

CAFM Consensus Statement for Procedural Training in Family Medicine Residency

Preamble:

Procedural skills are expected of all family medicine residency graduates. The Accreditation Council for Graduate Medical Education Review Committee for Family Medicine (RC-FM) in its 2014 revision of the Family Medicine requirements FAQ (frequently asked questions), stated that national organizations of family medicine should develop training guidelines for procedural training for the specialty.¹ A task force was convened with the support of the Association of Family Medicine Residency Directors (AFMRD) that included experienced faculty and program directors from across the country and CAFM member organizations. This consensus report represents the collective wisdom of experienced educators building upon a foundation of established literature and existing standards in determining best practices for informing what defines procedural competency.

The task force recognized that family physicians in practice may perform a wide range of procedures, and that there is significant variance among physicians-in-training for procedural skills. This variance may lead to confusion among employers, credentialing bodies, and patients about what services a trained family physician should be able to provide. Using procedure taxonomy that the STFM Group on Hospital Medicine and Procedural Training previously defined,^{2,3} as well as data from the American Academy of Family Physicians membership survey regarding the scope of procedures performed in practice,⁴ the task force recommends a core list of procedures that family physicians should be able to perform at the completion of their residency. The task force also recommends a set of standardized criteria to be used for measuring competency in these procedures and has developed tools program directors and residency faculty may use to do so.

This consensus statement is intended as a roadmap to excellence for residency program directors to use in curriculum development and resident assessment. It is understood there are both local and regional differences in training that would affect how a program would apply these recommendations. These recommendations are not intended to supersede residency program directors' own judgment. They also are not designed to influence either hospital privileging of procedures or program requirements outlined by the Accreditation Council for Graduate Medical Education Review Committee for Family Medicine (ACGME RC-FM). However, this statement should be used as a framework to study procedural competence and allow for cross-residency research and collaboration.

Definitions:

The 2009 consensus statement on advanced procedural training in family medicine³ revisited the definition of a procedure to include some primarily cognitive tasks, such as interpreting an electrocardiogram, fetal monitoring strip, or chest radiograph. While the current task force agrees with the rationale that some of these skills have a Current Procedural Terminology (CPT) code, and that asserting these skills are within the scope of family medicine would benefit family physicians when applying for clinical privileges, the current guideline focuses on the previously used definition as “the

mental and motor activities required to execute a manual task involving patient care.” Procedures that include both technical performance and interpretation of point-of-care testing are included in this document, but others that involve only interpretation (e.g. radiograph interpretation), or primarily clinical decision making (e.g. ventilator management, procedural sedation) have been omitted.

The current task force endorses the previous recommendation for universal family medicine resident training in resuscitation skills, including training equivalent to that provided in Advanced Cardiac Life Support, Neonatal Resuscitation Program, Pediatric Advanced Life Support, and Advanced Life Support in Obstetrics. The current task force also recognizes the value of training provided in Advanced Trauma Life Support courses and recommends that residents anticipating trauma management as part of their regular practice should participate in that course. However, the assessment of competency in the resuscitation skill set taught in these courses is already part of the curricula of the courses themselves, and “life support courses” is not a procedure cluster in this document.

The A lists of procedures refer to the group of procedures for which all family medicine residencies are expected to offer training. The degree to which residencies provide training and to which residents individually train in each procedure define subcategories within this group.

The A0 list of procedures refers to a group of simple procedures that family medicine residency graduates should be able to perform independently based on skills acquired either in medical school or through the normal residency experience (see Table 1). While not all graduating family medicine residents may have had exposure either in medical school or residency to every specific procedure on this list, the skills needed to competently perform them may be extrapolated from those skills taught and verified in the A1 list. The task force does not deem it necessary to designate minimum numbers or require specific documentation of training for procedures on the A0 list, although individual programs may choose to verify proficiency for procedures in this group at their discretion. Furthermore, the list of A0 procedures is meant to represent a sample of more common, simple procedures that a family physician may perform in practice, but it is not intended to be exhaustive. This is especially true with regard to CLIA waived or other point-of-care testing that may not be available at all residency sites.

