. Indications and interpretation of diagnostic tests pertinent to the urgent and emergent setting
   i. Electrocardiograms
   ii. Blood laboratory chemistry and hematologic studies
   iii. Radiologic imaging of:
      1. Acute head and cervical spine injuries
      2. Chest pathology
      3. Acute abdominal conditions
      4. Pelvis and extremity injuries

e. Medicolegal issues
   i. Informed consent and competency
   ii. Withholding and termination of treatment
   iii. Laws (e.g., commitment, Good Samaritan, reportable conditions, Emergency Medical Treatment and Labor Act [EMTALA])
   iv. Liability (e.g., duty to treat, negligence and standard of care, risk management)
   v. Disease prevention
   vi. Active and passive immunization
   vii. Antibiotic prophylaxis

Skills
In the appropriate setting, the resident should demonstrate the ability to independently perform or appropriately refer:
   1. Airway management
Family Medicine Residency, Fargo
Emergent Care

a. Heimlich maneuver
b. Ensuring airway patency and the use of advanced airway techniques
   i. Bag-valve mask ventilation
   ii. Oral endotracheal intubation in children and adults, including rapid sequence intubation
   iii. Laryngeal mask airway (LMA)
   iv. Esophageal obturator airway
c. Needle thoracentesis and tube thoracostomy
d. Initiation of mechanical ventilation
e. Cricothyroidotomy

2. Anesthetic techniques, including appropriate assessment and monitoring
   a. Local and topical anesthesia
   b. Regional and digital nerve blocks
   c. Procedural sedation and analgesia, including intravenous and alternate routes

3. Hemodynamic techniques
   a. Arterial catheter insertion and blood gas sampling
   b. Central venous access (e.g., jugular, femoral, subclavian)
   c. Venous cutdown
   d. Intraosseous infusion

4. Diagnostic and therapeutic procedures
   a. Control of epistaxis (anterior and posterior packing)
   b. Peritoneal tap and lavage
   c. Lumbar puncture
   d. Arthrocentesis
   e. Pericardiocentesis
   f. Nasogastric intubation
   g. Thoracentesis

5. Skeletal procedures
   a. Spine immobilization and traction techniques
   b. Fracture and dislocation immobilization techniques
   c. Fracture and dislocation reduction techniques
   d. Initial management of traumatic amputation

6. Other
   a. Repair of skin lacerations (including plastic closure)
   b. Management of wounds
   c. Management of foreign bodies in the skin and body orifices
   d. Mass casualty triage
   e. Multiple patient management
   f. Grief and loss counseling
   g. Critical incident stress debriefing
   h. Management of acute cardiorespiratory arrest in all age groups and implementation of the skills of Advanced Cardiac Life Support (ACLS) to lead a team resuscitative effort.
Implementation

A significant portion of management of emergencies will be provided by services other than the emergency department. Although much of the content of this guideline may be fulfilled while the resident is working in the emergency department, additional off-site experiences (e.g., helicopter or ground transport exposure) may be of educational value. Incorporating urgent care experiences into the overall educational plan may provide significant adjunctive learning, as an increasing number of family physicians now work in urgent care centers. Residents should have the opportunity to concentrate time spent in the emergency department on evaluation and management of patients who have presentations atypical of other outpatient experiences. Knowledge and skill acquisition may be supplemented through additional lecture series or course work, including, ACLS, Advanced Life Support in Obstetrics (ALSO), Advanced Trauma Life Support (ATLS), Neonatal resuscitation program (NRP), and other such courses.

Resource:

Urgent and Emergent Care AAFP Reprint No. 285
Family Medicine Residency, Fargo
Geriatric Care

Introduction

The percentage and number of older adults in our society is steadily increasing. Elderly persons occupy a large number of acute-care hospital beds, comprise the largest percentage of nursing home residents, and make more visits to physicians' offices than any other segment of the population. The acquisition of age-appropriate skills and knowledge in taking a patient’s history, performing a physical examination, making clinical and psychosocial diagnoses, and managing a patient’s condition must be an integral part of residency training. Yet, the American health care system has become more focused on acute and episodic care rather than preventative, chronic, and comprehensive care.

Although people do not suddenly acquire different characteristics at an arbitrarily predetermined age, there are many subtle, yet significant, differences in the diagnosis and management of older adults when compared with younger patients. The philosophy of providing comprehensive, continuing care includes the belief that a patient’s health in his or her later years is vitally affected by lifestyle and health care patterns established earlier in life. One goal of family medicine is to prepare younger adult and middle-aged patients for changes that occur with aging. Another goal is to assist elderly persons to function independently with self-respect, preserving their lifestyles as much as possible. This curriculum applies a comprehensive approach to the psychosocial and economic factors affecting aging patients and their families.

Goals

<table>
<thead>
<tr>
<th>PGY1</th>
<th>PGY2</th>
<th>PGY3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be able to perform comprehensive, standardized geriatric assessments and develop short- and long-term treatment plans.</td>
<td>Be able to perform comprehensive, standardized geriatric assessments and develop short- and long-term treatment plans.</td>
<td>Be able to perform comprehensive, standardized geriatric assessments and develop short- and long-term treatment plans.</td>
</tr>
<tr>
<td>Learning to optimize treatment plans by identifying local geriatric care resources, including local, state, and federal agencies.</td>
<td>Be able to optimize treatment plans based on knowledge of local geriatric care resources, including local, state, and federal agencies.</td>
<td>Be able to optimize treatment plans based on knowledge of local geriatric care resources, including local, state, and federal agencies.</td>
</tr>
<tr>
<td>Patient Care, Medical Knowledge</td>
<td>Systems-based Practice, Practice-based Learning and Improvement)</td>
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</table>
## Family Medicine Residency, Fargo  
### Geriatric Care

<table>
<thead>
<tr>
<th>PGY1</th>
<th>PGY2</th>
<th>PGY3</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning to navigate ambulatory, inpatient, and institutional care across health care providers, institutions, and governmental agencies.</td>
<td>Coordinate ambulatory, inpatient, and institutional care across health care providers, institutions, and governmental agencies.</td>
<td>Coordinate ambulatory, inpatient, and institutional care across health care providers, institutions, and governmental agencies.</td>
<td>Systems-based Practice</td>
</tr>
<tr>
<td>Demonstrate the ability to communicate effectively with the patient, as well as the patient’s family and caregivers, to ensure the diagnosis is clearly understood and the treatment plan is developed collaboratively.</td>
<td>Demonstrate the ability to communicate effectively with the patient, as well as the patient’s family and caregivers, to ensure the diagnosis is clearly understood and the treatment plan is developed collaboratively.</td>
<td>Demonstrate the ability to communicate effectively with the patient, as well as the patient’s family and caregivers, to ensure the diagnosis is clearly understood and the treatment plan is developed collaboratively.</td>
<td>Interpersonal and Communication Skills</td>
</tr>
<tr>
<td>Recognize his or her own practice limitations and seek consultation with other health care providers when necessary to provide optimal care.</td>
<td>Recognize his or her own practice limitations and seek consultation with other health care providers when necessary to provide optimal care.</td>
<td>Recognize his or her own practice limitations and seek consultation with other health care providers when necessary to provide optimal care.</td>
<td>Patient Care</td>
</tr>
</tbody>
</table>

### Objectives

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

1. Normal underlying physiologic changes due to aging in the various body systems
Family Medicine Residency, Fargo
Geriatric Care

a. Diminished homeostatic abilities
b. Altered metabolism and effects of drugs
c. Physiology of aging in various organ systems

2. Normal psychological, social, and environmental changes of aging
   a. Reactions to common stresses such as retirement, bereavement, relocation, and ill health
   b. Changes in family relationships that affect health care of the elderly

3. Unique modes of presentation for care, including atypical presentations of specific diseases in elderly patients

4. Risks and adverse outcomes in geriatric care
   a. Polypharmacy
   b. Iatrogenic illness
   c. Immobilization and its consequences
   d. Over-dependency.
   e. Inappropriate institutionalization
   f. Non-recognition of treatable illness
   g. Over-treatment
   h. Inappropriate use of technology
   i. Unsupported family

5. Means for promoting health and health maintenance through screening for and assessment of risk factors

6. Services available to promote rehabilitation or maintenance of an independent lifestyle for elderly people, thus increasing their ability to function in their existing family, home, and social environments

7. Indications and benefits of the house call in the assessment and management of elderly patients

8. Characteristics of the various types of long-term care facilities and alternative housing available to the elderly

9. Specific regulations for patient care in long-term facilities

10. Financial aspects of health care of the elderly understanding local, state, and federal programs that assist the elderly to finance the cost of their health care

11. Means to actively promote health in the elderly through exercise, nutrition, and psychosocial counseling

12. Elder abuse and neglect

13. Community resources, including those used to help patients maintain independence

14. Evaluation of the functional status of the elderly patient

15. Problems that are characteristic of older patients or that differ significantly in presentation and / or management in order adults
   a. Special senses: hearing and vision loss, speech disorders, taste, vestibular, and proprioceptive.
Family Medicine Residency, Fargo
Geriatric Care

b. Respiratory: pneumonia and other respiratory infections
c. Cardiovascular: hypertension, congestive heart failure, myocardial infarction, thromboembolism, temporal arteritis, cerebral vascular accident, transient ischemic attacks, and postural hypotension
d. Oral Conditions: caries, periodontal disease, tooth loss and denture care, oral-pharyngeal cancers, and oral-systemic linkages
e. Gastrointestinal: dentition problems, acute abdomen, malnutrition, constipation, and fecal impaction
f. Genitourinary: incontinence, urinary tract infections, bacteriuria, and sexual dysfunction
g. Musculoskeletal: degenerative joint disease, fractures, contractures, osteopenia / osteoporosis, podiatric problems, falls, decubiti, and pressure ulcers
h. Neurological: delirium, dementia (e.g., Alzheimer’s disease), altered mental status, dizziness, tremor, memory loss, gait disorders, and sleep disorders
i. Metabolic: dehydration, diabetes, hypothyroidism, medication-induced illness, malnutrition, anemia, hypothermia, and malignancies
j. Psychosocial: abuse (physical, financial, and psychological), alcoholism and other substance abuse, grief reactions, depression, psychological effects of illness, pain, terminal care, malnutrition, and failure to thrive
k. Dermatologic: xerosis, cutaneous neoplasms, skin manifestations of internal illness, blistering diseases, and environmental and traumatic lesions

Skills
In the appropriate setting, the resident should demonstrate the ability to independently perform or appropriately refer:

