OHSU Obstetrics Rotation

There are three main parts to this rotation: labor and delivery, antepartum rounding, and OB clinics. All students will round daily each weekday morning on the Mother/Baby Unit (MBU) (13C and 14C). Half of the ob team will be assigned to clinic. This also means you are part of the team that does afternoon rounds on the high risk antepartum and complicated post partum patients. The other half of the ob team will be assigned to labor and delivery during the day. When it is slow on L&D, you may be asked to join the afternoon rounding team.

Daily schedule

5:50 or 6:00 through 7:15 am: Round on the MBU on all ob patients. Try to have your notes done by 7:00 a.m. The residents rounding will co-sign/edit your notes so they need some extra time to do that before we meet for sit-down round.

7:15 a.m -- meet in the 14C conference room. We will present and discuss each high risk patient on our Aback board@ with the Perinatologist on our service each week. If you rounded on a patient on the board, you should present her. The resident who saw her may add some things too. Try to keep some continuity. This can be difficult. We do not discuss routine deliveries (c-sections included), but IF you see a patient who spikes and temp, has hypertension, is on magnesium prophylaxis, you should bring them up to one of the residents that a.m. before rounds and we=ll be sure to add them to our list to discuss.

After we discuss the back board, we ask that one of the students grab the board and transport it to L&D on 12C where we=ll all go for L&D rounds. The mole (2nd year OB resident working the night shift) will present the board and what happened overnight. Whoever is on L&D during the day should pick up any exam or laboring patients. Write your initials by the patients= names. Ask the resident who will be running L&D that day/night who are the best patients to follow. Sometimes we may redistribute students as we want everyone to get the chance to help manage laboring patients and help with deliveries. Read about L&D expectations below.

Around 8 a.m. -- We may take a quick coffee run and meet in the lounge on L&D to discuss an OB topic with the perinatologist on that week. We will post a sign up list and you can choose a topic to discuss before your L&D rotation ends. Presentations should be about 15-20 minutes and handouts are appreciated, but not required. Some teams choose to review journal articles more often.

8:25 a.m. (Tues) - The clinic team leaves for chart review for Dr. Sig Linda Jacobson=s clinic that starts at 9 a.m. These patients have multiple social issues requiring Social Work --- substance abuse, homeless, epilepsy. See Clinic expectations below.

8:25 a.m. (Thurs) - The clinic team leaves for chart review for Dr. Richard Lowensohns=s clinic

that starts at 9 a.m. These patients have Diabetes - gestational, Type I and Type II. Many pts are Spanish speaking only and we have 2 interpreters present in the clinic. Use them if needed. 9:00 a.m. (Monday and Wednesday) - This is our High Risk Perinatal Clinic. Pts are seen here because of twins, maternal or fetal medical problems, or other reasons that make their pregnancy is not quite Anormal@.

Afternoons - Hopefully after voiding and having a nutritious and filling lunch, the clinic team should round on those patients on the backboard. Be ready to present your patients at evening check out rounds. L&D team should continue to follow their patients. Be prepared to present them at check out rounds.

5:30 pm (Monday-Wed) - Check out rounds.
6:00 pm (Thurs.)
5:00 pm (Fri.)

Fridays -- We round earlier on Fridays so everyone can make 7:30 Ground Rounds in the 8th floor conference room. Continental breakfast often available. We meet on L&D to do both the backboard and L&D at 7:00 a.m.

Weekends. On Saturday and Sunday mornings, the team getting off of call rounds on the MBU patients. Be ready to report to L&D at 8:00 a.m. to present the backboard patients. The oncoming team should also report to L&D at 8:00 for rounds. If you are not on call Friday, Sat. or Sun. nights, you do not need to be anywhere near OHSU. Enjoy yourselves.