The A1 list of procedures is the focus of this document. These are procedures that the task force holds all graduates of family medicine programs in the United States should be adequately trained to perform (see Table 2). This core procedure listing should guide the efforts of family medicine faculty in training their residents to have a common skill set that can be reliably provided by family physicians in practice. Except for prenatal ultrasonography, this document intentionally excludes reference to most obstetrical procedures, which are outlined in the Consensus Guidelines for Maternity Care (currently under development and review). In some cases, procedures are grouped together because of overlapping or translational skills. That is to say, proficiency in one procedure within the group implies proficiency for the other, even if the second procedure is not directly observed or evaluated.

The A2 list of procedures comprises the remainder of procedures for which all family medicine residencies are expected to offer training (see Table 3). This group contains procedures that may be routinely taught to all residents in more procedurally intensive programs, but other programs may only offer focused training to interested residents as an elective experience, which may be arranged either within or outside the family medicine practice.

The *B* and *C* lists refer to groups of more complex or advanced procedures, for which training may not be offered in all family medicine residencies. Some residencies may offer focused training in one or more of the *B* procedures to interested residents, but the *C* procedures may require additional training outside of a typical family medicine residency curriculum to achieve competency. See Appendix A for advanced procedures.

Table 1: A0 Procedures

Procedure Cluster	Procedures
Anesthesia	Topical anesthesia
	Local anesthesia or field block
Cardiovascular	ECG performance and interpretation
	Phlebotomy
	Peripheral venous cannulation
	Arterial puncture
ENT	Removal of foreign body from ear or nose
	Cerumen disimpaction
	Anterior nasal packing for epistaxis
	Office tympanometry*
Gastrointestinal and Colorectal	Placement of nasogastric or enteral feeding tube
	Digital rectal exam
	Fecal disimpaction
Genitourinary	Bladder catheterization
Laboratory	Urinalysis (dipstick, microscopy)
	Wet mount and KOH prep
Musculoskeletal	Simple closed reduction of subluxed joint without sedation (e.g. nursemaid elbow or lateral patellar dislocation)
Ocular	Fluorescein examination (without slit-lamp)
	Superficial conjunctival foreign body removal (without slit-lamp)
Pulmonary	Handheld spirometry*
Skin	Remove corn/callus
	Drain subungual hematoma
	Laceration repair with tissue glue or skin staples
Women's Health	Pap smear collection

*May involve equipment not available at all clinical sites

Table 2: A1 Procedures

Procedure Cluster	Procedure	Minimum Number	PCAT
Anesthesia	Digital block	3	Nerve block
Gastrointestinal and Colorectal	Anoscopy	2	Anoscopy

Genitourinary	Newborn circumcision	5	Newborn circumcision
Musculoskeletal	Upper and lower extremity splints	2 (including at least 1 upper and 1 lower extremity splint)	Casting and splinting
	Upper and lower extremity casts	2 (including at least 1 upper and 1 lower extremity cast)	Casting and splinting
	Injection/aspiration of joint, bursa, ganglion cyst, tendon sheath, or trigger point	5 (including at least 1 knee and 1 subacromial/ subdeltoid bursa)	Musculoskeletal Injection
Skin	Removal of skin tags	1 (or demonstration of competency with skin biopsy)	Destruction of skin lesion
	Biopsies (punch, shave), including vulvar biopsy	2	Skin biopsy
	Excisional biopsy	3	Skin and subcutaneous excision
	Destruction of skin lesion (including warts) using cryosurgery, RF/electrocautery, chemical ablation, or intralesional injection	3 (for each method)	Destruction of skin lesion
	Remove ingrown nail, or full toenail	3	Nail removal
	Incision and drainage of abscess, including paronychia	3	Incision and drainage
	Simple laceration repair with sutures	3	Skin laceration repair (simple)
Ultrasound	Basic obstetrical ultrasound: AFI, fetal presentation, placental location	25*	OB ultrasound (limited)
	Ultrasound guidance for needle placement	3 per application; 10 overall	See PCATs for each application
Women's Health	Bartholin's cyst management (Word catheter)	2 (or demonstration of competency with I&D abscess)	Bartholin's cyst management (Word catheter)
	Remove cervical polyp	1 (or demonstration of competency with endometrial biopsy)	Cervical polypectomy
	Endometrial biopsy	2	Endometrial biopsy
	Contraceptive implant insertion and removal	1 (following completion of device manufacturer training)	Implantable contraception
	Intrauterine device insertion	3	Intrauterine device