1. Basic elements of geriatric assessment, including the standardized methods for assessing physical, cognitive, emotional, and social functioning as appropriate
2. Screening examinations for mental status, depression, and functional status including activities of daily living (ADL) and instrumental activities of daily living (IADL)
3. Physical diagnosis, including:
   a. Mobility, gait, and balance assessments
   b. Recognition of normal and abnormal signs of aging
   c. Preoperative assessment
   d. Obtain a comprehensive history and mental status examination, utilizing all available sources of information
   e. Evaluation of the appropriate use of assistive devices (e.g. canes, walkers, wheel or power chairs)
4. Conduct an efficient and comprehensive physical examination in the following venues: office, hospital, and nursing home settings. The physician should be mindful of the patient's modesty and mobility
5. Appropriate selection, interpretation, and performance of diagnostic procedures
6. Appropriate house calls and coordination of home care
7. Develop problem lists in practical, clinical, functional, psychological, and social terms
8. Set appropriate priorities and limitations for investigation and treatment
9. Communicate with the patient and/or caregivers the proposed investigation and treatment plans in a way that promotes understanding, adherence, and appropriate attitudes.
10. Communicate hope and empathy
11. Counsel patients about age-related psychological, social, and physical stresses and changes of the normal life cycle of aging, dying, and death
12. Coordinate a range of services appropriate to the patient's needs and support systems
13. Integrate factors of the patient's family life, home life, and general lifestyle into the diagnostic and therapeutic process
14. Appropriate use of critical care resources which includes dealing with ethical issues, including advance directives, decision-making capacity, euthanasia, assisted suicide, health care rationing, and palliative and end-of-life care

**Implementation**
This curriculum should be taught during both focused and longitudinal experiences throughout the residency program. Physicians who have demonstrated skills in caring for the elderly and who have a positive attitude toward the elderly should be available to act as role models to the residents and should be available to give support and advice to individual residents regarding the management of their own patients. A multi-disciplinary approach coordinated by the family physician is an appropriate method for structuring teaching experiences. Individual teaching and small group discussion will help promote appropriate attitudes.

The resident should be responsible for caring for elderly patients and have opportunities to act as decision maker and case manager. Each family medicine resident's panel of patients should include a significant number of elderly patients, including healthy elderly patients and those with minor health problems, the chronically ill, the critically ill, the acutely ill, and the injured. The resident should be required to have experience providing continuing care for elderly patients in the ambulatory setting, the home, the hospital, and assisted living facilities.

**Resource:**
Care of the Older Adults  AAFP Reprint No. 264
Family Medicine Residency, Fargo
Musculoskeletal and Sports Medicine

Introduction

The human body is an intricately designed machine, one of the most complex mechanical engineering accomplishments ever developed. Under normal circumstances, the mechanics of the human body function smoothly and possess the ability to correct or heal a number of problems. Most people will experience some problems with the muscles, bones and supporting structures of their bodies during their lifetime. Acute and chronic problems of the musculoskeletal system are some of the most common reasons for primary care medical visits in the United States. Some will have conditions the Family Physician can manage on their own, and some will require consultation and collaboration with Orthopedic specialists. Possession of a solid knowledge base of common orthopedic conditions and the ability and technical skill to manage or appropriately refer these patients are mandatory attributes of the competent Family Physician.

The combined burden of medical conditions affecting the musculoskeletal system and preventable chronic diseases that are related to improper nutrition and inactivity in the United States is staggering. Musculoskeletal complaints rank second only to upper respiratory infections as the reason for seeking medical attention (Woodwell 2004). Yet, studies indicate musculoskeletal and sports medicine education in U.S. medical schools and primary care residencies may be inadequate (Freedman 1998). The goals and objectives outlined below will equip family medicine training programs to provide optimal care of patients in preventing and treating those who have musculoskeletal complaints.

Goals

<table>
<thead>
<tr>
<th>Competencies</th>
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<tbody>
<tr>
<td>Patient Care, Medical Knowledge, Systems-based Practice</td>
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<td>Patient Care, Medical Knowledge, Interpersonal and Communication Skills, Professionalism</td>
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<th>PGY1-2</th>
<th>PGY3</th>
<th>Competencies</th>
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<tr>
<td>Perform an appropriate musculoskeletal history and physical examination, and formulate an appropriate differential diagnosis and recommend treatment, including requisite subspecialty referrals</td>
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<td>Patient Care, Medical Knowledge, Systems-based Practice</td>
</tr>
<tr>
<td>Perform an evidence-based, age-appropriate, and activity-specific preparticipation physical examination</td>
<td>Perform an evidence-based, age-appropriate, and activity-specific preparticipation physical examination</td>
<td>Patient Care, Medical Knowledge, Interpersonal and Communication Skills, Professionalism</td>
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Family Medicine Residency, Fargo
Musculoskeletal and Sports Medicine

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<tr>
<td>Learning the skills to communicate effectively with a wide range of</td>
<td>Communicate effectively with a wide range of individuals regarding</td>
<td>Interpersonal and Communication Skills</td>
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<tr>
<td>individuals regarding musculoskeletal health care, including patients,</td>
<td>musculoskeletal health care, including patients, their families,</td>
<td></td>
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<tr>
<td>their families, coaches, school administrators, and employers</td>
<td>coaches, school administrators, and employers</td>
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<tr>
<td>Learning how exercise impacts disease states such as diabetes and</td>
<td>Understand how exercise impacts disease states such as diabetes and</td>
<td>Patient Care, Medical Knowledge,</td>
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<tr>
<td>hypertension and learning to formulate an appropriate exercise</td>
<td>hypertension and be able to formulate an appropriate exercise</td>
<td>Interpersonal and Communication Skills</td>
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<tr>
<td>prescription</td>
<td>prescription</td>
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<tr>
<td>Understand that sports medicine involves caring for the medical</td>
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<td>Patient Care</td>
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<tr>
<td>conditions of athletes in addition to the musculoskeletal conditions</td>
<td>conditions of athletes in addition to the musculoskeletal conditions</td>
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</table>

Objectives

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

1. Normal anatomy and physiology

2. Normal growth and development

3. Musculoskeletal history taking

4. Principles of musculoskeletal physical examination

5. Indications, contraindications, and interpretation of laboratory data (e.g., joint fluid)

6. Indications, limitations, contraindications, informed consent for office-based musculoskeletal procedures, and demonstrate the ability to independently perform or appropriately refer procedures, such as:
   a. Common joint aspirations
   b. Common joint injections
c. Common injections for bursitis
d. Common injections for tendinopathy

7. Testing
   a. Interpretation of radiographs
   b. Use of magnetic resonance imaging (MRI), computed tomography (CT) scanning, bone scanning, and musculoskeletal ultrasound
   c. Indications for arthrogram, myelogram and arthroscopy
   d. Application of electromyography (EMG) and nerve conduction studies

8. Pathogenesis/pathophysiology and recognition of:
   a. Joint pain, swelling, and erythema
   b. Muscular pain, swelling, and injury
   c. Musculoskeletal trauma
   d. Fractures
   e. Dislocations
   f. Tendinopathy spectrum
   g. Tendon ruptures (partial and complete)
   h. Nerve injuries
   i. Bone and joint deformities
   j. Bone and joint infections
   k. Metabolic bone diseases
   l. Musculoskeletal congenital anomalies
   m. Musculoskeletal birth injuries
   n. Compartment syndrome
   o. Avascular necrosis
   p. Osteoporosis
   q. Overuse syndromes
   r. Back pain syndromes

9. Pediatric Problems:
   a. Hip dislocation
   b. Congenital hip dysplasia
   c. Legg-Calvé-Perthes disease
   d. Osgood-Schlatter disease
   e. Slipped capital femoral epiphysis
   f. “Clubfoot” (talipes equinovarus)
   g. Intoeing (metatarsus adductus, tibial torsion, femoral anteversion)
   h. “Bowleg” (genu varum) and “knock knee” (genu valgum)
   i. Physeal injuries (Salter-Harris classification)
   j. Transient synovitis
   k. Child abuse patterns of injury
   l. Dislocation of the radial head (nursemaid’s elbow)
   m. Blount disease
   n. Rickets
Family Medicine Residency, Fargo
Musculoskeletal and Sports Medicine

o. Osteogenesis imperfecta
p. Thoracolumbar scoliosis

10. Sports medicine-specific consideration:
   a. General considerations
   b. Ethical, psychosocial, economic, and medicolegal issues
   c. Interaction with members of the sports medicine team
   d. Nutrition, fluids and electrolytes, and dietary supplements
   e. Injury prevention
      i. Discouraging use of improper techniques
      ii. Promoting rule changes and enforcement of rules designed to enhance participant safety
      iii. Proper equipment, fit, and maintenance
      iv. Taping, strapping, and bracing techniques
      v. Environmental factors affecting participant and spectator safety
   f. Conditioning and training techniques, including principles of aerobic and resistance training
   g. Appropriate exercise prescription for:
      i. Healthy persons of all ages, taking into account physiologic differences related to age and sex
      ii. Patients who have chronic illnesses, including diabetes, hypertension, congestive heart failure, asthma, and chronic obstructive pulmonary disease
      iii. Pregnant women
      iv. Physically or mentally challenged athletes
      v. Patients who have various cardiovascular conditions, especially those known to increase the risk of sudden death
   h. Sports medicine education promotion for patients and their families, athletes and their families, allied health professionals, coaches, and school administrators
      i. Patient care aspects
      ii. The important role of family physicians as part of a team of physicians for organized sports
      iii. The role of family physicians as medical directors and/or on-site medical care providers for mass participation sporting events
      iv. Appropriate assessment and care of acutely injured athletes, including, but not limited to:
         1. Evaluation, on-field management, and transport of suspected cervical spine injury
Family Medicine Residency, Fargo
Musculoskeletal and Sports Medicine

