Curriculum Guide for Obstetric Medicine (OM) ATSM

1 What is this ATSM about?

This ATSM is designed to ensure that trainees/doctors completing this training will be able to provide safe obstetric care for women with the medical conditions that commonly complicate pregnancy, have the ability to access appropriate medical resources and liaise with colleagues from other specialties for rarer medical conditions. They should know when to refer for tertiary level care. They should be able to agree a plan for pregnancy and labour that optimises the woman’s experience in the context of her medical condition.

During training doctors should be exposed to and participate in a wide variety of scenarios as well as attending educational events to support their learning in this area. Their ability to reflect on and learn when projects have gone well or indeed if they have failed are all skills that should be developed and consolidated as training progresses.

Satisfactory sign off to complete the ATSM will require the ATSM Educational Supervisors to make decisions on the level of supervision required for each Advanced Obstetric Capability in Practice (AOCiP) and if this is satisfactory, the ATSM will be awarded. More detail is provided in the programme of assessment section of the curriculum and in the online Curriculum training resource here.

2 Design of the ATSM

As with the 2018 OM ATSM, the 2019 ATSM is made up of component modules which are now called Advanced Obstetric Capabilities in Practice (AOCiP) rather than Advanced Skills Modules (ASMs).

There are three mandatory AOCiPs within the OM ATSM (AOCiP 5, 7 and 8), as shown below in Table 1 which shows how all the AOCiPs make up the various ATSMs and subspecialty training in Maternal and Fetal Medicine (MFM).

The content of the AOCiPs, and the level of competency required for completion of training (level 5) are the same in the ATSM and in MFM subspecialty training, meaning that a OM ATSM 2019 holder will not need to repeat these modules if they subsequently enter subspecialty training. Subspecialty trainees in MFM have three AOCiPs (12, 13 and 14) solely relevant to subspecialty training which take MFM skills to a higher level.

It is anticipated that for a full-time trainee who is accessing one or two ATSM training sessions each week, 18-24 months of training will be required to complete this ATSM.

This ATSM has a work intensity score of 2.0. Trainees/doctors can register for more than two ATSMs concurrently providing the work intensity score is no greater than 3.0.
Here are the GMC-approved key skills and descriptors:

Table 1

| AOCIP1 | The doctor uses ultrasound to screen for, and manage, pregnancy complications, other than fetal abnormality |
| AOCIP2 | The doctor confirms fetal normality and manages the key conditions targeted by the Fetal Anomaly Screening Programme (FASP) |
| AOCIP3 | The doctor is able to manage a wide range of common conditions affecting the fetus |
| AOCIP4 | The doctor describes, obtains informed consent for and performs amniocentesis |
| AOCIP5 | The doctor is able to recognise and manage common medical conditions in the pregnant woman |
| AOCIP6 | The doctor safely manages pregnancy in women with mental health, social and lifestyle factors |
| AOCIP7 | The doctor manages intrapartum medical complications and pre-existing conditions |
| AOCIP8 | The doctor has obstetric medicine skills covering a wide range of maternal medical conditions |
| AOCIP9 | The doctor recognises key intrapartum scenarios and manages them using the necessary technical and non-technical skills |
| AOCIP10 | The doctor uses ultrasound to optimise outcomes during labour and the immediate puerperium |
| AOCIP11 | The doctor takes a key role of leadership, management and patient safety on labour ward |
| AOCIP12 | The doctor is able to lead in providing care to women with pregnancies complicated by the full range of fetal concerns |
| AOCIP13 | The doctor can independently manage, in conjunction with specialists from other disciplines, pregnancies complicated by the widest range and most complex of maternal medical conditions |
| AOCIP14 | The doctor can apply knowledge of clinical and molecular genetics to the management of complex pregnancy |
**AOCP 5: The doctor is able to recognise and manage common medical conditions in the pregnant woman.**

<table>
<thead>
<tr>
<th>Key Skills</th>
<th>Descriptors</th>
</tr>
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</table>
| Uses investigations to support diagnosis and surveillance of common medical conditions | • Is able to make a thorough assessment of the presenting problem with appropriate investigation and consideration of differential diagnoses.  
• Recognises and devises an appropriate management plan for the common medical conditions presenting in pregnancy.  
• Recognises complexity and the need for referral to tertiary and/or subspecialist services. |
| Liaises with midwives and other health-care professionals | • Optimises the woman’s care and patient journey. |

