

## Poll Results

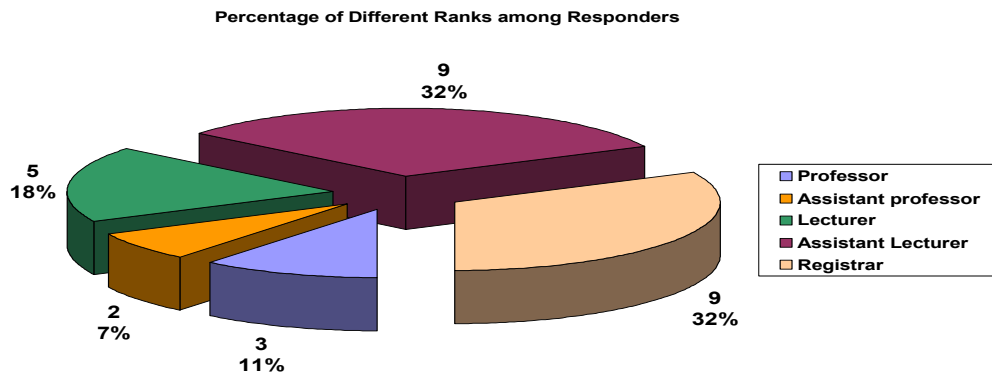
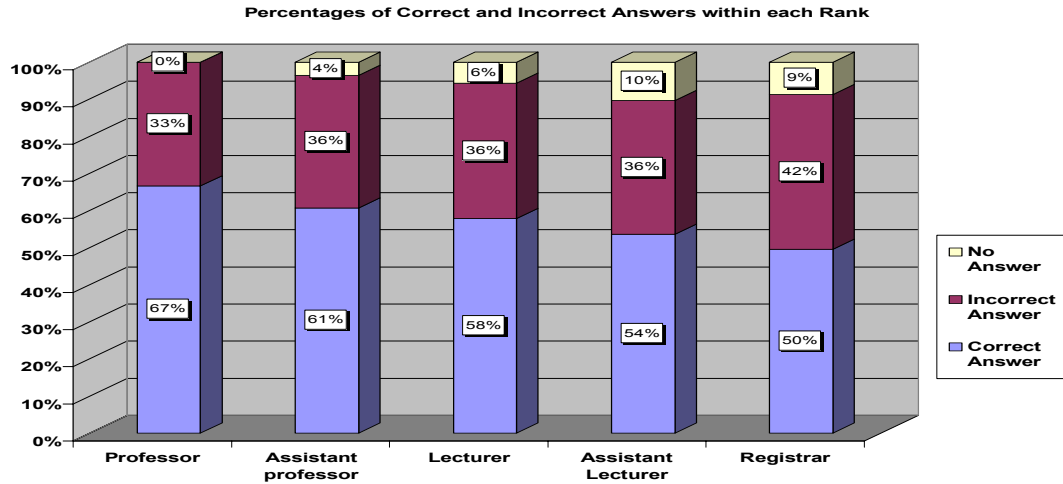
### Categorization of the questions (developed by the ASJOG)

	Relevant information, lack of which does not affect the outcome
	Important information, lack of which may affect the outcome
	Essential information, lack of which is considered dangerous