*See statement on ultrasound below

Table 3: A2 Procedures

Procedure Cluster	Procedures	Minimum Number	PCAT
Anesthesia	Peripheral nerve block (other than digital nerve)	3	Nerve block
	Hematoma block	3	Nerve block
Cardiovascular	Central venous cannulation	10	Central venous cannulation
	Percutaneous arterial cannulation	5	Arterial cannulation
	Umbilical vein cannulation (neonatal)	3	Umbilical vein cannulation (neonatal)
ENT	Lingual frenotomy	1	Lingual frenotomy
	Endotracheal intubation	10	Endotracheal intubation
Gastrointestinal and Colorectal	Paracentesis	3	Paracentesis
	Incision and drainage of perianal abscess	1	
	Excision of thrombosed external hemorrhoid	2	External hemorrhoidectomy
	Remove perianal skin tags	1 (or demonstration of competency with excision of thrombosed external hemorrhoid)	External hemorrhoidectomy
Genitourinary	Vasectomy	5	
Musculoskeletal	Reduction of shoulder dislocation	3	
Neurological	Lumbar Puncture	3	Lumbar puncture
Ocular	Slit Lamp Examination	3	Slit lamp examination
	Removal of superficial corneal foreign body	2	Slit lamp examination
Pulmonary	Thoracentesis	3	Thoracentesis
Skin	Fine needle aspiration of cyst (including breast)	2	FNA of cyst
	Needle biopsy of solid mass	2	FNA biopsy
Ultrasound	Advanced prenatal ultrasound: dating, anatomic survey	40*	
Women's Health	Cervical dilation	2	
	Colposcopy	10	Colposcopy
	Cervical cryotherapy	3	
	Uterine aspiration/D&C	10	

*See statement on ultrasound below

Point-of-Care Ultrasonography

In their 2008 and 2009 papers, the STFM Group on Hospital Medicine and Procedural Training recognized the importance of ultrasound training for family physicians, both for obstetrical and non-obstetrical applications, and included them in their A1 procedure lists. The American Academy of Family Physicians endorses access to and training in diagnostic ultrasonography in the management of women's health care issues,⁵ and use of real-time ultrasound has been listed as best practice for procedural guidance in several applications by many organizations.⁶⁻⁹ Potential benefits of performing ultrasound examinations at the point-of-care include improved patient access, immediate availability of results, and decreased costs to the healthcare system.¹⁰ The current task force endorses the previous recommendation for training all U.S. family medicine residents in certain point-of-care ultrasound applications, and seeks to more clearly define the recommended scope of that training.

Residency curricula for ultrasound training should include didactics and supervised scanning. Didactics should cover ultrasound physics, machine usage, indications and application-specific information, and practice management.¹⁰ The minimum experience threshold for supervised scanning to establish competency is a matter of debate, and likely varies with the individual application, physician comfort with ultrasound in general, and the defined level of accuracy the learner is required to achieve.¹¹ While many learners may require more experience to achieve competency in the American Institute for Ultrasound in Medicine standard second- or third-trimester examination,¹² previous research has shown family medicine trainees to have demonstrated proficiency with fetal biometry by 40 scans.¹³ The number of scans required to achieve competency in limited obstetric ultrasound, such as is taught in Advanced Life Support in Obstetrics (ALSO®),¹⁴ is currently under study.¹⁵ In the interim, this task force proposes a minimum threshold of 25 scans, similar to that which has been demonstrated in prior research and proposed by other specialty societies.^{16,17} For ultrasound-guided procedures, there is significant skill overlap among the individual applications. This is the basis of the combined recommendation for a minimum threshold of experience both for ultrasound-guided needle placement in general and for each individual application.

Competency in ultrasound should be defined by the learner's demonstration of both the understanding of the technology as well as the ability to perform the ultrasound examination and interpret the information obtained in the context of the clinical question.⁵ Methods of determining competency may include traditional written or oral testing of cognitive skills as well as practical testing of image acquisition and interpretation using observation of bedside skills, simulation, over-reading of images by experienced ultrasonographers, and monitoring of error rates through a quality assurance process.¹⁷

The task force recognizes many family medicine programs incorporate additional diagnostic point-of-care ultrasound into their training and clinical practice and encourages further curriculum development and research into the impact of such training. Because the potential applications are too numerous to list and there is not broad consensus on how to prioritize training and competency assessments for these applications, the task force has categorized them as "advanced procedures."