**AOCP 7: The doctor manages intrapartum medical complications and pre-existing conditions.**

<table>
<thead>
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<th>Key Skills</th>
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</table>
| Diagnoses and manages hypertensive disorders of pregnancy | • Recognises these conditions when they present both classically, and in an atypical manner, and can formulate a differential diagnosis.  
• Institutes emergency care and makes a longer-term plan for management, considering both maternal and fetal risks and needs.  
• Applies clinical skills and investigations to monitor the condition and modifies plans accordingly.  
• Manages uncommon intrapartum complications of these conditions, with support from other specialist teams.  
• Liaises with consultants and other specialties and works effectively as part of a multidisciplinary team.  
• Communicates effectively with the woman and her support structure, to enable decision making.  
• Is able to discuss risks for future pregnancies and make plans for reducing these risks. |
| Manages the intrapartum care of a woman with diabetes | • Devises an individualised management plan using a targeted history and review of relevant investigations performed before and during pregnancy.  
• Counsels on the maternal and fetal risks associated with pre-existing and gestational diabetes in pregnancy and labour.  
• Liaises with the multidisciplinary team regarding blood sugar control, long-term complications of diabetes, and acute diabetic presentations (including ketoacidosis).  
• Makes an appropriate plan for labour and birth, and the postnatal period.  
• Provides contraceptive and pre-pregnancy planning advice. |
| Manages the intrapartum care of a woman with | • Using a targeted history, and by reviewing results of investigations performed before and during pregnancy, manages the care of the woman during labour with pre-existing medical disorders, with |
other pre-existing medical disorders

particular emphasis on women with haemoglobinopathies, epilepsy, hepatitis B and C, HIV, herpes, cardiac, respiratory and renal disease, and previous thromboembolic disease, or elevated chance of VTE.
- Devises a management plan accordingly.
- Is able to recognise situations of greater complexity which require tertiary level and/or subspecialist care.
- Counsels on the maternal and fetal risks associated with these conditions in pregnancy and labour.
- Makes an appropriate plan for labour and birth, and the postnatal period, including managing acute presentations caused, or complicated, by these conditions.
- Provides contraceptive and pre-pregnancy planning advice.

Can assess and manage a critically ill or collapsed woman

- Able to make a rapid differential diagnosis, institute investigations and commence immediate resuscitation while calling for specialist assistance from the multidisciplinary team.
- Provides ongoing obstetric input to women who have been transferred to non-obstetric high dependency or critical care areas.
- Debriefs the team and family after the event in a manner that is easy to understand.

AOCiP 8: The doctor has obstetric medicine skills covering a wide range of maternal medical conditions.

<table>
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<th>Key Skills</th>
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| Manages the care of the pregnant woman with co-existing medical problems | • Is able to use a focused history, examination and results of investigations to risk assess a pregnant woman with a co-existing medical problem.  
• Is able to gather important information and liaise with specialist teams.  
• Interprets common investigations including ECG, echocardiogram and blood gas results.  
• Communicates effectively with women with medical problems.  
• Devises a preconception, antenatal, intrapartum and postpartum plan for surveillance and treatment in women with pre-existing medical disorders, or those presenting for the first time during pregnancy.  
• Devises an antenatal, intrapartum and neonatal plan for fetal and new born surveillance in pregnancies complicated by pre-existing medical disorders, or those presenting for the first time during pregnancy.  
• Recognises cases with greater chance of complexity and refer appropriately for tertiary and/or subspecialist care.  
• Is able to recognise and manage obstetric complications arising as a result of the maternal medical condition.  
• Works effectively with the multidisciplinary team to optimise care. |
These key skills also map to a variety of *generic professional capabilities*. Evidence supporting progress in this ATSM should also link to generic core capabilities in practice, such as dealing with complexity, teamwork and leadership and knowledge of patient safety issues.

When considering whether progress is being made in the ATSM it is the trainee’s/doctor’s wider skills as a medical professional, and those relating to knowledge and processes of leadership and teamwork, which need to be assessed in the round, as well as clinical competence.

To help trainees/doctors and trainers assess progress in this ATSM, there is a Statement of Expectations for trainees for each AOCiP. It offers guidance as to what constitutes acceptable progress in the ATSM.