2. Evaluation, and on-field and sideline management of suspected concussion or other head injury

3. Evaluation, on-field management and transport of severe fractures and dislocations

   v. iv. Medical management of ill and injured athletes, taking into account important sport-specific considerations

   vi. Rehabilitation oversight for ill and injured athletes, and return to play decision-making

   vii. Medical care considerations for special athlete groups

   viii. Preadolescent athletes

   ix. Adolescent athletes

   x. Female athletes

   xi. Geriatric athletes

   xii. Physically challenged athletes

   xiii. Student athletes

   xiv. Recreational athletes

   xv. Athletes who have chronic diseases

   i. h Communication and interaction with patients and their families, athletes and their families, coaches, and school administrators

   j. Exercise-induced asthma testing

   k. Understanding of cardiac screening for exercise-related cardiac problems

11. Problems associated with exercise

   a. Exercise addiction

   b. Abuse of anabolic steroids and other performance-enhancing drugs

   c. Pressures placed on athletes by themselves, family members, teammates, coaches, and fans to participate even when injured

   d. Performance pressures placed on athletes by themselves, family members, teammates, coaches, and fans

   e. The intermittent exerciser

   f. How to deal with unmet and unrealized expectations

   g. Alcohol and illicit drug use and abuse

   h. Eating disorders

12. Management and therapy

   a. Outline of expected course with and without therapy

   b. Patient education for acute and chronic problems
Family Medicine Residency, Fargo
Musculoskeletal and Sports Medicine

c. Targeted pharmacologic treatment
d. Supportive/corrective devices, including braces, casts, splints, and orthotics
e. Complementary and alternative modalities
f. Prevention
   i. Preparticipation screening
   ii. Conditioning and training
   iii. Injury prevention
   iv. Physical fitness/exercise prescription
   v. Bone loss
      1. Nutrition
      2. Exercise
      3. Pharmacology
g. Rehabilitation
   i. Physical therapy
      1. Cold, heat
      2. Ultrasound and phonophoresis
      3. Exercises
      4. Electrical stimulation (e-stim) and iontophoresis
   ii. Occupational therapy
   iii. Complementary modalities (e.g., osteopathic manipulative therapy [OMT], massage, acupuncture)
   iv. Psychosocial aspects of trauma
h. Surgery and follow-up care
   i. Internal and external fixation devices
   ii. Artificial joint replacement
   iii. Arthroscopy

In the appropriate setting, the resident should demonstrate the ability to independently perform or appropriately refer:
1. Basic management of:
   a. Fractures (simple, stable, closed, and nondisplaced that do not require surgical correction)
   b. Ligament sprains
      i. Finger
      ii. Toe
      iii. Ankle
      iv. Knee
      v. Vertebral column
      vi. Wrist
      vii. Elbow
      viii. Shoulder
   c. Muscular strains (e.g., hamstring, trapezius)
   d. Other problems
Family Medicine Residency, Fargo
Musculoskeletal and Sports Medicine

i. Costochondritis
ii. Bursitis, tendinopathy, tenosynovitis
iii. Common fibrocartilage injuries such as labral and meniscal tears
iv. Dislocations (e.g., nursemaid’s elbow)
v. Neurologic conditions (e.g., concussions, nerve entrapment syndromes, brachial plexopathies)
vi. Synovial cysts (e.g. Baker cyst, ganglion cysts)
vii. Patellofemoral syndrome apophysitis (e.g., Osgood-Schlatter disease)
viii. Osteochondroses/aseptic necrosis
ix. Osteoarthritis/crystalline-induced arthritis (e.g., gout, pseudogout)
x. Metabolic bone disease (osteoporosis, Paget disease)
xi. Acute and chronic low back pain
xii. Foot conditions
   1. Hallux valgus (bunions)
   2. Plantar fasciitis
   3. Morton neuroma
xiii. Osteomyelitis
xiv. Rheumatologic disorders

e. Procedures (indications, contraindications, and complications)
i. Splints (upper and lower extremity)
ii. Plaster and fiberglass casts
   1. Short leg
   2. Short and long arm
   3. Thumb spica
   4. Cast problems
iii. Dislocation reduction
   1. Simple anterior shoulder
   2. Radial head
   3. Simple posterior elbow
   4. Phalanges
   5. Patella

2. Orthopedic emergency recognition and stabilization
   a. Acute compartment syndrome
   b. Hip dislocation
   c. Knee dislocation
   d. Unstable pelvis fracture
   e. Cervical spine fracture
   f. Spinal cord injury
   g. Cauda equina syndrome
   h. Neurovascular compromise

3. Functional rehabilitation
   a. Prescription of home exercise programs
Implementation
This Curriculum Guideline should be implemented longitudinally throughout the three years of residency training. Research has shown that early exposure to a sports medicine curriculum enhances basic medical knowledge in musculoskeletal medicine (Watts 2011). The continuing patient care experience in the family medicine center provides the principal site for training in ambulatory musculoskeletal care. Residents will also have a ambulatory sports medicine rotation and an orthopedic rotation that includes both inpatient and outpatient orthopedic care.

Resource:
Musculoskeletal and Sports Medicine AAFP Reprint No. 265
Family Medicine Residency, Fargo
Obstetrics

Introduction

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

Goals

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Developing skills to communicate effectively with female patients of all ages, demonstrating active listening skills, a respectful approach to issues that may be sensitive for women, and collaborative care planning with the patient</td>
<td>Communicate effectively with female patients of all ages, demonstrating active listening skills, a respectful approach to issues that may be sensitive for women, and collaborative care planning with the patient</td>
<td>Communicate effectively with female patients of all ages, demonstrating active listening skills, a respectful approach to issues that may be sensitive for women, and collaborative care planning with the patient</td>
<td>Interpersonal and Communication Skills, Professionalism</td>
</tr>
<tr>
<td>Perform comprehensive physical examinations of female anatomy, with appropriate screening tests for pregnant women</td>
<td>Perform comprehensive physical examinations of female anatomy, with appropriate screening tests for pregnant women, and be able to perform obstetrical procedures (detailed below)</td>
<td>Perform comprehensive physical examinations of female anatomy, with appropriate screening tests for pregnant women, and be able to perform obstetrical procedures (detailed below)</td>
<td>Patient Care, Medical Knowledge</td>
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<tr>
<td>Medical Knowledge, Systems-based Practice, Practice-based Learning and Improvement</td>
<td>Develop treatment plans for common pregnancy complications, utilizing community resources when indicated, and demonstrate appropriate post-operative care following caesarean section, both inpatient and for office follow-up</td>
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</tr>
<tr>
<td>Patient Care, Interpersonal and Communication Skills</td>
<td>Learning primary care counseling skills for psychosocial, behavioral, and reproductive issues in women, as well as comprehensive wellness counseling based on the patient’s age and risk factors</td>
<td>Developing effective primary care counseling skills for psychosocial, behavioral, and reproductive issues in women, as well as comprehensive wellness counseling based on the patient’s age and risk factors</td>
<td>Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive issues in women, as well as comprehensive wellness counseling based on the patient’s age and risk factors</td>
</tr>
<tr>
<td>Medical Knowledge, Interpersonal and Communication skills, Systems-based Practice</td>
<td>Consult and communicate appropriately with obstetrician-gynecologists (OB-GYNs), maternal-fetal medicine specialists, and allied health care professionals to provide optimum health services for women</td>
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<td>Systems-based Practice</td>
<td>Act as patient advocate and coordinator of care</td>
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Family Medicine Residency, Fargo
Obstetrics

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**Objectives**

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

I. Family-centered maternity care

A. Preconception counseling and planning
   1. Counseling in the areas of:
      a. Nutrition
      b. Contraception
      c. Prevention of birth defects
      d. Optimization of health prior to conception
      e. Assessment of immunization status and appropriate vaccinations, as needed
      f. Screening for preconception genetic counseling
      g. Exercise
      h. Occupational hazards assessment
      i. Anticipatory guidance regarding realistic assessment of expectations about work

B. Antenatal care: first trimester
   1. Diagnosis of pregnancy, including differentiation and management or referral of abnormal gestations (e.g., gestational trophoblastic disease, ectopic pregnancy)
   2. Initial prenatal history and evaluation, including clinical assessment of gestational age
   3. Assessment and management of complications and symptoms in the first trimester
      a. Spotting/bleeding
      b. Pelvic pain
      c. Hyperemesis gravidarum
      d. Musculoskeletal changes and discomforts
      e. Body image changes
      f. Life cycle stresses and changes in family dynamics
Family Medicine Residency, Fargo Obstetrics

4. Risk factor screening
   a. Appropriate counseling to help patients make personal decisions regarding risk factor screening and assessment
      i. Options for early screening for chromosomal abnormalities through noninvasive prenatal testing, including ultrasound examination for nuchal translucency, alpha-fetoprotein (AFP)/quadruple marker testing, combined or sequential screening protocols, and cell-free DNA testing
      ii. Cystic fibrosis and Tay-Sachs disease screening
      iii. Referral for genetic counseling regarding other genetic diseases, with attention to maternal age and other risk factors
      iv. Referral for amniocentesis

5. Counseling for prevention or treatment of substance abuse and sexually transmitted infections (STIs), to specifically include:
   a. Tobacco cessation counseling in pregnancy
   b. Alcohol abuse risks and fetal alcohol syndrome
   c. Opiate abuse and referral for treatment with methadone or buprenorphine, and counseling with regard to neonatal abstinence syndrome
   d. Other substances of abuse and pregnancy risks
   e. Risk factors for STIs (including viral hepatitis and HIV) and their impact on pregnancy and fetal outcome

6. Prenatal nutrition counseling for optimal nutrition for the developing fetus and the mother, including:
   a. Vitamins, iron, and folic acid supplementation, as needed
   b. Counseling regarding appropriate weight gain based on maternal pre-pregnancy body mass index (BMI), and counseling regarding increased risks of obesity (or inadequate weight gain in normal or underweight women) in pregnancy

7. Psychosocial stressors of pregnancy
   a. Counseling and support of the patient and her family through the multiple adjustments required for normal and complicated pregnancies, including the impact on her partner and other children in the family, and referral to psychological support services as appropriate.

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

9. First trimester pregnancy loss
   a. Diagnosis and differentiation of failed pregnancies (threatened, incomplete, complete, embryonic demise), and recognition and referral of ectopic pregnancies
Family Medicine Residency, Fargo
Obstetrics

b. Management of uncomplicated spontaneous abortion
c. Referral for surgical intervention when indicated for spontaneous abortion complicated by infection, retained products of conception, or in otherwise high-risk situations
d. Counseling regarding grief in event of any first trimester loss, whether planned or spontaneous abortion
e. Appropriate medical evaluation for recurrent early pregnancy loss

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

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

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

13. Counseling regarding and promotion of appropriate immunizations in pregnancy

C. Antenatal care: second and third trimester

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

2. Second and third trimester screening and risk assessment for:
   a. Gestational diabetes (including first trimester screening when appropriate based on risk factors)
   b. Sexually transmitted infections
   c. Bacterial or yeast vaginitis
   d. Group B beta-hemolytic strep screening
   e. Asymptomatic bacteriuria, urinary tract infection, and complications
   f. Iron deficiency anemia

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

4. Obstetrical complications: assessment and management, including indications for consultation with obstetrician or need for transfer of care
   a. Preterm labor
   b. Malposition
   c. Placental abruption
   d. Trauma/deceleration injuries
   e. Blood factor isoimmunization
   f. Pregnancy-induced hypertension, preeclampsia, and eclampsia
   g. HELLP syndrome and acute fatty liver of pregnancy
   h. Fetal demise
Family Medicine Residency, Fargo Obstetrics

