OBSTETRICS CURRICULUM

Description:

Obstetrics is taught over the four years of residency. Three months in the first year follow a 10 days orientation in July followed by two months in the second year, three months in the third year and two months in the fourth year. The third and fourth year Obstetrics rotations are designed to provide increasing responsibility as the chief of service.

PGY1:

Objectives:

MEDICAL KNOWLEDGE:

I. Basic science /Mechanisms of Disease
   A. Anatomy
      a. Describe the muscular and vascular anatomy of the pelvis and vulva.
      b. Describe the anatomic changes in the mother caused by normal physiologic adaptation to pregnancy.
      c. Describe the anatomic changes that occur during the intrapartum period, such as cervical effacement and dilatation.
      d. Describe the anatomic changes that occur during the puerperium, such as alterations in the breast and uterine involution.
   B. Physiology
      a. Describe the major physiologic changes in each organ system that occurs in pregnancy.
   C. Embryology and developmental biology
      a. Describe the normal process of gametogenesis.
      b. Describe the normal process of fertilization.
      c. Describe the normal process of embryologic development of the singleton pregnancy.
      d. Describe the embryology of multiple gestations.
   D. Pharmacology
      a. Describe the role for nutritional supplementation in pregnancy (eg, iron, folic acid).
      b. Describe the impact of pregnancy on serum and tissue drug concentrations and drug efficacy.
      c. Describe the factors that influence transplacental drug transfer, such as:
         i. Molecular size
         ii. Lipid solubility
         iii. Degree of ionization at physiologic pH
iv. Protein binding

E. Microbiology and immunology
   a. Describe the principal features of the host immunologic response:
      i. Antigen processing and recognition
      ii. Hormonal-mediated immunity
      iii. Cell-mediated immunity
      iv. Phagocytosis
      v. Cytokine activation
      vi. Complement activation
   b. Describe how the maternal immune response is altered by pregnancy.
   c. Describe the basic features and timing of development of the fetal immunologic response.
   d. Describe the etiology and pathophysiology of the most common genital tract infections.

II. Antepartum Care
   A. Antepartum fetal monitoring
      a. Describe the indications, contraindications, advantages and disadvantages of antepartum diagnostic tests such as:
         i. Non stress test
         ii. Contraction stress test
         iii. Biophysical profile
         iv. Vibroacoustic stimulation
         v. Doppler velocimetry

III. Medical complications
   A. Diabetes mellitus
      a. Classify diabetes mellitus in pregnancy.

IV. Obstetric Complications
   A. Second-trimester pregnancy loss
      a. Describe the usual symptoms and clinical manifestations of a second-trimester abortion.
      b. Describe the risk factors for, and etiologies of, second-trimester pregnancy loss, such as:
         i. Fetal karyotype and structural abnormalities
         ii. Incompetent cervix
         iii. Infection
         iv. Uterine anomalies
   B. Preterm labor
      a. Describe the multifactorial etiology of preterm labor.
   C. Bleeding in late pregnancy
      a. Describe the etiology of bleeding in late pregnancy.
b. Describe the factors that predispose to placenta previa and abruptio placentae.

**D. Hypertension in pregnancy**
   a. Describe the possible causes of hypertension in pregnancy.
   b. Describe the usual clinical manifestations of chronic hypertension, gestational hypertension, and preeclampsia.

**E. Multiple gestation**
   a. Describe the factors that predispose to multiple gestation.
   b. Describe the physical findings suggestive of multiple gestation

**F. Intrauterine growth restriction**
   a. Describe the factors that predispose to fetal growth restriction.

**G. Isoimmunization and Alloimmune Thrombocytopenia**
   a. Describe the major antigen-antibody reactions that result in red cell isoimmunization or thrombocytopenia

**H. Postterm pregnancy**
   a. Describe the potential fetal and neonatal complications of postterm pregnancy, such as:
      i. Macrosomia
      ii. Meconium aspiration syndrome
      iii. Oligohydramnios
      iv. Hypoxia
      v. Dysmaturity syndrome
      vi. Fetal demise

**I. Premature rupture of membranes**
   a. Describe the possible causes of premature rupture of membranes (PROM) in preterm and term patients.
   b. Describe the indications for, and complications of, expectant management in patients with PROM.
   c. Describe the indications for, and complications of, induction of labor in patients with PROM.

**J. Fetal death**
   a. Describe the clinical history that characterizes fetal death.
   b. Describe the possible causes of fetal death.