<table>
<thead>
<tr>
<th>Statement of Expectations for the ATSM in OM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meeting expectation AOCiP5</strong></td>
</tr>
<tr>
<td>A trainee/doctor meeting expectations will be able to safely plan care in pregnancies complicated by medical problems in conjunction with the woman. They will be familiar with the necessary investigations and be able to interpret the results. They should know when to seek the input from colleagues in other specialties and when to refer for tertiary care.</td>
</tr>
<tr>
<td><strong>Meeting expectations AOCiP7</strong></td>
</tr>
<tr>
<td>The trainee/doctor meeting expectations will be conversant with the medical problems commonly encountered in pregnant women and will know how to manage acute presentations and labour complicated by these conditions. They will be able to work effectively with their medical colleagues to minimise the effect of pregnancy on the underlying medical conditions. They will be able to review the woman’s progress through pregnancy and individualise her intrapartum management plan. They will be able to respond appropriately to a medical emergency in the pregnant woman.</td>
</tr>
<tr>
<td><strong>Meeting expectations AOCiP8</strong></td>
</tr>
<tr>
<td>The trainee/doctor meeting expectations will be able to manage the woman’s medical condition, in the context of pregnancy, from preconception to puerperium. They will be able to plan care of mother and fetus to optimise outcome. They will work effectively as one member of the multi-disciplinary team.</td>
</tr>
</tbody>
</table>

### 3 The Capabilities in Practice (CiPs) explained

Each AOCiP is made up of the following components:

a) A high-level learning outcome describing in a generic way what a doctor will be able to do once they have successfully achieved the CiP.

b) Key skills and descriptors which give further detail to this statement and give guidance on how the trainee/doctor can be judged against the expectations of the CiP.

c) Procedures which need to be learned and mastered as part of the CiP.

d) Knowledge criteria needed by the trainee/doctor to provide a foundation for the skills and practices covered by the CiP.

### a) High-level learning outcome

The high-level learning outcome of each AOCiP describes in a generic way what a doctor can do once they have successfully completed the CiP. A competency level must be proposed by a trainee/doctor for each of these high-level learning outcomes using the entrustability scale listed in Table 2 at ATSM Educational Supervisor meetings, and prior to ARCPs. The trainer will make their own judgement based primarily on the
evidence presented by the trainee/doctor, and this may be aligned with the trainee/doctor opinion, or may differ.

b) Key skills and their descriptors

Beneath each high-level learning outcome are a series of key skills which provide further detail and substance to what the purpose and aims are of the AOCiP. These give guidance to the trainer and trainee/doctor as to what is needed to be achieved for completion of the AOCiP. Competency levels do not need to be ascribed to these individual key skills prior to assessments; however the evidence collected by the trainee/doctor should be supporting progress in the acquisition of these skills over the course of training. Review of these key skills, and progress with them, forms an essential part of the global assessment of progress with the AOCiP.

c) Practical procedures

There are no procedures in the OM ATSM.

d) Knowledge criteria

It is recognised that the full spectrum of obstetric medicine will not be witnessed by the trainee whilst they undertake the ATSM, and expecting independent competency in managing the full range of obstetric medicine problems is unachievable. However, a certain level of knowledge is expected as this will facilitate the evidence-based management of all obstetric medical problems, common and uncommon. The knowledge criteria for each AOCiP make clear what level of theoretical understanding and foundation knowledge is expected of an OM ATSM holder. This will be at a higher level than the knowledge base expected for the MRCOG examinations. Trainees who do not witness the range of medical problems covered by this ATSM should, at the very least, have working knowledge of them all.

4 How are the levels of supervision used to assess progress?

Each clinical AOCiP has to be signed off using the new 5 levels of supervision, as defined in Table 2 below.

<table>
<thead>
<tr>
<th>Level</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Entrusted to observe</td>
</tr>
<tr>
<td>Level 2</td>
<td>Entrusted to act under direct supervision: (within sight of the supervisor).</td>
</tr>
<tr>
<td>Level 3</td>
<td>Entrusted to act under indirect supervision: (supervisor immediately available on site if needed to provide direct supervision)</td>
</tr>
<tr>
<td>Level 4</td>
<td>Entrusted to act independently with support (supervisor not required to be immediately available on site, but there is provision for advice or to attend if required)</td>
</tr>
<tr>
<td>Level 5</td>
<td>Entrusted to act independently</td>
</tr>
</tbody>
</table>

This method of sign-off moves away from a process of box-ticking and towards a process that says ‘I trust you to do these work activities. If not, I need to identify the underlying competencies that need to be developed so that you can progress to the next level of trust.’
The approach focuses on the outcome of training and defines this outcome in terms of the work that a trainee/doctor is trusted to do. By the end of training, doctors are ‘trusted’ to undertake all work tasks independently and without supervision. An AOCiP is therefore a critical part of professional work that can be identified as a unit to be entrusted to a trainee/doctor once efficient competence has been reached.