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

5. Medical complications during pregnancy, with appropriate consultation or referral to obstetrician:
   a. Asthma
   b. Pyelonephritis and renal calculi
   c. Cholelithiasis and acute cholecystitis
   d. Preexisting hypertension or diabetes
   e. Thromboembolic disease
   f. Dilated cardiomyopathy

D. Peripartum care: labor and delivery
   1. Normal labor and delivery
      a. Understand the physiology of the three stages of labor and demonstrate effective management of all three stages, including management of normal and abnormal labor curves and active management of the third stage of labor
      b. Demonstrate appropriate utilization and interpretation of external electronic fetal monitoring, with knowledge of the benefits and limitations of use and respect for individual and family desires for labor
      c. Use appropriate obstetric analgesia and anesthesia; evaluate the need for pain control interventions and counsel appropriately. Include family presence and awareness of labor support methods such as Lamaze and Bradley methods. Anticipate and plan for needs of special populations (e.g., opiate-dependent patients or other substance-abusing patients, women with extreme obesity).
      d. Understand and demonstrate methods for protecting the perineum during the second stage of labor; understand indications for episiotomy
      e. Understand the normal course of the third stage of labor and the steps involved to prevent excessive bleeding and reduce risk of postpartum hemorrhage using the active management techniques, as described in Advanced Life Support in Obstetrics (ALSO)
      f. Support and counsel patients regarding breastfeeding in the immediate postpartum period, utilizing support staff such as lactation consultants when indicated
   2. Complications during labor and delivery
      a. Fetal malposition: understand fetal-pelvic relationships and the importance of early detection of malposition; distinguish types of malposition and understand their compatibility with vaginal delivery
      b. Labor dystocia: understand risk factors, prevention, recognition, and management, including augmentation of labor and utilization of appropriate obstetric consultation when indicated
c. Post-term pregnancy: understand indications and risk assessments for induction of post-term pregnancy, including post-dates monitoring, and selection of management options, including cervical ripening agents, Pitocin induction, and artificial rupture of membranes; understand appropriate assessment and use of Bishop scoring for induction management

d. Premature and prolonged rupture of membranes: Knowledge of appropriate interventions, including induction or augmentation of labor and use of prophylactic antibiotics when indicated

e. Meconium: demonstrate awareness of the need for appropriate personnel to be present at the time of delivery and for appropriate intrapartum management of the neonate born with meconium-stained fluid, including counseling mothers and families about expectations for delivery

f. Emergencies: recognize signs and symptoms of potentially life-threatening emergencies during the peripartum period and utilize appropriate resuscitative techniques for mothers and babies; with obstetric consultation, co-manage placental abruption/hemorrhage, preeclampsia, eclampsia, amniotic fluid embolism, and disseminated intravascular coagulation (DIC)

g. Fetal distress: recognize early signs of fetal compromise and demonstrate appropriate interventions, including position change, tocolytics, maternal fluid and oxygen resuscitation, and amnioinfusion, as well as timely consultation, when necessary

h. Shoulder dystocia: understand risk factors, prevention, recognition, and management using ALSO protocols

i. Assisted deliveries: understand indications for and appropriate use and application of a vacuum extractor; understand indications for forceps

j. Cesarean section: understand indications, risks/benefits, and need for timely consultation

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

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

E. Postpartum care

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

2. Recognition and appropriate evaluation and management of postpartum complications in the hospital, including:
   a. Delayed postpartum hemorrhage
   b. Postpartum fever and endometritis
Family Medicine Residency, Fargo
Obstetrics

c. Pain associated with normal uterine involution, episiotomy, or laceration repair; epidural- or spinal anesthesia-related pain or headache; and musculoskeletal injury associated with labor
d. Thromboembolic disease
e. Lactation: addressing difficulties in the newborn period
f. Postpartum depression and other mood disorders
   i. Later postpartum follow-up
      1. Normal and abnormal postpartum lochia and bleeding patterns
      2. Awareness of and counseling/management for common breastfeeding difficulties, including problems with milk supply, latch, nipple soreness or cracking, blocked milk ducts, engorgement, and mastitis
      3. Continued screening, assessment, and management of postpartum mood disorders
      4. Postpartum intimate relationships and family dynamics
      5. Parenting education and resources
         a. Interpregnancy care: counseling regarding child spacing, risks and monitoring related to prior pregnancy outcomes (e.g., gestational diabetes, pregnancy-induced hypertension, prior preterm labor or birth, and thromboembolic disease) with specific knowledge of risk reduction for prevention of preterm birth

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

G. Consultation and referral
   1. Understanding of the roles of the obstetrician, gynecologist, and subspecialist
   2. Recognition of a variety of resources in women’s health care delivery systems (e.g., Special Supplemental Nutrition Program for Women, Infants, and Children [WIC], Planned Parenthood)
   3. Regionalized perinatal care for high-risk pregnancies
   4. Collaboration with other health care professionals (e.g., childbirth educator, lactation consultant, certified nurse midwife, nutritionist, dietician, parenting educator, social services, U.S. Department of Health and Human Services, mental health and addiction professionals)

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

A. Pregnancy: independent performance
   1. History, physical examination, counseling, and laboratory and clinical monitoring throughout pregnancy
   2. Assessment of pelvic adequacy with pelvimetry
   3. Assessment of estimated fetal weight by Leopold maneuvers
Family Medicine Residency, Fargo
Obstetrics

4. Performance and interpretation of non-stress tests and stress tests
5. Limited obstetric ultrasound examination (fetal position, amniotic fluid index, placental location, cardiac activity)
6. Management of labor with accurate assessment of cervical progress and fetal presentation and lie
7. Induction and augmentation of labor, including artificial rupture of membranes
8. Placement of fetal scalp electrode
9. Placement of intrauterine pressure catheter
10. Amnioinfusion
11. Local block anesthesia
12. Spontaneous cephalic delivery
13. Active management of the third stage of labor
14. Episiotomy
15. Repair of episiotomies and lacerations (including third-degree)
16. Neonatal resuscitation

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

Implementation

Core knowledge and skills should require a minimum of two months of experience in a structured obstetrics educational program, with an additional one month dedicated to gynecologic care. Adequate emphasis on both ambulatory and hospital care should be provided. Residents will obtain substantial additional experience in maternity care throughout the three years of their continuity practices. Core family medicine faculty members skilled in performing and teaching comprehensive maternity care, in addition to OB-GYN specialists in a supportive role.

Programs for family medicine residents should have a collaborative relationship between family medicine faculty and OB-GYNs at the training institution; OB-GYNs may be a formal part of the faculty or be collaborative consultants. An operational committee has been established with regard to the practice of maternity care at Sanford Health Fargo involved in graduate medical education; part of its mission should be the training of family medicine residents. Members of the committee should represent both family medicine and obstetrics and gynecology.
Family Medicine Residency, Fargo Obstetrics

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

Resources: Maternity Care AAFP Reprint No.261
Family Medicine Residency, Fargo
Outpatient Alcohol and Chemical Dependency Treatment

Introduction

Alcoholism and chemical dependency are an ever rising problem in the everyday practice of medicine. Family physicians must be able to recognize the interrelationships among biologic, psychologic, and social factors in all patients. Attention must be paid to these principles as a continuum throughout the family medicine residency program.

Goals

<table>
<thead>
<tr>
<th>PGY2</th>
<th>PGY3</th>
<th>Competencies</th>
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<tbody>
<tr>
<td>Learning to recognize, initiate treatment for, and utilize appropriate referrals for chemical dependency to optimize patient care.</td>
<td>Be able to recognize, initiate treatment for, and utilize appropriate referrals for chemical dependency to optimize patient care.</td>
<td>Systems-based practice, Patient care</td>
</tr>
<tr>
<td>Learning the skills to effectively interview and evaluate patients with chemical dependency using appropriate techniques and skills to enhance the doctor-patient relationship.</td>
<td>Demonstrate the ability to effectively interview and evaluate patients with chemical dependency using appropriate techniques and skills to enhance the doctor-patient relationship.</td>
<td>Interpersonal and Communication Skills, Patient Care</td>
</tr>
<tr>
<td>Have sensitivity to and knowledge of the emotional aspects of chemical dependency</td>
<td>Have sensitivity to and knowledge of the emotional aspects of chemical dependency</td>
<td>Patient Care, Professionalism</td>
</tr>
<tr>
<td>Learning of the necessary resources and protocols to intervene effectively and professionally in emergent chemical dependency situations.</td>
<td>Be able to intervene effectively and professionally in emergent chemical dependency situations.</td>
<td>Professionalism, Systems-based Practice</td>
</tr>
<tr>
<td>Understand the impact of chemical dependency on the family unit.</td>
<td>Understand the impact of chemical dependency on the family unit.</td>
<td>Interpersonal and Communication Skills</td>
</tr>
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</table>
Family Medicine Residency, Fargo
Outpatient Alcohol and Chemical Dependency Treatment

Objectives

1. Basic behavioral knowledge
   a. Normal, abnormal, and variant psychosocial growth and development across the life cycle
      b. Recognition of interrelationships among biologic, psychologic, and social factors in all patients
      c. Reciprocal effects of chemical dependency on patients and their families
      d. Factors that influence adherence to a treatment plan
      e. Family functions and common interactional patterns in coping with stress
      f. Awareness of one's own attitudes and values, which influence effectiveness and satisfaction as a physician
      g. Stressors on physicians and approaches to effective coping
      h. Ethical issues in medical practice, including informed consent, patient autonomy, confidentiality, and quality of life

2. Chemical dependency

   1. Delirium, dementia, amnestic and other cognitive disorders
      a. Substance-related disorders
      b. Alcohol
      c. Amphetamines
      d. Caffeine
      e. Cannabis
      f. Cocaine
      g. Hallucinogens
      h. Inhalants
      i. Nicotine
      j. Opioids
      k. Phencyclidine
      l. Sedative-, hypnotic- or anxiolytic-related disorders
      m. Polysubstance-related disorder

3. Problems related to abuse or neglect
   a. Additional conditions
      i. Nonadherence / noncompliance
   b. Malingering
   c. Borderline intellectual functioning
   d. Age-related cognitive decline
   e. Bereavement
Skills

In the appropriate setting, the resident should demonstrate the ability to independently perform or appropriately refer:

1. Use of evaluation tools and interviewing skills, which enhance data collection in short periods of time and optimize the doctor/patient relationship.
2. Techniques to elicit the context of the visit [BATHE (background, affect, trouble, handling and empathy) or other techniques].
3. Mental status examination
4. Evaluation of indications for special procedures in psychiatric disorder diagnosis, including psychologic testing, laboratory testing and brain imaging
5. Elicit and recognize the common signs and symptoms of the disorders under Knowledge
   a. Teach patients methods for evaluating and selecting reliable websites for medical information
6. Assessment of depression [PHQ-9, Beck, Zung, Hamilton Scales, SIG-E-CAPS mnemonic (sleep, interest, guilt, energy, concentration, appetite, psychomotor and suicidal ideation)]
7. Evaluation of indications for psychiatric or chemical dependency consultation
8. Management of emotional aspects of nonpsychiatric disorders
9. Techniques for enhancing compliance with medical treatment regimens
10. Initial management of psychiatric emergencies: the suicidal patient, delirium
11. Proper use of psychopharmacologic agents
    a. Diagnostic indications and contraindications
    b. Dosage, length of use, monitoring of response, side effects and compliance
    c. Drug interactions
    d. Associated medical problems
12. Family support therapy
14. Utilization of community resources
    a. Patient care team of other mental health professionals
15. Crisis-counseling skills
16. Modification of patient environment
17. Variations in treatment based on the patient's personality, lifestyle and family setting
18. Identification of, intervention in and therapy for drug and alcohol dependency and abuse
19. Appropriate care of health disorders listed under psychopathology
20. Appropriate referral procedures to ensure continuity of care, provide optimal information sharing and enhance patient compliance
   a. Indications
   b. Process
   c. Follow-up

Implementation

In addition to continuity clinic, community medicine, rural rotation, residents will have a one week rotation in an outpatient alcoholism and chemical dependency clinic.