Competency Assessment

Competency is defined with two parameters. The first is that of a minimum volume of experience with which a skillful resident could achieve the technical skills required to perform the procedure. The task force feels it is important to establish the concept that a minimum volume would represent a minimum number of times a trainee should perform a procedure under supervision before faculty would consider allowing the trainee to perform it independently. This is *not* synonymous with establishing a minimum threshold case log for residency experience, as ACGME review committees in other specialties have done.^{18,19} The proposed minimum volumes have been derived by the expertise of task force members based on the assumption of training learners with the highest procedural aptitudes. These minimums should be adjusted based on data from ongoing research surveys of programs' and graduates' actual exposure volumes and comfort levels. Procedural experience may come from the use of simulation and models²⁰, and this practice especially is encouraged for high-risk procedures and those where there is insufficient clinical volume within a practice to provide adequate exposure to all residents.

The second parameter is of greater importance and comprises a formalized standardized assessment using a procedure competency assessment tool (PCAT). Assessment tools developed for each procedure or group of related procedures should reflect the continuum of technical and cognitive skills required to demonstrate both a minimum level of proficiency and an aspirational level of expertise for the given procedure. After having logged the minimum number for a given procedure (or in some cases a group of related procedures), the resident may request a formal competency assessment while performing the procedure under supervision but without guidance of the preceptor. The preceptor is not expected to endorse the resident's competence upon the first request unless the resident clearly demonstrates the skills outlined in the PCAT.

The task force anticipates that a significant proportion of residents would need to log far more than the minimum number before they are able to pass the competency assessment. Once the resident demonstrates competence in performing the procedure in question, the supervising faculty may sign them off as competent to perform independently. The supervision policy for residents "signed off" on a particular procedure would remain at the discretion of the individual program.

As noted in Table 2, competency in some simpler procedures may be inferred from demonstrated competency in other procedures that involve similar or more complex skills. For example, a residency may choose directly to evaluate a learner's competency in performing skin tag removal. Alternatively, the skills needed to perform a skin tag removal are implied by demonstrated competency in skin biopsy, even if direct observation of skin tag removal itself is not performed.

The proposed PCATs have been adapted from the Operative Performance Rating System currently used in surgical specialties.²¹⁻²³ The instruments use a 5-point Likert scale, with behavior tiers ranging from "novice" to "expert" for a set of competency domains related to the specific procedure. The target for determining competency would be achievement of at least a "competent" level for every domain listed in the tool. Although they may be used as a formative teaching tool,^{24,25} the PCATs are designed primarily to evaluate operators performing procedures without preceptor guidance.

While residency programs may choose to modify the proposed PCATs or develop their own local tools in order to meet individual program needs, widespread use of a standardized set of assessment tools

would facilitate research on the impact of the PCATs on outcomes of interest to CAFM organizations, such as the percentage of residency graduates who incorporate office procedures into their subsequent practice. This task force recommends that AFMRD and STFM establish and support a learning collaborative for the continuing development, field testing, refinement, and dissemination of this method of procedural competency assessment.

The task force recommends that program directors continue to use the end of residency letter to attest to a graduate's competency in each core or advanced procedure. While the letter should serve as sufficient documentation of a graduate's residency experience, the program director's attestation is strengthened by language of adherence to a CAFM-endorsed standard process for demonstrating competency. Graduates should continue to track procedural experience post residency to demonstrate continued mastery of procedures actively performed in practice.

Conclusion

Providing common procedures to patients is a vital part of family medicine practice in both the inpatient and outpatient setting. Patients and payers have been uncertain about what scope of procedures they can expect from their family physicians because of the lack of a declared core set of procedures in which family medicine residents are trained. This consensus statement is the first step in meeting a portion of the entrustable professional activities²⁶⁻²⁸ of our profession. When defining comprehensive primary care, family medicine programs must include a set of common core procedures so they can provide clarity to the public and to meet their expectations of what procedures family physicians will provide. The task force has taken the step to define competency more clearly. Faculty will no longer have to use the subjective measures employed in the past but instead use refined, explicit competency assessment tools that are cogent and consistent. Implementation of these recommendations will provide training programs with a clear target for training and tools to achieve the goal of producing family physicians skilled in a broad range of procedures.

