West Virginia University
School of Medicine

Department of Anesthesiology

Clinical Base Year
Obstetrics Curriculum

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Residency Program Director

I. Educational Purpose and Goals

The purpose of the in-patient obstetric rotation is to expose the resident to the routine management of the labor process and delivery, common obstetric problems and complications, and the alterations in anatomy and physiology associated with pregnancy.

Goals and Objectives

At the conclusion of the first year rotation, the resident should be able to:

1. Examine and evaluate uncomplicated patients
2. Diagnose and treat STDs and UTIs in obstetric patients
3. Identify patients with obstetric complications and seek appropriate consultation
4. Recognize the indications for antepartum testing
5. Recognize the indications for obstetric ultrasound
6. Explain the principles of informed consent
7. Perform a competent obstetric history and physical examination
8. Record accurate progress notes and discharge summaries
9. Recognize the indications for genetic counseling.
10. Recognize abnormal laboratory results and obtain appropriate consultation
11. Evaluate triage patients and refer complicated patients to more senior physicians
12. Manage an uncomplicated labor case.
13. Recognize abnormal labor and obtain appropriate consultation
14. Diagnose ROM and premature labor and consult senior resident for management guidelines
15. Diagnose chorioamnionitis and consult senior resident for management guidelines
16. Diagnose and treat preeclampsia
17. Interpret FHR tracings and obtain consultation for assessment of abnormal tracings
18. Recognize the indications and contraindications for the use of oxytocin. May write orders for oxytocin for patients who have been evaluated by a senior resident
19. Discuss principles of operative delivery
20. Perform the following surgical procedures:
    a. Spontaneous vaginal delivery with supervision
    b. Cord blood gas studies
    c. Midline episiotomy

d. Repair of vaginal and perineal lacerations (with supervision)
e. Manual extraction of placenta (with supervision)
f. Amnioinfusion
g. Neonatal resuscitation (including intubation)
h. Vaginal delivery after cesarean (VBAC)
I. Assist in performing postpartum tubal ligations

21. Recognize shoulder dystocia and seek consultation
22. Recognize uterine inversion and seek consultation
23. Recognize postpartum hemorrhage and seek consultation
24. Express emotional support to patients with a nonviable pregnancy
25. Manages routine postpartum and postoperative patients
26. Appropriately evaluate the febrile obstetric patient and select appropriate antibiotic therapy
27. Recognize the indications and contraindications for all methods of contraception
28. Provide instructions for lactating women

Mother Infant Care Center - Laboring patients

A. Prior to being sent for evaluation, all patients should be discussed with the senior resident on the MICC .

B. Special situations on the MICC:

1. Premature rupture of membranes: Patients presenting to the MICC with the chief complaint of PROM before 34 weeks should have only a sterile speculum exam to confirm ROM, to obtain a cervical culture, and, if adequate fluid is available, a sample sent for phosphatidylglycerol. Do not perform a digital examination. Discuss with staff or SR. Most of these patients should receive steroids and antibiotics. Pediatrics must be notified.

2. Third Trimester Bleeding: Many patients present with passage of "bloody show' or vaginal bleeding. If the chief complaint is "bright red vaginal bleeding", the possibility of placenta previa must be considered. C/O painful bleeding or dark bleeding may be abruptio placenta. Caution and clinical experience must be used very carefully in this situation. The resident in L&D should be consulted for all such situation. If significant bleeding has occurred do not examine digitally or with speculum. Real time sonography should be used to evaluate placental location.

3. Labor Following Cesarean Section: Patients with previous a single C-Sections using a transverse lower uterine incision will have the opportunity to undergo a trial of labor. Operative reports need to be reviewed, and uterine scar type documented on the antepartum chart. **Patients with 2 prior sections may undergo trial of labor if they have had a vaginal delivery.**

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CHARTING GUIDELINES – MICC – *Encompasses:* ***Professionalism, System Based Practice, Interpersonal & Communication Skills***

All notes and entries will be dated and timed.

On admission H&P/resident admission note; document estimated fetal weight (by Leopold's or ultrasound) and adequacy of pelvis.

A. Oxytocin Augmentation/ Induction

1. ALL patients receiving oxytocin MUST have an oxytocin note.

2. Oxytocin notes must include indication for the medication, clinical pelvimetry, cervical exam, EFW, and assessment of fetal well-being.

B. All other medications ordered while on the MICC (antibiotics, tocolytics, steroids, etc.) must have an entry in the medical record documenting the assessment of the patient's condition and indication for the medication.

C. Labor progress must be documented; an explanation must be provided in the chart for any labor abnormalities. Appropriate planning and thought processes must be clearly documented in the progress notes.