Resources

Human Behavior and Mental Health AAFP Reprint No. 270
Family Medicine Residency, Fargo  
Pediatric Care

Introduction

Family physicians must develop knowledge and skills appropriate to manage medical, physical, social, and emotional problems in patients of all ages, including infants and children. Family physicians have a unique opportunity to treat all members of the family and to appreciate the influence that family members and siblings have on an individual infant or child. It is the responsibility of the family physician to monitor the development of each child so that the child can reach his or her full potential, and to improve the health of children and families in the community in a proactive and responsive manner.

Goals

<table>
<thead>
<tr>
<th>PGY1</th>
<th>PGY2</th>
<th>PGY3</th>
<th>Competencies</th>
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<tbody>
<tr>
<td>Demonstrate the ability to take an age-appropriate history and perform a physical examination</td>
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<td>Demonstrate the ability to take an age-appropriate history and perform a physical examination, recognizing appropriate developmental milestones and acceptable and unacceptable deviation</td>
<td>Patient Care, Medical Knowledge</td>
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<tr>
<td>Develop a differential diagnosis and start to synthesize a treatment plan for common pediatric conditions in both the outpatient and inpatient settings</td>
<td>Synthesize an appropriate differential diagnosis and treatment plan for common pediatric conditions in both the outpatient and inpatient settings</td>
<td>Synthesize an appropriate differential diagnosis and treatment plan for common pediatric conditions in both the outpatient and inpatient settings</td>
<td>Patient Care, Medical Knowledge</td>
</tr>
<tr>
<td>Practicing effective communication with the patient, family and caregivers.</td>
<td>Demonstrate the ability to communicate effectively with the patient, as well as the patient’s family and caregivers, to ensure the development and clear</td>
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<td>Interpersonal and Communication Skills</td>
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## Objectives

At the completion of residency, the resident is expected to display the following knowledge, skills, and attitudes:

The resident should demonstrate attitudes that encompass:

1. Empathic concern for the health of the child in the context of the family
2. The importance of continuity and access to care for prevention and treatment of acute and chronic illness
3. Promotion of healthy lifestyles for children and families
4. Awareness of unique vulnerabilities of infants and children that may require special attention, consultation, and/or referral
5. Awareness of social, cultural, and environmental factors that impact the health and well-being of infants and children
6. The importance of educating the public about environmental factors that can adversely affect children and developing community programs to promote the health of children
7. The importance of obtaining and utilizing information about school performance and learning disabilities in order to assist in the creation of a management plan

## Knowledge

In the appropriate setting, the resident should demonstrate the ability to apply knowledge of:
1. Fetal and neonatal period
   a. Risk factors determined by gestational age assessment
   b. Effects of labor and delivery on the infant
   c. Adaptations to extrauterine life
   d. Newborn metabolic screening
   e. Diagnosis and role-appropriate management of:
      i. Meconium-stained amniotic fluid
      ii. Perinatal asphyxia
      iii. Respiratory distress
      iv. Cyanosis
      v. Apnea
      vi. Bradycardia
      vii. Seizures
      viii. Hypoglycemia
      ix. Possible sepsis
      x. Developmental dysplasia of the hip
      xi. Birth-related injuries
      xii. Neonatal abstinence syndrome (in utero drug exposure)
      xiii. Anemia
      xiv. Rh factor and blood type incompatibility
      xv. Polycythemia
      xvi. Jaundice
      xvii. Premature and post-date gestations
      xviii. Congenital and neonatal infections
      xix. Maternal factors: infections (e.g., HIV, hepatitis); medical conditions (e.g., diabetes, hypertension)

2. Well newborn and child care
   a. Recommended schedule and content of examinations from birth to adolescence
   b. Anticipatory guidance appropriate to age and developmental stage
      i. Circumcision
      ii. Feeding options and variations
      iii. Temperament and behavior
      iv. Colic
      v. Developmental stages and milestones
      vi. Developmental screening tests
      vii. Family and social relationships
      viii. Effective parenting
      ix. School readiness (including school failure, bullying, and peer pressure)
      x. Sleep problems
      xi. Physical activity and exercise
Family Medicine Residency, Fargo
Pediatric Care

d. Use of over-the-counter (OTC) medications and complementary and alternative medicine (CAM)

d. Drug usage (OTC, prescribed, or illicit) in lactation

c. Adolescent screening for risk-taking behaviors, sexual activity, and psychiatric disorders

d. Sexual development and Tanner staging
   i. Reproductive health maintenance and health promotion

3. Physical growth
   a. Feeding strategies
   b. Growth and caloric requirements
   c. Normal growth and variants, including dental development
   d. Failure to thrive
   e. Obesity

4. Prevention and screening
   a. Injury prevention
      i. Motorized vehicles
      ii. Unmotorized vehicles (e.g., bicycles, skates, skateboards)
      iii. Drowning
      iv. Choking and asphyxiation
      v. Poisoning and toxin exposures
      vi. Firearms
      vii. Falls
      viii. Burns and fire safety
   b. Child abuse
   c. Immunization
   d. Screening
      i. Anemia
      ii. Lead
      iii. Fluoride
      iv. High-risk children (e.g., lipids, tuberculosis [TB], other infectious diseases)
      v. Hypertension
      vi. Vision
      vii. Hearing
      viii. Other environmental health issues: actinic damage, media exposure, violence

5. Psychological disorders
   a. Recognize families with high risk for parent-child interaction problems, dysfunction, or psychiatric problems
   b. Evaluation, treatment, and referral for:
      i. Feeding and eating disorders
      ii. Elimination disorders
Family Medicine Residency, Fargo
Pediatric Care

iii. Somatic symptom disorder and related disorders
iv. Sleep-wake disorders
v. Obsessive-compulsive disorder and related disorders
vi. Disruptive behavior, impulse control, and conduct disorders
vii. Psychotic disorders
viii. Neurodevelopmental disorders
   1. Intellectual developmental disorder
   2. Attention-deficit/hyperactivity disorder (ADHD)
   3. Tic disorders
   4. Learning disorders
   5. Autism spectrum disorder
ix. Anxiety disorders
x. Bipolar disorder and related disorders
xi. Depressive disorders (including disruptive mood dysregulation disorder)
xii. Gender dysphoria
xiii. Trauma- and stressor-related disorders
xiv. Psychiatric emergencies (including suicidality)

6. Social and ethical issues
   a. Adoption
   b. Divorce, separation, and death
   c. Impact of family violence and drug/alcohol abuse
   d. Child abuse
   e. Withholding and withdrawing life support
   f. Non-traditional families

7. Genetics
   a. Common chromosomal abnormalities
   b. Screening issues (including ethical, legal, and social implications)
   c. Appropriate referral for necessary genetic diagnosis and counseling

8. Chronic and preventive care for specific populations
   a. Children with special needs or developmental delays
   b. Cancer survivors
   c. Premature infants
   d. Children in foster care

9. Diagnosis, management, and appropriate referral of medical problems in infants and children
   a. Allergic/immunologic
      i. Asthma
      ii. Atopy and eczema
      iii. Allergic rhinitis
      iv. Anaphylaxis
Family Medicine Residency, Fargo
Pediatric Care

v. Immunodeficiency

b. Inflammatory
   i. Arthritides including juvenile idiopathic arthritis (formerly juvenile rheumatoid arthritis)
   ii. Vasculitis syndromes
      1. Kawasaki disease
      2. Henoch-Schönlein purpura
      3. Wegener granulomatosis
   iii. Rheumatic fever
   iv. Systemic lupus erythematosus (SLE)
   v. Juvenile dermatomyositis

c. Renal and urologic
   i. Glomerulonephritis
   ii. Hematuria and proteinuria
   iii. Urinary tract infections, including pyelonephritis
   iv. Vaginitis
   v. Vesicoureteral reflux
   vi. Hypospadias, urethral prolapse, labial adhesions
   vii. Enuresis
   viii. Undescended testis
   ix. Hydrocele
   x. Phimosis and foreskin adhesions
   xi. Nephrolithiasis
   xii. Electrolyte and acid-base imbalance (mild)

d. Endocrine/metabolic and nutritional problems
   i. Thyroid disorders
   ii. Diabetes (type 1 and type 2)
   iii. Obesity
   iv. Failure to thrive
   v. Abnormal growth patterns (short and tall stature)
   vi. Premature or delayed puberty, thelarche, and/or menarche
   vii. Dyslipidemia (familial or acquired)
   viii. Adrenal disorders

e. Neurologic problems
   i. Seizure disorders (including non-epileptic seizures)
   ii. Headache
   iii. Syncope
   iv. Psychomotor delay and cerebral palsy
   v. Tics and movement disorders
   vi. Altered mental status
vii. Ataxia
viii. Stroke
ix. Traumatic brain injury, including concussion
x. Macrocephaly and microcephaly

f. Common skin problems
i. Atopic, contact, and other dermatitides
ii. Psoriasis
iii. Viral and other exanthems
iv. Verruca vulgaris
v. Nevi
vi. Bites and stings
vii. Bacterial and fungal infections
viii. Parasites (lice, scabies, and bed bugs)
ix. Diaper rash
x. Acne
xi. Urticaria
xii. Erythema multiforme
xiii. Burns
xiv. Hair loss
xv. Normal newborn and childhood variants