**V. Intrapartum Care**

**A. Intrapartum fetal assessment**
   a. Describe the possible causes for, and clinical significance of, abnormal fetal heart rate patterns:
      i. Bradycardia
      ii. Tachycardia
      iii. Increased variability
      iv. Decreased/absent variability
      v. Early decelerations
      vi. Variable decelerations
      vii. Late decelerations
      viii. Sinusoidal waveform
B. Labor and Delivery
   a. Describe appropriate indications for induction of labor.
   b. Describe appropriate indications for, and complications of, cervical ripening agents:
      i. Osmotic dilators
      ii. Prostaglandin preparations
   c. Describe appropriate indications for, and complications of, labor-inducing agents:
      i. Oxytocin
      ii. Prostaglandin preparations
   d. Describe the normal course of labor.
   e. Describe the risk factors for abnormal labor.

C. Anesthesia
   a. Understand the types of anesthesia that are appropriate for control of pain during labor and delivery:
      i. Epidural
      ii. Spinal
      iii. Pudendal
      iv. Local infiltration
      v. General
      vi. Intravenous analgesia/sedation
   b. Describe appropriate indications for, and contraindications to, these forms of anesthesia/analgesia.

VI. Postpartum Care
   A. Evaluation of the newborn
      a. Describe the rationale for administration of topical antibiotics to prevent neonatal ophthalmic infection.

   B. Ultrasound
      a. Describe the basic principles of the use of ultrasound in diagnostic imaging

PATIENT CARE / CLINICAL SKILLS
I. Basic Science / Mechanisms of Disease
   A. Physiology
      a. Evaluate symptoms and physical findings in a pregnant patient to distinguish physiologic from pathologic findings.
      b. Interpret common diagnostic tests in the context of the normal physiologic changes of pregnancy.

II. Antepartum Care
   A. Preconceptional care
      a. Perform a thorough history, assessing historical and ongoing risks that may affect future pregnancy.
b. Counsel a patient regarding pregnancy-associated risks and complications, such as:
   i. Advanced age
   ii. Hypertension
   iii. Diabetes
   iv. Genetic disorder
   v. Prior aneuploid or anomalous fetus/newborn

B. Prenatal care
   a. Perform a comprehensive history and physical examination.
   b. Order and interpret routine laboratory tests and those required because of risk factors during pregnancy.
   c. Counsel patients about lifestyle modifications that improve pregnancy outcome.
   d. Counsel patients about warning signs of adverse pregnancy events.
   e. Schedule and perform appropriate antepartum follow-up visits for routine obstetric care.

III. Medical Complications
    A. Diabetes mellitus
       a. Interpret screening tests for gestational diabetes.
    B. Diseases of the Urinary System
       a. Evaluate signs and symptoms of urinary tract pathology in pregnant patients.
       b. Describe the indications for the common diagnostic test for renal disease in pregnancy.
       c. Interpret the results of common diagnostic tests for renal disease in pregnancy.

IV. Obstetric Complications
    A. Second-trimester pregnancy loss
       a. Perform an accurate physical examination and diagnostic tests to identify the site of genital tract bleeding, assess cervical effacement and dilatation, and evaluate uterine contractions.
       b. Perform diagnostic tests to assess patients with threatened second-trimester pregnancy loss, such as:
          i. Ultrasonography
          ii. Genital tract cultures
    B. Preterm labor
       a. Obtain a complete obstetric history in patients with preterm labor.
       b. Perform a thorough physical examination to determine uterine size, fetal presentation, and fetal heart rate and to assess cervical effacement and dilatation.
c. Perform and interpret biophysical, biochemical and microbiologic tests to assess patients with suspected preterm labor.
d. Recognize the indications for, and complications of, interventions for preterm labor, such as:
   i. Antibiotics
   ii. Tocolytics
   iii. Corticosteroids
   iv. Amniocentesis
   v. Cerclage
   vi. Bed rest

C. Bleeding in late pregnancy
   a. Perform a focused physical examination in patients with bleeding in late pregnancy.
   b. Interpret diagnostic tests, such as:
      i. Hematocrit
      ii. Platelet count
      iii. Coagulation profile
      iv. Kleihauer-Betke test
      v. Apt test

D. Hypertension in pregnancy
   a. Perform a physical examination pertinent to patients with hypertension.

E. Intrauterine growth restriction
   a. Assess uterine size by physical examination and identify size/date discrepancies.