The concept allows each task to be linked explicitly to the most crucial competencies which are then observed during normal clinical practice.

AOCiPs emphasise the role of observation and judgement, and replicate real-life practice. For example, a consultant must decide what each trainee/doctor can be trusted to do, as well as determine the amount of supervision, direct or indirect, that they need to undertake activities safely. These kinds of judgements are routinely made in the workplace and are based on the experience of the consultant. By the end of training, a doctor must be trusted to undertake all the key critical tasks needed to work as a consultant – and that becomes the outcome and end point of training.

The trainee/doctor will make a self-assessment to consider whether they meet expectations for the time spent undertaking the ATSM, using the five supervision levels listed in Table 2 and highlighting the evidence in the ePortfolio. The ATSM Educational Supervisor will then consider whether the trainee/doctor is meeting expectations or not by assigning one of the five supervision levels.

Trainees/doctors will need to meet expectations for the time spent undertaking the ATSM as a minimum to be judged satisfactory to progress. The expectations for the level of supervision expected by the end of training for all the AOCiPs in this ATSM is level 5.

5 How are the procedures associated with the clinical CiPs assessed?

There are no procedures in this ATSM.

6 What kind of evidence might be relevant to this ATSM?

As a trainee/doctor progresses through their ATSM training they will be expected to collect evidence which demonstrates their development and acquisition of the key skills, procedures and knowledge. Examples of types of evidence are given below, but please note that this is an indicative, not a prescriptive, list. Other sources of evidence may be used by agreement except for the workplace-based assessments – i.e. if they are listed, then at least one must be presented as evidence. The emphasis should be firmly on the quality of evidence, not the quantity. This evidence will be reviewed by the ATSM Educational Supervisor when they are making a global assessment of the progress against the high-level learning outcome of each CiP.

- CbD
- Mini-CEX
- Discussion of correspondence Mini-CEX
- Reflective practice
- TO2 (including SO)
- NOTSS
- Local, Deanery and National Teaching
- RCOG (and other) eLearning
The mapping of workplace-based assessments to the AOCiPs in this ATSM is shown in Table 3 below:

### Table 3

<table>
<thead>
<tr>
<th>AOCIP</th>
<th>OSATS</th>
<th>Mini-CEX</th>
<th>CbD</th>
<th>NOTSS</th>
<th>TO1/TO2</th>
<th>Reflective practice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AOCIP 5:</strong> The doctor is able to recognise and manage common medical conditions in the pregnant woman.</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>AOCIP 7:</strong> The doctor manages intrapartum medical complications and pre-existing conditions.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>AOCIP 8:</strong> The doctor has obstetric medicine skills covering a wide range of maternal medical conditions.</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

### 7 Generic Capabilities in Practice

The non-clinical skills previously referred to in the 2018 ATSM curricula have now been removed because they are covered by the 10 Core CiPs 1-8, 13 and 14. Trainees/doctors undertaking the ATSM at ST6 and ST7 will be assessed against the expectations for a senior trainee/doctor laid out in the explanatory documents for these core CiPs, which can be found with the details of the core curriculum ([Core CiP Guides](#)). However, the evidence collected for the sign-off of these core CiPs at senior level is expected to reflect the ATSM undertaken by the trainee/doctor. At least one quality improvement project therefore should pertain to fetal medicine, and teaching sessions and evidence of advanced communication skills using CbDs should, for example, be obtained through fetal medicine working. Post-CCT trainees/doctors who will have these generic CiPs signed off already should, nevertheless, provide evidence which proves they have these non-clinical skills as required by someone who has a special interest in obstetric medicine.
When can an AOCiP be assessed?

A trainee/doctor can make a self-assessment of their progress in an AOCiP at any point in the training year. The first question for a trainee to ask themselves is:

- Do I think I meet the expectations for this year of training?
  - If the answer is yes than the next questions to ask are:
- Have I produced evidence and linked that evidence to support my self-assessment?
- Is this the best evidence to support this? Have I got some evidence about the key skills?
- Is this evidence at the right level?
- Do I understand the knowledge requirements of this CiP? If not do I need to look at the knowledge syllabus as outlined in the full curriculum?

Once the trainee/doctor has completed the self-assessment the ATSM Educational Supervisor needs to review the evidence and ask the same questions.

- Do I agree with the trainee/doctor for the self-assessment for this AOCiP? Is this sufficient evidence to support sign off of the AOCiP at level 5?
- Is this the best evidence? Would some of this evidence be more appropriate in other CiPs as evidence? For example would the CBD about a change of practice be better linked to a clinical CIP?
- Is there other evidence that has been missed?
- Is the level right for this trainee? Are they meeting the standards of expectations?