g. Musculoskeletal problems
i. Clubfoot
ii. Pes planus and pes cavus
iii. Developmental dysplasia of the hip
iv. Genu valgum and genu varum
v. Rotational problems and gait abnormalities
   1. In- and out-toeing
   2. Metatarsus adductus
   3. Medial tibial torsion
   4. Femoral anteverision
vi. Scoliosis (idiopathic or acquired)
vi. Aseptic necrosis of the femoral head (Legg-Calvé-Perthes disease)
viii. Slipped capital femoral epiphysis
ix. Nursemaid’s elbow
x. Other common sprains, dislocations, and fractures
xi. Back pain
xii. Growing pain
xiii. Limping differential by age group
xiv. Apophysitis (Osgood-Schlatter disease and Sever disease)
xv. Preparticipation physical evaluation
Family Medicine Residency, Fargo
Pediatric Care

h. Gastrointestinal problems
   i. Gastroenteritis (viral, bacterial, and parasitic)
   ii. Dysphagia
   iii. Chronic diarrhea
   iv. Constipation and encopresis
   v. Hepatitis
   vi. Gastroesophageal reflux
   vii. Ulcer
   viii. Food intolerance and malabsorption, protein-calorie malnutrition
   ix. Pyloric stenosis
   x. Intussusception
   xi. Volvulus
   xii. Meckel diverticulum
   xiii. Recurrent and chronic abdominal pain
   xiv. Hernia
   xv. Inflammatory bowel disease (Crohn disease, ulcerative colitis)
   xvi. Irritable bowel syndrome
   xvii. Celiac disease
   xviii. Appendicitis
   xix. Pancreatitis
   xx. Cholecystitis
   xxi. Bilious emesis
   xxii. Hematemesis
   xxiii. Hematochezia
   xxiv. Jaundice in the non-neonate

i. Cardiovascular problems
   i. Congenital heart disease and valvular disease
   ii. Acquired heart disease
   iii. Evaluation of heart murmurs
   iv. Chest pain
   v. Hypertension
   vi. Syncope
   vii. Innocent and pathologic murmurs

j. Respiratory tract problems
   i. Viral upper respiratory tract infections
   ii. Reactive airway disease and asthma
   iii. Cystic fibrosis
   iv. Bronchiolitis
   v. Foreign body aspiration
vi. Viral or bacterial pneumonia
vii. Pertussis
viii. Tonsillitis, pharyngitis, sinusitis
ix. Epiglottitis
x. Croup
xi. Epistaxis
xii. Bacterial tracheitis
xiii. Snoring
xiv. Obstructive sleep apnea
xv. Apparent life-threatening events (ALTEs), blue spells
xvi. Sudden infant death syndrome (SIDS)

k. Ear problems
   i. Otitis media (acute and with effusion)
   ii. Otitis externa
   iii. Hearing loss
   iv. Wax and foreign body in ear canal

l. Eye problems
   i. Amblyopia
   ii. Strabismus
   iii. Lacrimal duct stenosis (dacryocystitis)
   iv. Decreased visual acuity
   v. Conjunctivitis
   vi. Other causes of red eye
   vii. Congenital cataracts
   viii. Coloboma
   ix. Hordeolum and chalazion
   x. Periorbital and orbital cellulitis

m. Mouth problems
   i. Cleft lip and palate, including feeding strategies
   ii. Dental caries and abscess
   iii. Tooth eruption (normal and abnormal variants)
   iv. Aphthous stomatitis
   v. Common infections (e.g., thrush, cold sores, herpangina)
   vi. Ankyloglossia
   vii. Developmental oral lesions (e.g., geographic tongue)

n. Other serious infections
   i. Fever in children younger than 90 days old
   ii. Fever without source in children 90 days to 3 years old
   iii. Fever of unknown origin
   iv. Sepsis
Family Medicine Residency, Fargo
Pediatric Care

v. Meningitis and encephalitis
vi. Invasive streptococcal and staphylococcal disease
vii. Osteomyelitis and septic arthritis
viii. HIV

o. Lymphatic problems
   i. Reactive lymphadenopathy
   ii. Cervical adenitis

p. Childhood malignancies
   i. Lymphoma
   ii. Neuroblastoma
   iii. Wilms tumor
   iv. Leukemia
   v. Retinoblastoma
   vi. Central nervous system (CNS) tumors

q. Hematologic problems
   i. Anemias
   ii. Hemoglobinopathies, including thalassemia and sickle cell
   iii. Thrombocytopenia
   iv. Bleeding diathesis
   v. Thrombophilias

Skills
In the appropriate setting, the resident should demonstrate the ability to appropriately obtain informed consent and to independently perform (while maintaining universal precautions and/or sterile technique) or appropriately refer:

1. Accurate Apgar score assignment
2. Resuscitation of newborns, infants, and children
3. Age-appropriate history and physical examination (including preparticipation physical examination) with use of growth charts (e.g., Ballard)
4. Performance of developmental surveillance, as well as administration and interpretation of developmental screening tests (e.g., Modified Checklist for Autism in Toddlers [M-CHAT], Childhood Autism Rating Scale [CARS])
5. Psychosocial/behavioral questionnaire administration and interpretation (e.g., Conners and Vanderbilt for ADHD; Pediatric Symptom Checklist [PSC] for cognitive, emotional, and behavioral problems)
6. Appropriate history and physical examination for physical or sexual abuse
7. Hearing and vision screening test interpretation
8. Pneumatic otoscopy and tympanograms (including interpretation)
9. Bladder catheterization
10. Vascular access (emergency and elective) and blood sampling
11. Subcutaneous and intramuscular injections
12. Lumbar puncture
13. Calculation of maintenance and replacement fluid (including blood components) and electrolyte requirements
14. Interpretation of radiologic or other diagnostic studies (e.g., spirometry, electrocardiogram [EKG])
15. Coordination of patient care and specialty services, when required
16. Management of acute diagnosis/diagnoses in the presence of comorbid conditions
17. Intraosseous line placement
18. Local and regional anesthesia
19. Laceration repair (suture, tissue adhesive, skin staples)
20. Splinting and casting
21. Reduction of simple dislocations
22. Circumcision
23. Nail removal (fingernail or toenail)
24. Incision and drainage of superficial abscess
25. Biopsy or destruction of skin lesion
26. Fluorescein and Wood light examination of eye
27. Cerumen removal
28. Frenotomy (i.e., tongue-tie snipping) for true ankyloglossia in the newborn
29. Management of foreign body in skin or body orifice

**Implementation**
This curriculum should be taught during both focused and longitudinal experiences throughout the residency program. Physicians who have demonstrated skills in caring for children should be available to act as role models to the residents and should be available to give support and advice to individual residents regarding the treatment of their patients. Each family medicine resident’s panel of patients should include a significant number of pediatric patients.

**Resources:**
Care of Infants and Children AAFP Reprint No. 260
Family Medicine Residency, Fargo
Rural Health Rotation

Introduction

North Dakota and northern Minnesota are rural areas, each with their own challenges to health care. Especially in some areas of North Dakota, the population can be very sparse with health care more than 50 miles away. To serve these areas of the country, it is necessary to introduce residents to the peculiarities of practicing medicine in a rural setting. Additionally, sometimes unique problems arise from exposure to chemicals, equipment, livestock, etc. Residents will have the opportunity to experience the intimate experience of rural practice, and decide whether that type of practice will fit with their future goals.

Goals

<table>
<thead>
<tr>
<th>PGY2</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop an understanding of learning in the rural context</td>
<td>Medical knowledge</td>
</tr>
<tr>
<td>Learn to shape one’s skill set to the needs of the rural community</td>
<td>Patient care</td>
</tr>
<tr>
<td>Learn ways to deliver quality care with the resources and skills one has available in the moment</td>
<td>Patient care</td>
</tr>
<tr>
<td>Learn ways to continually acquire additional knowledge and skills as needed</td>
<td>Medical knowledge</td>
</tr>
<tr>
<td>Learn how to get help from others and work together</td>
<td>Professionalism</td>
</tr>
<tr>
<td>Observe ways rural health providers sustain themselves and others in rural practice and lifestyle</td>
<td>Professionalism</td>
</tr>
</tbody>
</table>

Objectives

Increasing knowledge and skill acquisition in the following areas are especially relevant to rural practice:

a. Maternity care
b. Pediatric and newborn care
c. Orthopedics and sports medicine, including basic fracture care
d. Surgical and procedural skills, including colposcopy, ultrasound examination, and endoscopy
e. Trauma and other emergency care and stabilization
f. Critical care in a rural setting
Family Medicine Residency, Fargo
Rural Health Rotation

g. Occupational health and safety, including recreation, agriculture, mining, and forestry
h. Behavioral health and psychiatry, including access issues unique to rural practice
i. Practice management in a small-practice setting and system integration
j. Telemedicine, the EHR, and other electronic tools and resources
k. Public health, including basic definitions; resources for rural health; access and barrier issues; funding and delivery of rural health care; interdisciplinary teams in rural health; health outcomes and disparities in rural populations; strategies for delivery of care; and cultural competence
l. Community-oriented primary care

Implementation

Each resident will have a two month rural family medicine rotation at various rural sites in North Dakota and Minnesota. The experience of each resident will vary widely. It is hoped that each resident will engage with the physicians, clinic and hospital staff, and the wider community, as well.
Family Medicine Residency, Fargo
Surgical Care

Introduction

Care of the surgical patient is an important part of the education and practice of family physicians. Although few family physicians perform major surgeries, many assist during major surgical procedures. Family physicians are called upon by their surgical specialist colleagues to evaluate patients for surgery, make preoperative and perioperative recommendations for care, and assist in the postoperative medical management of patients. Family physicians are often asked to help their patients understand their appropriateness for surgery and the risks and benefits of surgical procedures. Some patients may turn to their family physician to help them understand the exact nature of a surgical procedure. Importantly, family physicians need to know how to appropriately refer patients for surgery, particularly in emergent or life-threatening situations.