References

1. ACGME Review Committee for Family Medicine. Frequently Asked Questions: Family Medicine. *ACGME Website*. 2014. http://www.acgme.org/acgmeweb/Portals/0/PDFs/FAQ/120_family_medicine_FAQs_07012014.pdf. Accessed November 13, 2014.
2. Nothnagle M, Sicilia JM, Forman S, et al. Required procedural training in family medicine residency: a consensus statement. *Fam Med*. 2008;40(4):248-252.
3. Kelly BF, Sicilia JM, Forman S, Ellert W, Nothnagle M. Advanced procedural training in family medicine: a group consensus statement. *Fam Med*. 2009;41(6):398-404.
4. Table 12: Clinical Procedures Performed by Physicians at their Practice (as of June 30, 2014).

2014. <http://www.aafp.org/about/the-aafp/family-medicine-facts/table-12.html>. Accessed August 14, 2015.
5. Diagnostic Ultrasonography in Women's Health Care (Position Paper). 2014. <http://www.aafp.org/about/policies/all/ultrasonography-diagnostic.html>. Accessed August 14, 2015.
 6. Havelock T, Teoh R, Laws D, Gleeson F, BTS Pleural Disease Guideline Group. Pleural procedures and thoracic ultrasound: British Thoracic Society Pleural Disease Guideline 2010. *Thorax*. 2010;65 Suppl 2:ii61-76.
 7. Mayo PH, Beaulieu Y, Doelken P, et al. American College of Chest Physicians/La Société de Réanimation de Langue Française statement on competence in critical care ultrasonography. *Chest*. 2009;135(4):1050-1060.
 8. O'Grady NP, Alexander M, Burns LA, et al. Guidelines for the prevention of intravascular catheter-related infections. *Am J Infect Control*. 2011;39(4 Suppl 1):S1-34.
 9. Royall NA. Ultrasound-assisted musculoskeletal procedures: A practical overview of current literature. *WJO*. 2011;2(7):57.
 10. Dresang LT, Rodney WM, Dees J. Teaching prenatal ultrasound to family medicine residents. *Fam Med*. 2004;36(2):98-107.
 11. Jang T, Aubin C, Sineff S, Naunheim R. Ultrasound Training. *Acad Emerg Med*. 2003;10(10):1144-1145.
 12. American Institute of Ultrasound in Medicine. AIUM practice guideline for the performance of obstetric ultrasound examinations. *J Ultrasound Med*. 2013;32(6):1083-1101.
 13. Smith CB, Sakornbut EL, Dickinson LC, Bullock GL. Quantification of training in obstetrical ultrasound: a study of family practice residents. *J Clin Ultrasound*. 1991;19(8):479-483.
 14. Deutchman M, Myers T. Chapter O: Diagnostic Ultrasound in Labor and Delivery. In: Leeman L, Quinlan J, Dresang LT, eds. *Advanced Life Support in Obstetrics (ALSO) Provider Course Syllabus*. Leewood, KS: American Academy of Family Physicians; 2010.
 15. Cohen N, Farahi N, Gravel JW, et al. FMfocus: A Multi-Site Validation Study of Prenatal Ultrasound Training for Family Medicine Residents. 2014.
 16. Rodney WM, Prislín MD, Orientale E, McConnell M, Hahn RG. Family practice obstetric ultrasound in an urban community health center. Birth outcomes and examination accuracy of the initial 227 cases. *J Fam Pract*. 1990;30(2):163-168.
 17. American College of Emergency Physicians. Emergency ultrasound guidelines. *Ann Emerg Med*. 2009;53(4):550-570.
 18. ACGME Review Committee for Emergency Medicine. Frequently Asked Questions: Emergency Medicine. *ACGME Website*. 2013. http://www.acgme.org/acgmeweb/Portals/0/PDFs/FAQ/110_emergency_medicine_FAQs_07012013.pdf. Accessed August 15, 2015.
 19. Ciotti M. Minimum Thresholds for Obstetrics and Gynecology Procedures [Memorandum]. *ACGME Website*. 2012. http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramResources/220_Ob_Gyn%20Minimum_Numbers_Announcement.pdf. Accessed August 15, 2015.