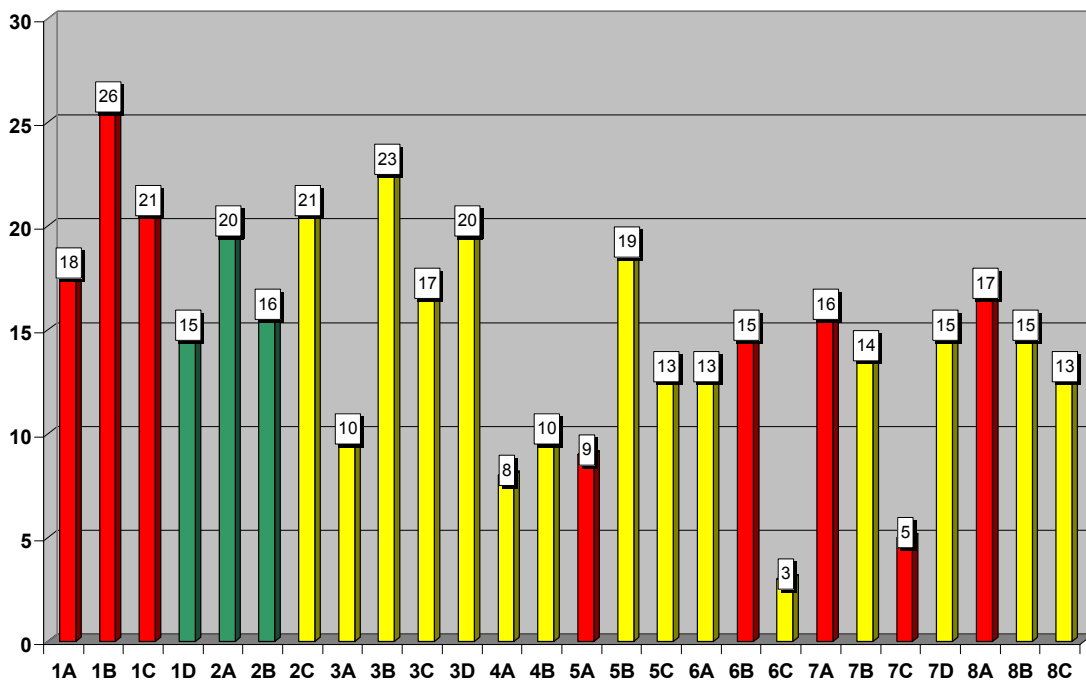
### Results of answered questions

Question*	Model Answer	Correct Answers	Incorrect Answers	Total Answers	No Answer
1A	T	18	9	27	1
1B	T	26	2	28	0
1C	T	21	6	27	1
1D	F	15	12	27	1
2A	T	20	6	26	2
2B	T	16	7	23	5
2C	T	21	6	27	1
3A	F	10	17	27	1
3B	T	23	3	26	2
3C	T	17	9	26	2
3D	T	20	6	26	2
4A	F	8	18	26	2
4B	F	10	13	23	5
5A	T	9	18	27	1
5B	T	19	8	27	1
5C	F	13	14	27	1
6A	T	13	11	24	4
6B	F	15	9	24	4
6C	F	3	23	26	2
7A	T	16	9	25	3
7B	T	14	11	25	3
7C	F	5	19	24	4
7D	T	15	10	25	3
8A	T	17	9	26	2
8B	F	15	12	27	1
8C	T	13	13	26	2

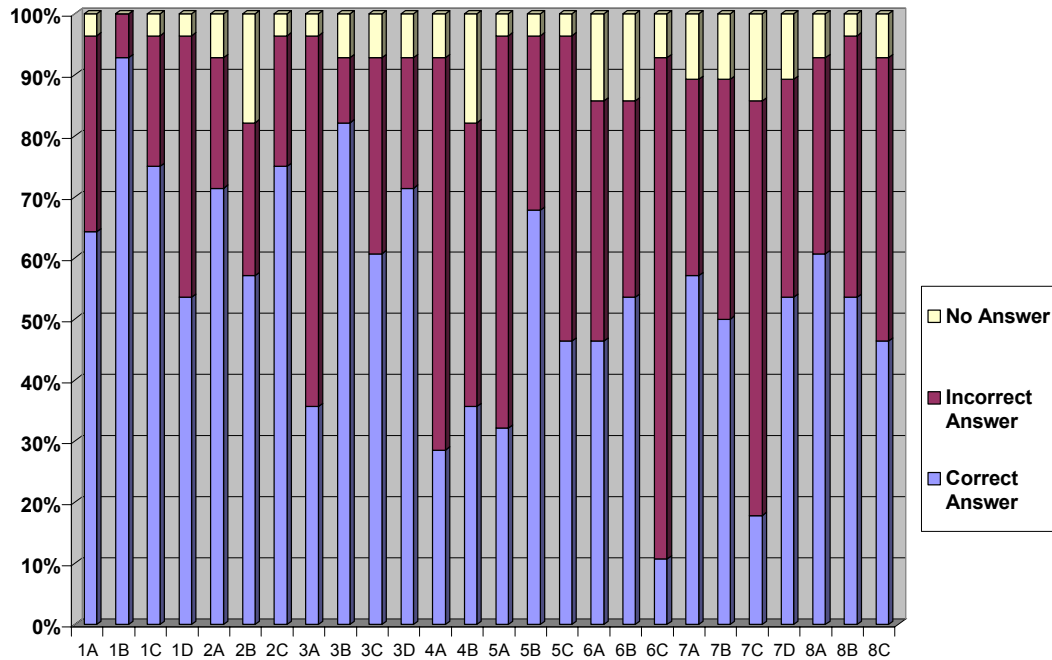
\*The colors indicate the category of the question stated in the first table



Numbers of Correct Answers by Question



## Correct and Incorrect Answers for each Question

**ASJOG Comment**

The main philosophy behind CME questions is not to test the reader but to test the harmony between the actual practice and EBM. Each single question was accurately and purposefully put to achieve this goal. The sample does not accurately represent all grades of seniority among hospital staff and may be too small to draw valid conclusions.

Another remark was quite evident from the first look at the statistical results, which is that the rate of correct answers decreased and that of unanswered questions increased as the seniority level of participants decreased. Perhaps junior doctors have less interest in medical and safety aspects of the labor ward as compared to more experienced staff.

We acknowledge that the questions were a little difficult. But we find this subject to be important to be neglected by junior doctors during studying.

There are some answers which we think deserve a more detailed discussion. For instance, the highest rate of correct answers was seen in question 1B, concerning the fact that GBS bacteriuria during pregnancy is a risk factor for neonatal GBS sepsis. This, in our opinion, is an important issue which deserves to be kept in mind by all obstetricians so that they adopt the concept of screening and treating pregnant women for bacteriuria, especially GBS. We apologize for the poor phrasing of question 6C which caused misunderstanding and led to a high rate of wrong answers.

We would like to stress that intrapartum chemoprophylaxis (question 7C) can not be effective using erythromycin orally in penicillin-allergic patients, intravenous write of administration is crucial in those cases.

The selection of patients for intrapartum chemoprophylaxis, as well as the correct dosage of antibiotics to be used are very important (question 4 to 8). They caused the highest rates of wrong answers in this survey and we invite the readers to read about them in the related article by Dr. Sherif Hanafi.

ASJOG believes that there might be more conclusions that could have been drawn from the results. To avoid going into longer analyses, we leave the reader to find them.

We hope there will be more participation in the future and we invite the readers who are non-Ain-Shams affiliated to kindly send us their answers through the different feedback channels we provide.

*The Editorial Board.*