F. Postterm pregnancy
   a. Determine gestational age using a combination of menstrual history, physical examination, and ultrasound examination.
   b. Recognize unusual causes of postterm pregnancy, such as:
      i. Lethal fetal anomaly (eg, anencephaly)
      ii. Placental sulfatase deficiency

G. Premature rupture of membranes
   a. Perform diagnostic tests to confirm rupture of membranes:
      i. Observation of vaginal pooling
      ii. Identification of a ferning pattern on microscopy
      iii. Identification of a positive nitrazine test
      iv. Identification of reduced amniotic fluid volume on ultrasound examination
      v. Instillation of dye via amniocentesis
   b. Assess patients with PROM for lower and upper genital tract infection

V. Intrapartum Care
   A. Intrapartum fetal assessment
      a. Perform and interpret the following methods of fetal monitoring:
i. Intermittent auscultation
ii. Electronic monitoring
iii. External
iv. Internal
v. Fetal scalp stimulation

B. Labor and Delivery
a. Obtain an accurate history describing onset of uterine contractions and ruptured membranes.
b. Perform a pertinent physical examination to assess:
   i. Status of membranes
   ii. Presence of vaginal bleeding
   iii. Fetal presentation
   iv. Fetal position
   v. Fetal weight
   vi. Cervical effacement
   vii. Cervical dilatation
   viii. Station of the presenting part
   ix. Clinical pelvimetry
   x. Uterine contractility
c. Assess the progress of labor.
d. Identify abnormalities of labor:
   i. Failed induction
   ii. Prolonged latent phrase
   iii. Protracted active phase
   iv. Arrest of dilatation
   v. Protracted descent
   vi. Arrest of descent
e. Select and perform the most appropriate procedure for delivery (see the list of procedures at the end of this unit).

C. Vaginal birth after cesarean delivery
a. Document an accurate history of a patient’s previous operative delivery.

D. Anesthesia
a. Perform selected procedures related to anesthesia and analgesia (see the list of procedures at the end of the unit).

VI. Postpartum Care
A. Evaluation of the newborn
a. Perform an immediate assessment of the newborn infant and determine if resuscitative measures are indicated.
   i. Resuscitate a depressed neonate:
   ii. Properly position the baby in the radiant warmer.
   iii. Suction the mouth and nose.
   iv. Provide tactile stimulation.
   v. Administer positive pressure ventilation with bag and mask.
vi. Administer chest compressions.
b. Assign Apgar scores.

B. The puerperium
   a. Perform a focused physical examination in postpartum patients.
   b. Prescribe methods of reversible contraception.

INTERPERSONAL & COMMUNICATION SKILLS

I. Antepartum Care
   A. Preconceptional care
      a. Counsel a patient regarding appropriate lifestyle modifications conducive to favorable pregnancy outcome.

B. Prenatal care
   a. Counsel patients about lifestyle modifications that improve pregnancy outcome.
   b. Counsel patients about warning signs of adverse pregnancy events.

II. Postpartum Care
   A. Evaluation of the newborn
      a. Counsel parents about the advantages and disadvantages of circumcision.

B. The puerperium
   a. Counsel patients about permanent sterilization.
   b. Perform postpartum surgical sterilization (see the list of procedures at the end of this unit).

PATIENT CARE / SURGICAL SKILLS

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<th>Procedure</th>
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<td>A. Antepartum</td>
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<td>a. Fetal Assessment, antepartum</td>
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<td>i. Biophysical profile</td>
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<td>ii. Contraction stress test</td>
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<td>iii. Nonstress test</td>
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<td>iv. Vibroacoustic stimulation</td>
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<td>b. Ultrasound Examination</td>
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<td>i. Abdominal ultrasonography</td>
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<td>B. Intrapartum</td>
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<td>A. Amnioinfusion</td>
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<td>B. Amniotomy</td>
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<td>C. Anesthetic/analgesic procedures</td>
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<td>a. Administration of parenteral</td>
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<td>Analgesics/sedatives</td>
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<td>b. Administration of narcotic antagonists</td>
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<td>Procedure</td>
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<td>c. Epidural anesthesia</td>
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<td>d. General anesthesia</td>
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<td>e. Spinal anesthesia</td>
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<td>D. Cardiopulmonary resuscitation</td>
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<td>a. Airway maintenance</td>
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<td>b. Bag-mask ventilation</td>
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<td>c. Chest compressions</td>
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<td>E. Cesarean delivery</td>
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<td>a. Low transverse</td>
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<td>F. Episiotomy and repair</td>
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<td>a. Mediolateral</td>
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<td>G. Fetal assessment, intrapartum</td>
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<td>a. Fetal heart rate monitoring (internal/external)</td>
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<td>b. Fetal scalp pH determination</td>
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<td>c. Fetal scalp stimulation test</td>
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<td>d. Vibroacoustic stimulation test</td>
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<td>H. Forceps delivery</td>
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<td>a. Outlet</td>
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<tr>
<td>I. Induction of labor with ripening agents or oxytocin</td>
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<td>J. Neonatal resuscitation, immediate</td>
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<td>K. Skin incision</td>
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<td>a. Vertical</td>
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<td>b. Transverse</td>
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<tr>
<td>L. Suction evacuation of first-Trimester fetal death</td>
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<td>M. Vacuum extraction</td>
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<tr>
<td>a. Outlet</td>
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<tr>
<td>N. Vaginal delivery, spontaneous</td>
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**C. Postpartum**