20. A product of the joint initiative of the ACGME Outcome Project of the Accreditation Council for Graduate Medical Education (ACGME), and the American Board of Medical Specialties (ABMS). *Toolbox of Assessment Methods, Version 1.1.*; 2000.
21. Larson JL, Williams RG, Ketchum J, Boehler ML, Dunnington GL. Feasibility, reliability and validity of an operative performance rating system for evaluating surgery residents. *Surgery*. 2005;138(4):640-7; discussion 647-9.
22. A User's Manual for the Operative Performance Rating System (OPRS). *American Board of Surgery Website*. 2012. http://www.absurgery.org/xfer/assessment/oprs_user_manual.pdf. Accessed August 16, 2015.
23. Benson A, Markwell S, Kohler TS, Tarter TH. An operative performance rating system for urology residents. *J Urol*. 2012;188(5):1877-1882.
24. Kogan JR, Holmboe ES, Hauer KE. Tools for direct observation and assessment of clinical skills of medical trainees: a systematic review. *JAMA*. 2009;302(12):1316-1326.
25. Nothnagle M, Reis S, Goldman R, Diemers A. Development of the GPSE: a tool to improve feedback on procedural skills in residency. *Fam Med*. 2010;42(7):507-513.
26. Cate O Ten. Nuts and bolts of entrustable professional activities. *J Grad Med Educ*. 2013;5(1):157-158.
27. Bhuyan N, Miser WF, Dickson GM, et al. From family medicine milestones to entrustable professional activities (EPAS). *Ann Fam Med*. 2014;12(4):380-381.
28. EPAs for Family Medicine End of Residency Training. *Family Medicine for America's Health Website*. http://fmahealth.org/sites/default/files/EPAs_for_FM_End_of_Residency_Training.pdf. Accessed October 26, 2015.

Appendix A: Advanced Procedures in Family Medicine

Procedure Cluster	B Procedures	C Procedures
Anesthesia	Intrathecal anesthesia	Epidural anesthesia
Cardiovascular	Pericardiocentesis	
	Umbilical artery cannulation	
	Venous cutdown	
	PICC	
	Pulmonary artery cannulation	
	Cardiac stress test	
	Cardioversion	
ENT	Incision and drainage of peritonsillar abscess	Myringotomy/tympanostomy
	Nasolaryngoscopy	Tonsillectomy
	Dental extraction	
Gastrointestinal and Colorectal	Esophagogastroduodenoscopy	Appendectomy
	Flexible sigmoidoscopy	Anal sphincterotomy
	Colonoscopy	
Genitourinary	Preputioplasty/penile superincision (dorsal slit)	Non-neonatal circumcision
Musculoskeletal	Fracture manipulation reduction	Acupuncture
	Bone marrow biopsy	
Neurological	Nerve conduction study	
Pulmonary	Thoracostomy insertion and management	Bronchoscopy
		Polysomnography
Skin	Allergy testing	
	Botulinum toxin injection	
	Non-surgical cosmetic aesthetics	
	Skin flap advanced closures	
Ultrasound	Non-obstetrical, point-of-care diagnostic applications (abdominal, cardiac, musculoskeletal, ocular, pelvic, skin/soft tissue, thoracic, vascular, etc.)	Advanced obstetrical applications (nuchal translucency, cervical length, umbilical cord doppler)
		Echocardiography
Women's Health	Bartholin's cyst management (marsupialization)	Hysteroscopy
	Dilation and evacuation	Hysteroscopic sterilization
	Loop electrical excision procedure	Laparoscopy
	Non-FNA breast biopsy	
	Tubal ligation	

Appendix B: Procedure Competency Assessment Tools

The following PCATs have been developed so far by the task force:

- Anoscopy
- Arterial Cannulation
- Bartholin's Cyst Management (Marsupialization)
- Bartholin's Cyst Management (Word Catheter Insertion)
- Casting and Splinting
- Central Venous Cannulation
- Cervical Cytology (Pap Smear)
- Cervical Polypectomy
- Colposcopy
- Destruction of Skin Lesion
- Endometrial Biopsy
- Endotracheal Intubation
- External Hemorrhoidectomy
- FNA Biopsy
- FNA of Cyst (including Breast Cyst)
- Implantable Contraception
- Incision and Drainage
- Intrauterine Device
- Lingual Frenotomy (for Ankyloglossia)
- Lumbar Puncture
- Musculoskeletal Injection (Joint, Bursa, Tendon, Trigger Point)
- Nail Removal
- Nerve Block
- Newborn Circumcision
- OB Ultrasound (Limited)
- Paracentesis
- Reduction of Dislocated or Subluxed Joint
- Skin and Subcutaneous Excision
- Skin Biopsy (Non-excisional, including Vulvar)
- Skin Laceration Repair (Simple)
- Slit Lamp Examination
- Thoracentesis
- Umbilical Vein Cannulation
- Vasectomy
- Wet and KOH Prep