MBU Rounds

The patients that belong to our service are written on the 13C wipe board in black. There is a clipboard with blank spaces to fill next to room numbers. Whomever arrives first should fill that in (maybe take turns) and each student should sign up for 2-3 patients at first. If there is an MS4 on the rotation, they should see any antepartum folks on the backboard (as they are doing a perinatal rotation). Be sure to check on orders written overnight by the mole or other resident. All deliveries have a printed delivery note to get a quick summary of their story. All folks who will be discharged should have a discharge summary face sheet. Take the initiative and write out prescriptions if you think a patient going home needs anything beyond prenatal vitamins, FeSo4, Tylenol, Motrin, or Colace.

The MBU Note

Antepartum: Subjective should assess vaginal bleeding, leaking of fluid, fetal movement, contractions, and preeclampsia sx (HA, blurry vision, RUQ pain, edema). Objective should include assessment of abdomen (gravid and nontender is normal) and LE (no, trace, 1+ edema, etc.) Also include any additional exams pertinent to any pt. complaints. Look at past notes for examples.

Post-partum Subjective should assess vaginal bleeding (lochia), ability to void, pain control, breastfeeding/bottlefeeding efforts, LE pain and preeclampsia (PET) sx if patient had PET. Objective should assess the fundus --- is it firm, tender or not and where is it located in relation to the umbilicus (normally at or 1-4 cm below the umbilcus). Assessment should include if the mother desires a circumcision for her newborn son, her contraception plans, and discharge plan. Women who are unsure of their contraception should have an info sheet on contraception (English or Spanish) ordered. Women usually must stay about 24 hours before discharge, but no longer than 48 hours (unless they delivered in the middle of the night). Women who have babies in the NICU are encouraged to stay the full 48 hours to stay and bond with the baby. Anyone will possible social issues you find concerning should have a social work consult ordered (including teen pregnancy).

Post-op: These patients usually stay 3-4 days. The subjective should be the same as the post partum with the addition of presence or absence of flatus, pain control, SOB, diet tolerance (clears, N/E, etc.) Most women pass flatus by POD2. Many women leave before having their first BM. We feed anyone who has passed flatus. We remove the dressings from their incision about 24 after surgery. Foleys often come out POD1. Pain control is intially with a PCA or Epidural PCA and later with vicodin or other narc combination. These women will need some po narcs for discharge. Staples are removed and steri-strips placed on a transverse incision from POD3-5. Midline incisions should be steri-stripped between POD5 and 7. Discuss staple removal with your resident.

BTLs (bilateral tubal ligation) - these are usually done on PPD 1 and the patient is discharged later that day or POD1.

Labor and Delivery

Any laboring patient, once in active labor ($\geq$4 cm dilated) or receiving magnesium, should have a SOAP note written every 2 hours. Other patients should have notes written as there are changes in labor or management. L&D notes include a brief subjective. Ojective includes mom=s vitals, Is and Os if on magnesium, and assessment of the fetal heart tone strip, which you will become better at reading each day. Include baseline tones, comment on short term and long term variability and presence of reactivity and/or decelerations. Assess the tocodynamometer reading (i.e. frequency of UC=s). Listen to lungs and check reflexes on those patients receiving Magnesium. Otherwise, the SVE (vaginal exam) is usually the only exam done --- most often by the resident. In the assessment, if the fetal strip looks good, you should make the statement Areassuring fetal status@. Dosages of commonly-used drugs and their indications are posted in the resident/student area. Feel free to use the list.

L&D acts also as an ER for anyone 20 weeks or more. We monitor them and assess them right there. A nurse or resident may approach you to see and assess a patient. If you do not speak Spanish and the patient does, the nurse or a resident will show you how to work the interpreter phones. It takes less time than you might think. Get the subjective and do a focused PE. Find a resident to present to (the person running the board can direct you to whom that

might be) and try to come up with what you want to do (do a sterile speculum exam, monitor longer, check her cervix).

During the day there are several c-sections, and possibly tubal ligations, amniocenteses, and circumcisions. You are welcome to be part of the teams involved in these procedures. We will do our best to involve you actively in the closure in c-sections. This is resident dependent as you will work with ob, ER and family medicine residents with varying experience. If you have been following a patient and they end up with a c-section, you should scrub in on the section. Pull your gloves for the OR Nurse and skeletonize the op note.