When the supervisor judges that the trainee has met the expectations for that year they can sign off the AOCiP. Most crucially this is a global judgement. There does not have to be evidence linked to every key skill. One piece of well presented evidence with some reflection may be enough to sign off the CiP. It is the quality of the evidence not the quantity which is key. The knowledge base should also be considered when giving a global rating.

Each clinical AOCiP in this module has to be signed off using the new 5 levels of supervision, as defined in Table 2 (above), and the generic capabilities will need to be signed off with reference to the statements of expectations described in the core curriculum for an advanced trainee/doctor. Each AOCiP must eventually be signed off to level 5.

Progress with the aspects of the generic CiPs relevant to the OM ATSM must be kept under constant review by the trainee/doctor and ATSM Educational Supervisor. The educational supervisor’s report prepared for the ARCP will document how these are being achieved and evidenced.

Once the ATSM Educational Supervisor has assigned an entrustability level for each AOCiP, based on the global assessment methodology, the trainee/doctor has an opportunity to document why they disagree with their ATSM Educational Supervisor, if disagreement exists over any one particular AOCiP.

The ATSM Educational Supervisor will be expected to make an overall assessment of progress with the ATSM, as detailed below in Table 4. The ATSM assessment will then feed into the educational supervisor’s report for the ARCP.
Table 4

<table>
<thead>
<tr>
<th>Global judgement to be used for each AOCiP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trainee/doctor self-assessment</strong></td>
</tr>
<tr>
<td>FOR EACH AOCiP (5, 7 and 8)</td>
</tr>
</tbody>
</table>

Link to evidence on the ePortfolio.

**ATSM Educational Supervisor’s assessment**
I agree with the trainee’s/doctor’s self-assessment and have added my comments to each AOCiP.

I do not agree with the trainee’s/doctor’s self-assessment for the following reasons:

**ATSM Educational Supervisor’s overall progress with the ATSM**
- Not meeting expectations for the OM ATSM; may not achieve level 5 on the entrustability scale across all AOCiPs in the appropriate time scale
- Meeting expectations for the OM ATSM; expected to achieve level 5 on the entrustability scale across all AOCiPs in the appropriate time scale.

9. Are there any examples or case studies?

**Example 1 – ATSM Educational Supervisor focus**

You are an ATSM Educational Supervisor having a meeting with a trainee/doctor, who asks for sign off of AOCiP 7 after considering the questions regarding the evidence. They feel that they meet the statement of expectations. They have submitted the following evidence linked to the AOCiP 7.

- WPBAs
- Reflection on the care and progress of a patient with a medically complicated pregnancy
- Evidence of involvement in a QI project relevant to obstetric medicine.
- eLearning module
- participation in non-obstetric medical clinics and specialist obstetric medicine clinics

Therefore, based on your meetings with the trainee/doctor you feel that they have provided evidence which demonstrates progress since commencing the ATSM. You note that the trainee has formulated sensible recommendations in the presentation of the QI project which set realistic expectations. You feel
the quality of the evidence which is linked to the AOCiP7 is good, so you can feel confident in signing off this AOCiP7 as complete.

**Example 2 – ST7 trainee (trainee/doctor focus)**
You are an ST7 trainee considering sign-off to level 5 for AOCiP8. You are 5 months into ST7 and have submitted the following evidence linked to the AOCiP.

- WPBAs (CBDs mostly)
- TO2s
- Log of relevant MDT meetings attended

You feel this evidence matches the Statement of Expectations for ST7 because it shows evidence of the cases you have seen and feedback from your TO2.

You discuss this AOCiP and your request to be signed off with your ATSM Educational Supervisor at your next meeting.

The ATSM Educational Supervisor considers the key questions:

- **Do I agree with the trainee/doctor for the self-assessment for this AOCiP? Is this sufficient evidence to support sign off of the AOCiP at level 5?**
- **Is this the best evidence? Would some of this evidence be more appropriate in other CiPs as evidence?**
- **Is the level right for this trainee?**

You discuss with the trainee/doctor that you do not feel able to sign off this AOCiP to level 5 at this time. The WPBAs demonstrate exposure to a relatively limited range of medical disorders in pregnancy, and there are no CbDs which address pre-conceptual care and counselling. You note that the trainee/doctor has not been on an obstetric medicine course, and you recommend that they do so, and that they present three detailed patient journeys to you, from pre-conceptual care through to a pregnancy managed by the multidisciplinary team complicated by a medical condition.