A. Circumcision, neonatal                                     | x          |                      |
| B. Repair of genital tract lacerations                       |            |                      |
| a. Perineal (first and second degree)                        | x          |                      |
| b. Vaginal                                                  | x          |                      |
| C. Sterilization                                            | x          |                      |
| D. Wound care                                               |            |                      |
| a. Debridement                                              | x          |                      |
| b. Incision and drainage of                                 |            |                      |
| i. abscess or hematoma                                      | x          |                      |
ROTATION DESCRIPTION

General Principles:

First year residents will pick-up and follow laboring & antepartum patients. Whenever, possible all Labor and Delivery patients except those of UW-certified nurse midwives should be followed by either the junior OB or FP resident assigned to OB. In general higher risk patients go to the OB resident; this will depend on the experience of individual residents and current patient volume and complexity. The chief resident assists in patient assignment and ongoing communication between residents.

Residents “pick-up” patients to manage either at the start of the duty shift with sign-out or a new admission. Board sign-out is an opportunity for discussion of patient management and a check that the resident understands all the relevant information. The information shared at board sign-out assists the resident coming on duty in prioritizing initial tasks, review charts and meeting patients. Information given at board sign-out does not replace personal chart and patient review.

For new admissions, the resident assigned to the patient is responsible for completing the admission history and physicals, students may do an H & P but the resident must also personally do an admission evaluation and check and countersign the history and physical and orders.

When a new patient is assessed, the resident must call the in-house faculty staff to discuss patient care and confirm the management plan. For all patients, the senior resident is first called to help formulate a management plan before calling the attending.

In general, laboring patients and patients on magnesium sulfate should be evaluated and a chart entry made at least every 2 hours. Stable antepartum patients may be evaluated less often.

The attending (and the senior resident) should be contacted prior to management changes (e.g. pitocin, epidural, rupture of membranes, antibiotic therapy) and if concerns arise regarding fetal heart tones or progress in labor.

The junior resident should scrub in on all operative deliveries, even if the resident had not been following them. This includes cesarean sections when a senior resident scrubs.

Residents share the responsibility of supervising the medical students as they participate in the labor, delivery, and postpartum care.
All Ob/Gyn clinic patients who present to the OB Triage should be seen by an Ob/Gyn junior or family practice resident. All patients without a private physician on our staff will be registered as teaching service cases, to be managed by the resident staff. Private patients are evaluated by triage nurses in consultation with the attending. Residents get involved with a decision to admit patients.

Residents should round on and write a note each day for all patients except those under care of Family Practitioner. If you will be taking over labor and delivery, the rounds should be completed prior to sign-out.

See patients in the High Risk Obstetrics Clinic whenever the senior resident is not available to do so.

**Duties**

**Orientation (20 days in July):**
The PGY1 resident will be shadowing the junior (PGY2) resident on Obstetrics rotation over 10 days. An additional 10 days will be spent learning to perform ultrasound examinations, especially skills utilized on L&D, i.e., presentation, amniotic fluid index, basic fetal biometry, placental localization.

**PGY1 Obstetrics Rotation:**

**Obstetrics Service:**

The Obstetrics Service consists of the Chief, OB junior resident, the “night float” resident, Ob resident on MFM service, Family Practice resident(s) and medical student (s) on Ob service.