Goals

<table>
<thead>
<tr>
<th>PGY1</th>
<th>PGY2</th>
<th>PGY3</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be able to perform a surgical assessment and develop an appropriate treatment plan</td>
<td>Be able to perform a surgical assessment and develop an appropriate treatment plan</td>
<td>Be able to perform a surgical assessment and develop an appropriate treatment plan</td>
<td>Medical Knowledge, Patient Care)</td>
</tr>
<tr>
<td>Learning about ambulatory, inpatient, and institutional care across health care providers, institutions, and agencies</td>
<td>Learning to navigate ambulatory, inpatient, and institutional care across health care providers, institutions, and agencies</td>
<td>Coordinate ambulatory, inpatient, and institutional care across health care providers, institutions, and agencies</td>
<td>Systems-based Practice, Patient Care</td>
</tr>
<tr>
<td>Learning the skills to communicate effectively with the patient, as well as with the patient’s family and caregivers, to ensure that the diagnosis and treatment plan are clearly understood</td>
<td>Demonstrates several of the skills needed to communicate effectively with the patient, as well as with the patient’s family and caregivers, to ensure that the diagnosis and treatment plan are clearly understood</td>
<td>Demonstrate the ability to communicate effectively with the patient, as well as with the patient’s family and caregivers, to ensure that the diagnosis and treatment plan are clearly understood</td>
<td>Interpersonal and Communication Skills</td>
</tr>
</tbody>
</table>
## Family Medicine Residency, Fargo
### Surgical Care

<table>
<thead>
<tr>
<th>PGY1</th>
<th>PGY2</th>
<th>PGY3</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning the skills to communicate effectively with the surgeon supervisor/consultant about the patient’s symptoms, physical findings, test results, and proposed plan of care</td>
<td>Demonstrate the ability to communicate effectively with the surgeon supervisor/consultant about the patient’s symptoms, physical findings, test results, and proposed plan of care</td>
<td>Demonstrate the ability to communicate effectively with the surgeon supervisor/consultant about the patient’s symptoms, physical findings, test results, and proposed plan of care</td>
<td>Interpersonal and Communication Skills, Professionalism</td>
</tr>
<tr>
<td>Recognize his or her practice limitations and seek consultation with other health care providers when necessary to provide optimal care</td>
<td>Recognize his or her practice limitations and seek consultation with other health care providers when necessary to provide optimal care</td>
<td>Recognize his or her practice limitations and seek consultation with other health care providers when necessary to provide optimal care</td>
<td>Professionalism, Practice-based Learning and Improvement</td>
</tr>
</tbody>
</table>

### Objectives

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

1. **Basic principles of surgical diagnosis**
   a. Basic surgical anatomy
   b. Wound physiology, care, and healing processes
   c. Clinical assessment, including history, physical examination, laboratory evaluation, and differential diagnosis of key signs and symptoms of surgical conditions
   d. Invasive versus noninvasive diagnostic tests
2. **Anesthesia**
   a. Premedication
   b. Agents and routes of administration
   c. Resuscitation methods
3. **Recognition of surgical emergencies**
   a. Respiratory
      i. Airway obstruction
      ii. Chest trauma
Family Medicine Residency, Fargo
Surgical Care

1. Flail chest
2. Hemothorax
3. Pneumothorax

b. Circulation
   i. Hypovolemia
      1. Gastrointestinal bleeding
      2. Traumatic blood loss

c. Acute abdomen
   i. Perforated viscus
   ii. Intestinal obstruction
   iii. Incarcerated hernia
   iv. Mesenteric ischemia
   v. Appendicitis
   vi. Diverticulitis

d. Soft tissue
   i. Necrotizing soft tissue infections
   ii. Thermal injuries

e. Trauma
   i. Advanced Trauma Life Support

4. Common surgical procedures
   a. Appendectomy
   b. Cholecystectomy
   c. Herniorrhaphy
   d. Colectomy
   e. Hemorrhoidectomy – surgical or simple banding
   f. Breast surgery – lumpectomy, mastectomy
   g. Arterial bypass
   h. Varicose vein procedures
   i. Thyroidectomy and thyroid nodules
   j. Parathyroidectomy

5. Ethical, legal, and socioeconomic considerations
   a. Informed consent
   b. Quality of life
   c. Cultural sensitivity
   d. End-of-life issues

6. Preoperative assessment
   a. Recognition of appropriate surgical candidates
   b. Surgical risk assessment
   c. Comorbid diseases
   d. Antibiotic prophylaxis
   e. Patient preparation (bowel, medication, schedule, etc.)
7. Intraoperative care
   a. Basic principles of asepsis and sterile technique
   b. Patient monitoring
   c. Fluid management
   d. Blood requirements
   e. Temperature control
   f. Use of basic surgical instruments

8. Postoperative care
   a. Routine
      i. Wound care
      ii. Patient mobilization
      iii. Nutrition management
      iv. Pain management
      v. Suctions and drains
   b. Common complications
      i. Fever workup and management
      ii. Wound dehiscence
      iii. Urinary retention
      iv. Hemorrhage
      v. Pneumonia
      vi. Atelectasis
      vii. Fluid overload
      viii. Transfusion reaction
      ix. Thrombophlebitis
      x. Pulmonary embolism
      xi. Oliguria
      xii. Respiratory insufficiency
      xiii. Ileus
      xiv. Infection
      xv. Shock

9. Outpatient surgery
   a. Patient selection
   b. Procedural sedation and analgesia
   c. Postoperative observation principles
   d. Follow-up care

10. Office care of common conditions
    a. Lumps, bumps, and abscesses
    b. Simple lacerations
    c. Superficial burns
    d. Common methods of anesthesia

11. Adjunctive and long-term care of organ donors and recipients
12. Adjunctive and long-term care of bariatric surgical patients
13. Recognition and care of surgical wounds
   a. Penetrating wounds
   b. Avulsion, crush, or shear injury wounds
   c. Bite wounds

Skills

In the appropriate setting, the resident should demonstrate the ability to independently perform or appropriately refer:

1. Preoperative assessment
2. Surgical risk evaluation, including assessment of medication use
   a. Surgical risk evaluation
   b. Physical assessment
   c. Radiographic assessment
   d. Noninvasive diagnostic procedures
   e. Invasive diagnostic procedures
      i. Paracentesis
      ii. Nasogastric lavage
      iii. Peritoneal lavage
      iv. Thoracentesis
      v. Bladder aspiration
      vi. Central venous access (central venous pressure, Swan-Ganz catheter)
      vii. Venous cutdown
      viii. Arterial puncture and catheterization
      ix. Needle aspiration and biopsy technique
3. Recognition of need for emergent surgical techniques
   a. Cricothyroidotomy
   b. Needle thoracostomy
   c. Pericardiocentesis
4. Intraoperative skills
   a. Preparation and draping of operative field
   b. First assist at major surgery
   c. Basic use of surgical instruments
   d. Incision and dissection
   e. Exposure and retraction
   f. Hemostasis
   g. Estimation of blood loss
   h. Fluid replacement
   i. Wound closure
      i. Technique selection (ligature, staples, adhesives)
      ii. Suture selection
      iii. Drains
Family Medicine Residency, Fargo
Surgical Care

iv. Dressings

5. Postoperative care
   a. Suture removal
   b. Dressing changes
   c. Drain removal

6. Minor surgical techniques
   a. Local anesthesia
   b. Simple excision
   c. Incision and drainage of cysts and abscesses
   d. Aspiration
   e. Foreign body removal
   f. Minor burns
   g. Cauterization and electrodesiccation
   h. Skin biopsy (punch, shave, excisional)
   i. Wound debridement
   j. Enucleation and excision of external thrombotic hemorrhoid
   k. Nail surgery
   l. Cryosurgery (liquid nitrogen)

7. Counseling about advance directives, organ donations, and end-of-life issues

8. Recognition and treatment of venous stasis ulcers, arterial ulcers, and neuropathic ulcers

9. Grading and treatment of decubitus ulcers

Resource:
Care of the Surgical Patient AAFP Reprint No. 259
**Family Medicine Residency, Fargo**  
**Women’s Health and Gynecologic Care**

**Introduction**

Women’s health care addresses the unique, multidisciplinary aspects of issues affecting women. In providing a wide range of medical services, the family physician can provide preventive and wellness care, diagnose general medical illnesses and disease processes unique to women, and care for women and their families.

Family physicians must be trained to care for women throughout the life cycle and must appreciate challenges such as adolescence, sexuality, balance of family life and career, parenting, relationships, and aging within the female patient’s culture. Health promotion—including screening, counseling, vaccination, and chemoprophylaxis—is a foundation of family medicine. The psychological and physiologic changes of menstruation, pregnancy, lactation, and menopause impact women in many aspects of their lives, requiring clinical skills on the family physician’s part to provide education, diagnostic testing (when appropriate), and treatment that is safe and effective.

Throughout the life cycle, female patients’ medical problems often present differently than men’s medical problems. Lifelong learning of the unique features of women’s health issues must be an integral part of training for all family physicians. Women are living to an advanced age more frequently than their male counterparts so cognitive, affective, and functional assessments, as well as end-of-life discussions, are important aspects of care.

**Goals**

<table>
<thead>
<tr>
<th>Competencies</th>
<th>PGY1, PGY2</th>
<th>PGY3</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal and Communication Skills, Professionalism</td>
<td>Communicate effectively with female patients of all ages, demonstrating active listening skills, a respectful approach to sensitive issues, and collaborative care planning with the patient</td>
<td>Communicate effectively with female patients of all ages, demonstrating active listening skills, a respectful approach to sensitive issues, and collaborative care planning with the patient</td>
<td>Patient Care, Medical Knowledge, Medical Knowledge, Systems-based Practice,</td>
</tr>
<tr>
<td>PGY1, PGY2</td>
<td>PGY3</td>
<td>Competencies</td>
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<tr>
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<tr>
<td>female patients, including reproductive issues.</td>
<td>female patients, including reproductive issues, and utilize community resources when indicated</td>
<td>Practice-based Learning and Improvement</td>
<td></td>
</tr>
<tr>
<td>Understand some of the differences of cardiovascular disease in the female patient compared with the male patient</td>
<td>Understand the risks of heart disease and stroke in the female patient compared with the male patient</td>
<td>Patient Care, Medical Knowledge</td>
<td></td>
</tr>
<tr>
<td>Counsel and understand appropriate exercise during adolescence, reproductive years, pregnancy, and the postmenopausal period</td>
<td>Counsel and understand appropriate exercise during adolescence, reproductive years, pregnancy, and the postmenopausal period</td>
<td>Patient Care, Interpersonal and Communication Skills, Medical Knowledge)</td>
<td></td>
</tr>
<tr>
<td>Understand appropriate screening guidelines for osteoporosis and be able to develop treatment plans for patients with decreased bone density</td>
<td>Understand appropriate screening guidelines for osteoporosis and be able to develop treatment plans for patients with decreased bone density</td>
<td>Patient Care, Medical Knowledge</td>
<td></td>
</tr>
<tr>
<td>Developing effective primary care counseling skills for psychosocial, behavioral, and reproductive problems in women</td>
<td>Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive problems in women</td>
<td>Patient Care, Interpersonal and Communication Skills</td>
<td></td>
</tr>
<tr>
<td>Consult with obstetrician-gynecologists (OB-GYNs), other physician specialists, and allied health care professionals to provide optimum health services for women</td>
<td>Consult with obstetrician-gynecologists (OB-GYNs), other physician specialists, and allied health care professionals to provide optimum health services for women</td>
<td>Medical Knowledge, Systems-based Practice</td>
<td></td>
</tr>
<tr>
<td>Learning to act as patient advocate and coordinator of care for female patients across the continuum of outpatient, inpatient, and institutional care</td>
<td>Act as patient advocate and coordinator of care for female patients across the continuum of outpatient, inpatient, and institutional care</td>
<td>Systems-based Practice</td>
<td></td>
</tr>
</tbody>
</table>
Objectives