Paperwork (we all hate it. We all do it.)

There is a bunch. Students, interns, chiefs, and staff all do it. Unfortunately you should see this as a part of being a physician and not scut work. You can use this experience to become more efficient at it (as you will do more of it than ever as a resident) and to expedite finishing up work so we can move on to the next fun thing going on (or at least use the restroom or visit the cafeteria).

Deliveries: All deliveries require an entry into OB Link. This is on the computers in the resident - student area. The nurses will record pertinent data on a 1/2 sheet of paper that can be entered after a delivery. We=ll orient you to this program. The lined copy of this note that is printed out goes into the chart after the last completed progress note. The extra copy is put into the envelope in the front of the chart. Post-partum orders should be completed. There are two pages at the end of the chart that should be complete by now. First is the cervicogram page. The second is the statistics sheet with a lot of boxes to mark off. A discharge sheet should be placed on the front of the chart and updated. If the patient was not a high risk patient/preterm birth, then the short discharge form should be used. Otherwise the long one is used. All deliveries should have a purple sheet filled out. These are located in the res/stud area. Any deliveries that are not perinatal patients on our service or WHC patients should have their primary clinics notified of their delivery. Numbers are posted on the bulletin board.

C-sections: Besides OB Link, the cervicogram, that statistic sheet, and the long discharge form, post op orders need to be completed. An operative note should be done in the chart. If the patient had a spinal or general anesthesia, a PCA order form should be completed.

Clinic Expectations

The clinics are very busy. You will have the chace to see several patients alone and present them to staff and residents. You will gain some experiences doing PAP smears/speculum exams as part of the the first prenatal visit. With all first time patients, they need a full h&p written in the chart. Do as much as possible. The resident will be with you for the speculum, pelvic, and breast exam, if indicated. SOAP notes should go in the chart. The flow sheet should be completed. The nurse will have completed the bp and UA. You should measure fundal height and fetal heart tones and record them. Assess the subjective, checking for signs of rupture,

preterm labor, bleeding, and preeclampsia. At the clinic, there is a list of all patients with appts. The nurse will highlight and write room numbers of patients ready to be seen. Charts are placed in the door. Put your initials up by the patient you will see.

General comments about the rotation

Who the residents are on L&D: The team usually consists of the chief, who runs the service and helps to make big decisions. The second or third year resident in ob runs the L&D board. At night this is always a second year. At night the third year is on call for the ER. If you are interested in seeing patients there, tell the third year on call that night. Whomever is running the L&D board is often seen running around like crazy. We all are happy to take time to explain things, but there may be times an acute issue needs to be handled and the question needs to be deferred. Don=t be shy to remind us later. Things happen quickly (to the surprise of many folks not very familiar with this specialty) so stick around. The interns are ob, family practice, and sometimes ER. Because the experience varies so much, what each allows you to do will vary. Interns are not expected to give up deliveries. As they get more comfortable, however, they will involve you more and more, especially if you have been diligently following a patient.

Expectations you should have of us

Explain things you don=t understand.
Teach you how to read fetal heart tracings.
Teach you how to manage normal labor.
Teach you how to diagnose and work up pre-eclampsia (PET)
Help you become more efficient and proficient in your note writing.
Teach you the maneuvers of delivery.
Help you improve OR skills -- scrubbing, gowning, gloving, and suturing (which you can also practice on placentae)

Expectations we have of you

Pick up and follow your patients. Treat them like they are yours.
Don=t expect to do cervical checks. Some of us may allow you to do these as the rotation goes on, but most ruptured patients will only be checked by the residents.
Work as a team.
Treat the nurses as part of the team. Ask them questions. They can teach everyone.
Don=t wait for the residents to ask you to start afternoon rounds. Take the intiative and start anytime after 2:00 pm.
Come to us if you have any problems/issue with the rotation or have suggestions re: how to improve it.
Be available. Write your name and pager number on the wipe board near the L&D secretary.

You will notice the residents remain on the floor. Things happen too quickly to page people too far away (like forceps and emergent c-sections). We try to call during these events, but it=s not always possible.