D. Sonogram reports must show, at a minimum, # of fetus, presentation, placentation, fetal biometry, AFI, cardiac activity and a basic anatomic survey. An US note must be completed for each scan.

E. Patients in preterm labor requiring tocolytics must have an ultrasound on admission. Normal fetal anatomy, presentation, and EFW are of particular importance. If a sonogram has been performed by a reliable source over the 10 days prior to admission, this requirement may be waived.

F. Delivery notes are to be recorded. These must indicate the type of delivery, indications for intervention, complications, delivering physician, staff, birth weight and APGAR scores, etc. In general, follow the usual format for an operative note. The resident on Labor and Delivery is required to complete the L&D delivery summary.

G. At a minimum, all antepartum and postpartum patients must have a daily progress note. Frequency of documentation should reflect severity of patient status. Additional notes are required for documenting significant events complications, or interventions.

H. All student notes must be co-signed by a resident.

I. All hand written notes should be dated, timed and signed.

J. All patients admitted at term, and all preterm patients admitted for PTL, PPROM, PIH, and bleeding should be counseled for delivery.

* Genetically transmissible diseases

1. Neural tube defects
2. Aneuploidy
3. Polycystic kidney disease, or other inherited disorder of metabolism
4. Tay-Sach's disease
5. PKU
6. Sickle cell anemia
7. Thalassemia
8. Cystic Fibrosis
9. Others, as suggested by patient's family history

REVIEWED June, 2005

Resident Duties: Encompasses**: Professionalism, Practice Based Learning, Interpersonal & Communication Skills**

Junior Resident:

Assist the students on the ward during rounds. You will be responsible for postpartum rounds but may need to assist in antepartum rounds at the direction of the resident in charge.

1. Once the ward paperwork is completed, you are expected to assist in the management of the MICC or see patients in the clinic (check daily schedule).
2. You are the first call for the examination room and problems on the MICC during the day.
3. Check appropriate schedule for daily activities, and attend all division conferences and rounds.
4. You are (does not apply to night float coverage) first call for the E. R. during night call.
5. You are responsible for morning and afternoon rounds on your postpartum patients.
6. Periodic assessments and notes are required for all Labor Hall patients.
7. If you have questions or problems ask the Senior Resident for assistance.

Patient Follow-Up - Encompasses: ***Patient Care, Practice Based Learning & Improvement***

1. Most antepartum service patients discharged from the hospital should have a follow-up visit in the High Risk Ob clinic. If a patient is deemed to be stable for

follow-up outside of High Risk OB clinic, this appointment must be coordinated and given to the patient prior to her leaving the hospital. Exceptions include admissions for hyperemesis or other self-limiting problems. Verify with High Risk OB ward attending.

2. All postpartum patients with complications (chronic hypertension on medication, diabetics - both of those requiring medication adjustment and close f/u) will upon discharge have an appointment on hand to be followed by a member of the Ob team.

3. All patients with the following conditions or complications will be seen for postpartum/post-operative visit by her surgeon / resident in charge. Additionally these patients will have their follow-up appointments on hand at the time of discharge from the hospital:
   - cesarean deliveries
   - fourth degree perineal lacerations
   - wound infections / hematoma / seromata / dehiscence
   - any other patient with a complicated course

   ** Patients with complications will be followed by the responsible physician in their continuity clinic, regardless of the clinical service where that resident may be rotating in. There will be no exceptions or negotiations on this item.

   ** Patients with post-operative complications identified after release from the hospital will be referred to the resident surgeon for follow-up, as delineated above.

DAILY ITINERARY ON L&D

5:45 am Junior residents arrive
- Make list & divide patients as follows:
  - Off Service Residents – Uncomplicated post-partums
  - Split Post-Ops and antepartums between OB Junior & MFM Resident

6:00-7:15am Rounds
- Senior resident to arrive @ 6:15 to begin seeing antepartums behind the Junior Resident
- Medical Students arrive @ 6:15 and are assigned patients ~ not to exceed 5 patients each

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7:15-7:30am Check out with Night Float

7:30am ROUNDS

RECOMMENDED READING

Operative Obstetrics, 2nd ed. Hankins, Appleton & Lange, 2002
*Obstetrics: Normal and Problem Pregnancies, 4th ed., 2001
***Williams Obstetrics, 22nd ed, 2005**
Maternal/Fetal Medicine, Creasy and Resnick, 5th ed., 2001
Drugs in Pregnancy and Lactation: A Reference Guide to Fetal and Neonatal Risk, 5th ed., 2001
ACOG Technical Bulletins and Committee Opinion (ACOG Compendium)
Obstetrics and Gynecology
American Journal of Obstetrics and Gynecology

Curriculum Timeline

Approved by Education Committee September 19, 2007