**Weekdays:**

- Arrive by 6AM on L&D to meet Chief resident. The Chief Resident assigns residents and medical students to specific patients on Labor and Delivery or antepartum and postpartum floors. This assignment must be made on a daily basis, at 6AM, so that the junior residents and medical students have ample time to round on the patients, write notes and orders as appropriate before the morning report on L&D from 7:30 AM to 8:30 AM. Some of the assignments may be made the day before so that the junior resident may start rounding earlier.
- Round on postpartum patients, complete written notes, discharge orders and summaries.
- Check on identities of babies for whom circumcision is desired. The Ob Junior residents and the resident on night float are responsible for completing all circumcisions on Postpartum Day# 0 or 1.
• All off-service patients should also be rounded on prior to the Morning report and presented daily.
• The postpartum patients who are ready for discharge should be able to leave by 10:00 AM every day.
• The PGY1 resident should be the main Ob resident on all primary Cesarean sections.
• The postpartum sterilization procedures will be performed by the junior Ob resident with the Faculty on service, unless he/she is otherwise engaged on L&D. It may be delegated to the Gyn junior resident if the Ob resident is unable to leave L&D.
• Any cross coverage between Ob and Gyn services is to be arranged on an individual basis through the respective chief of service.

7:30 am – 8AM Morning Report:
• The residents on OB service, faculty on service, the FP faculty and the MFM faculty will attend the morning report.
• During the morning report, the resident presenting each case is expected to have all the details, including lab results, ultrasound reports as well as prenatal records.
• The resident(s) on nights will present details of patients on the Board; complicated patients on postpartum, overnight changes in antepartum patients as well as patients had complicated deliveries overnight.
• The medical students will present one normal postpartum case once a week to initiate discussion on contraception / postpartum care.

8AM - 5:00 PM (7PM on some days):
• Manage patients on L&D with the help of the senior resident on Obstetrics service as well as the faculty on service.
• The junior resident on Obstetrics service will be first on call for issues arising in postpartum and antepartum patients.
• Ensure that all circumcisions are completed before the day of discharge.

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**Wednesdays:** Arrive by 6AM to round on assigned patients. There is a sign-out at 7AM for all Ob and Gyn service residents on L&D. A formal Morning
Report will not be held. 7:30 AM to 1PM is spent attending mandatory didactics. Please refer to monthly didactic schedule for details. The senior Family Practice resident along with the Faculty on service will be in-charge of the L&D during this time. Return to L&D at 1PM.

**Night float:** PGY1 residents spend one month on night float rotation along with a senior resident. The hours are outlined in the grid below. There are no additional calls. The residents on night float round on some of the postpartum patients before morning report, perform circumcisions (share the duty with the Day Obstetrics team), present details of patients on L&D, ante-partum patients, complicated postpartum patients at the morning report.

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* Morning Report

The junior resident may be asked by the attending staff to give a 5-10 minute presentation on a topic. During the month of Night float, the resident will be assigned RCC on Wednesday afternoons from 1PM – 3PM. PGY1 residents start seeing patients in RCC from September 1.

**Call**
The PGY1 resident will take calls along with a senior resident unless extenuating circumstances demand changes to the rule. While on Obstetrics Service, the resident may be assigned one or two Wednesday night calls followed by 24 ours off on Thursday, Friday night call, Sunday day call and Saturday 24 hour call.

**Duty Hours**
During Obstetrics Day rotation, PGY1 resident may have to work an average of 56 hours/ week from August to December and 74 hours/week from January to June. During Obstetrics Night Float rotation, the resident works
an average of 72 hours. This includes time for rounds, sign-outs, didactics and RCC.

**Resident Continuity Clinic (RCC)**
From September 1, one half day a week will be spent in RCC. The day may vary from month to month. Please refer to RCC clinic schedule and policies for details.

**SYLLABUS**

**Didactics**

Obstetrics curriculum will also be taught through a series of lectures, grand rounds, Mortality and Morbidity meetings, Tracing review conferences, Obstetrics emergency drills, Vacuum and forceps practicum, surgical skills training workshops, and Obstetrics topic review. The series run in a two-year cycle. Every 6 months the resident will be provided with a list of conferences held under each curriculum. The conferences attended by the resident will be marked. Please refer to the Didactics schedule for details.

RCC and High risk Obstetrics clinic exposure to patients are a valuable learning opportunity.

**Self Study**

**Text book:**

Williams Obstetrics 21st edition: Chapters 1-30 and 40-42

**Journals:**

Green Journal (Obstetrics and Gynecology) – each month

**Online:**

1. Fetal Monitoring CDROM
2. CREOG quiz online.
3. UptoDate online

**EVALUATION**

1. Morning Report evaluation, Communication skills by Faculty on service
2. Clinical skills focused evaluation by RCC preceptor.
3. Surgical skills focused evaluation by faculty assisting in surgery.
4. M&M evaluation form by M&M moderator
5. Journal club evaluation by faculty moderator
6. CREOG in-training examination