At the completion of residency, the resident is expected to display the following knowledge, skills, and attitudes:

I. Women’s Health
   A. Health promotion, disease prevention, and periodic health evaluation
      1. Basic aspects of normal growth and development of females from puberty to adulthood (and variants of normal)
      2. Normal physiology of reproduction in healthy women from puberty to menopause
      3. Normal physiological sexual responses and diagnosis of sexual dysfunction (including initial treatment and referral to appropriate resources)
      4. Recommendations on breastfeeding
      5. Recommendations for human papillomavirus (HPV) vaccination
      6. Appropriate evaluation and counseling using evidence-based guidelines for:
         a. Nutritional needs through the female life cycle
         b. Cancer screening guidelines, including HPV
         c. Vaccination
         d. Exercise
         e. Osteoporosis prevention
         f. Smoking cessation
         g. Complementary therapies
         h. Oral health in pregnant and non-pregnant women
         i. Risks and unique presentations of cardiovascular disease in women (including appropriate testing and treatment strategies for symptomatic women)
      7. Women’s unique risks in the community (including poverty, violence, access to health care for pregnant and non-pregnant women, and teen pregnancy) and the impact of these factors on infant morbidity and mortality
   B. Family planning and early pregnancy evaluation and management
      1. Recommendations for preconception counseling for women of all reproductive age groups
      2. Appropriate evaluation and counseling using evidence-based guidelines for contraception for women in all reproductive age groups, including perimenopause
         a. Permanent
         b. Reversible
            i. Oral
Family Medicine Residency, Fargo
Women’s Health and Gynecologic Care

II. Injectable
III. Patches
IV. Long-acting reversible contraception (LARC)
   a. Intrauterine devices (IUDs)
   b. Implants
V. Intravaginal contraceptive ring
VI. Natural family planning
VII. Barrier methods
VIII. Postcoital (emergency) contraception

3. Counseling for unintended pregnancy (including options of adoption and termination of pregnancy)
4. Counseling for medication and aspiration options for elective abortion
5. Assessment and management of early pregnancy loss, including expectant, medication, and aspiration options
6. Assessment and management of post-miscarriage and post-abortion symptoms and complications
7. Etiologies of female infertility, as well as a family-centered approach to evaluation, testing, counseling, and referral resources (including counseling regarding assisted reproductive technology and adoption)

C. Menstruation
   1. Physiology of normal menstruation and problems of amenorrhea and abnormal uterine bleeding (including office evaluation and treatment for these conditions)

D. Infectious disease
   1. Epidemiology of, screening for, and treatment of reproductive tract infections, including sexually transmitted infections and pelvic inflammatory disease
   2. Risk factors, presenting symptoms, and evaluation of types of vaginitis, as well as their specific treatments
   3. Risks of, screening tests for, and presentations of HIV in women, as well as initial evaluation, counseling, and referral to resources in the community for both pregnant and non-pregnant female patients who have HIV

E. Diseases of the reproductive tract (Please also see AAFP Curriculum Guideline No. 261 – Maternity Care)
   1. Methods of prevention, screening, colposcopic evaluation, and treatment of HPV infection and cervical dysplasia
   2. Presenting symptoms of endometriosis, and diagnostic testing and initial management of the condition with consideration of the reproductive goals of the patient
   3. Evaluation of pelvic masses in women of different ages
Family Medicine Residency, Fargo
Women’s Health and Gynecologic Care

4. Risk factors, presenting symptoms, and office diagnosis of endometrial pathology (including hormonal effects on the uterus)
5. Epidemiology and presenting symptoms of uterine fibroids (including evaluation and treatment options)
6. Presenting symptoms, evaluation, and initial treatment of polycystic ovary syndrome (including the association with type 2 diabetes)
7. Differential diagnosis of chronic pelvic pain (including infection, endometriosis, tumors, and common underlying issues of sexual abuse)

F. Gynecology in older women
1. Menopause, including:
   a. Diagnosis
   b. Physical, emotional, and sexual impact of the climacteric
   c. Risks and benefits of hormone replacement therapy
   d. Other appropriate symptomatic treatments
2. Presenting symptoms of pelvic floor dysfunction (including types of urinary incontinence and pelvic floor prolapse, as well as medical and surgical treatment options)

G. Breast health
1. Anatomy and physiology of benign diseases of the breast (including cysts, adenomas, and fibrocystic changes through the menstrual cycle)
2. Types, risks, and psychological impact of breast implants
3. Recommendations and controversies related to screening for breast cancer using clinical examination, self-examinations, and imaging and genetic testing
4. Initial recommendations for treatment modalities, referral resources, and primary care follow-up for patients who have breast cancer

H. Mental health
1. Unique risks and presentations of mental health problems in women, including:
   a. Major depressive disorder and postpartum depression
   b. Anxiety disorders and stress management
   c. Problems with self-esteem
   d. Eating disorders and obesity
   e. Alcohol and substance abuse
   f. Chronic pain and disability

2. Physiology and diagnostic criteria of premenstrual syndrome (PMS) and premenstrual dysphoric disorder (PMDD), and available treatments for each

I. Domestic and sexual violence
Family Medicine Residency, Fargo
Women’s Health and Gynecologic Care

1. Epidemiology, risk factors, and red flags for identifying intimate partner violence or sexual harassment, and resources available to assist affected women
2. Components of the evaluation and treatment of victims of rape and sexual assault (including psychosocial and legal issues)
   J. Family-centered maternity care (Please also see AAFP Curriculum Guideline No. 261 – Maternity Care)

II. Gynecology
   A. Health promotion, disease prevention, and periodic health evaluation
      1. Microscopic diagnosis of urine
      2. Vaginal wet mount preparation
      3. Obtaining cervical cytology, HPV tests, and cultures
      4. Gynecologic and breast examination, including atraumatic (patient-centered) speculum and bimanual exam
      5. Counseling results of cervical cytology, mammography, osteoporosis screening, and other tests
   B. Family planning, contraception, and infertility
      1. Counseling for all forms of birth control (including use of oral contraceptives and other hormonal contraception, and natural family planning)
      2. IUD insertion and removal
      3. Diaphragm fitting
      4. Implantation devices (including removal)
      5. Emergency contraception
      6. Counseling pregnancy options (including adoption, abortion, and parenting)
      7. Pregnancy loss and infertility
   C. Menstruation
      1. Physiology of puberty, menarche, and menstrual cycles, including normal variations
      2. Abnormal menstruation
         a. Amenorrhea: evaluation and management of both primary and secondary
         b. Anovulatory bleeding
         c. Dysfunctional uterine bleeding
         d. Postcoital bleeding
         e. Dysmenorrhea and menorrhagia (office evaluation (including endometrial biopsy) and treatment options)
      3. PMDD and PMS
   D. Infections of the genital tract
1. Vaginitis and vulvitis: presenting symptoms, evaluation, and treatment for both acute and recurrent
2. Cervicitis and pelvic inflammatory disease (presentation, evaluation, and outpatient versus inpatient management; complications including tubo-ovarian abscess)

E. Diseases of the reproductive tract

1. Benign and malignant neoplasms of the external and internal genitalia
   a. cervical polypectomy
   b. cautery of benign disease
   c. Bartholin duct cyst management
   d. vulvovaginal biopsy
   e. Vaginal foreign body removal
2. HPV disease: methods of prevention; current screening recommendations; and colposcopic evaluation, biopsy, and treatment of cervical dysplasia
3. Endometriosis: presenting symptoms, diagnosis, and initial management, including appropriate counseling, prognosis, and referral
4. Identification and evaluation of pelvic masses in women of different ages
5. Uterine pathology, evaluation and treatment: fibroids, endometrial hyperplasia, postmenopausal vaginal bleeding, and other benign or malignant uterine lesions
   a. endometrial biopsy
6. Pelvic pain: evaluation and differential diagnosis of acute and chronic pelvic pain, including recognition of emergencies (e.g., ovarian torsion) and awareness of association between historical or ongoing sexual or domestic abuse and chronic pelvic pain
7. Female sexual dysfunction: evaluation, counseling, and management, including problems of libido, dyspareunia, and anorgasmia
8. Trauma: patient-centered, sensitive evaluation of both accidental trauma to the genital region and trauma in victims of intimate partner violence and sexual assault

F. Gynecology in older women

G. Breast disease: evaluation and management of problems including:

1. Mastodynia
2. Galactorrhea and nipple discharge
3. Benign breast disease (fibroadenoma, fibrocystic disease)
4. Counseling and indications for referral for breast reduction surgery and breast implants
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5. Counseling, referral, and primary care follow-up for patients who have breast cancer
6. Breast cyst aspiration

H. Urogynecology

1. Urinary tract infections (UTIs): diagnosis and management of uncomplicated acute UTI, as well as recurrent or complicated UTI; indications and management of prophylactic antibiotics
2. Incontinence: screening, evaluation, and treatment options for stress incontinence and overactive bladder, including medications, pelvic floor therapies, behavioral modifications, and referral for surgery
3. Interstitial cystitis: presenting symptoms, evaluation, and referral

I. Gynecologic surgery

1. Assistance with common major surgical procedures, including hysterectomy and bilateral tubal ligation
2. Post-operative management following gynecologic or obstetric surgery

J. Advanced skills in gynecology (optional)

1. Loop electrosurgical excision procedure with paracervical block
2. Uterine aspiration for incomplete first trimester abortion

Implementation

Core cognitive ability and skills require experience in structured rotations in obstetrics and gynecology. Emphasis on the ambulatory care of patients (including counseling, examination, and outpatient procedures) is crucial. Residents will obtain additional experience in continuity of care for both pregnant and non-pregnant women throughout their three years of longitudinal experience in the family medicine center, and will return to the family medicine center for scheduled time during obstetric and gynecologic rotations. Workshops in gynecologic procedures, didactics, and communication seminars enhance clinical experience.

Faculty role models and family physicians who provide maternity care should be available to teach residents and observe their interactions with female patients. Residents of both genders should care for an adequate number of female patients of all ages (along with their families) to learn the full spectrum of issues affecting women.
Low-risk maternity care is an important part of family medicine training. Family medicine residents are encouraged to make family-centered maternity care a significant part of their practice (see AAFP Curriculum Guideline No. 261 – Maternity Care).

Resource:

AAFP curriculum guideline No. 282 Women’s Health and Gynecologic Care