

ORIENTATION: OBSTETRICS & GYNECOLOGY AT MCMASTER

Welcome!

McMaster University Medical Center is a Level III faculty that deals with both High Risk and Low Risk Obstetrics. As well, we offer a full service of gynecology including subspecialties in Urogynecology, Laparoscopy, and Reproductive Endocrinology & Infertility. We encourage all house staff including both clerks and PGY 1's to be involved with all patients in both Labour and Delivery and the gynecology services.

Logistics

You are expected to report at 0700h for teaching (even if you are scheduled in clinic or OR). Hand over: All house staff must meet in the lounge in the call area by 0700h for teaching rounds and hand-over occurs afterwards 0730h sharp. Handover at the end of the day will occur at 1700h in the lounge. Hand over on weekends occurs at 0800h in the resident lounge.

Leaving post-call or for half-days

Before you leave post-call in the morning (or before leaving for academic half days), it is your responsibility to hand over patients on L&D or any other patients that requires attention. You must inform the individual assuming care for that person, what the plan of care is to be and who that person should contact regarding the patient's care.

Call

Call begins at 5pm during the week and 8am on weekends. If for some reason you are going to be late for call, please contact the resident that you will be working with to let them know and give them some indication of when you will be here.

Educational Rounds

Each morning educational rounds will occur. Below is a framework that we will try to work around and hopefully we will all learn something during your rotation here at McMaster.

- **Monday 0700h:** Ob/Gyn teaching rounds. Chief Resident to facilitate.
- **Tuesday 0700h:** Dr. Fedorkow facilitates teaching sessions in a topic in gynecology
- **Wednesday 0800h:** Department morning rounds – subspecialty residents, OB staff, or NICU can present.
 - Grand Rounds are scheduled every 1st Wednesday of the month at 0730 and alternate between McMaster and SJH. House staff that is on call Tuesday night will cover until oncoming staff arrives. Everyone else is expected to attend.
- **Thursday 0700h:** Ob/Gyn teaching rounds. Chief Resident to facilitate
- **Friday 0700h:** Ob/Gyn teaching rounds. Chief Resident to facilitate. Once during their rotation, the interns are expected to present. Please discuss topic ahead of time with your Chief Residents.

Responsibilities

There are two Ob/Gyn Wards: 4C (Antenatal and Postpartum) and 4B (MFM and Gynecology). No one should leave post call until all rounds have been completed or you have negotiated something with your colleagues prior to rounds. This includes weekends. If the outgoing staff has completed rounds on the weekend, it is expected that the same courtesy be done for the next crew coming on. Both wards should be checked for either Ob/Gyn patients as patients often overflow either way. Initial the patient list to indicate that the patient has been seen. House staff should follow all patients that they have delivered. After that, the patients should be divided up amongst the house staff (clerks and interns). Patients should be seen daily and a brief note written in the chart regardless of whether they have been seen by a staff person. A resident or an intern should co-sign all clerk notes.

Who should be seen on rounds?

All patients from Ob/Gyn should be seen daily. Family Practice patients are seen by the Interns or clerks only and reviewed directly with the family doctor MRP. Midwifery patients are seen by their own service unless the OB service was consulted during their care (i.e. C/S).

The MFM resident rounds on patients of Dr. P. Smith, Dr. B. DeFrance, Dr. S. Winsor, Dr. S. MacDonald, Dr. B. Brennan, Dr. S. Sharma, Dr. M. Morais and Dr. M. Osmond.

Urogynecology, Laparoscopy and REI (Reproductive Endocrinology and Infertility) patients are rounded on by subspecialty resident except on weekends and then they are rounded on by the Resident on-call.

Labour & Delivery

There are two areas in L&D. The first is Triage (for patient assessment) and the second is the Labour Ward for admitted actively labouring patients or those requiring close observation. If there are more than two PGY1's in house, then there should be a heavier weight (i.e. 2 residents in OB and 1 in GYN) placed on L&D. Priority is in Labour and Delivery. Following hand over, before teaching sessions, house staff should report to Labour and Delivery to pick up and meet their patients (including new patients for induction). Introduce yourself to the patient and to her nurse.

WHOEVER IS COVERING L&D DURING THE DAY SHOULD PUT THEIR NAMES AND PAGER NUMBERS ON THE SIGN UP BOARD IN L&D AND TRIAGE. WHEN HAND OVER OCCURS, THE EVENING CREW SHOULD UPDATE THE BOARDS.

Seeing a patient in Triage

Interns and Clerks are *first-call* to triage for low risk patients. The two common issues you will be called for:

1. Is this patient in labour?
2. Has this patient Ruptured Membranes? ***** **DO NOT DO ANY DIGITAL EXAM IF YOU SUSPECT RUPTURE OF MEMBRANES. ALWAYS CHECK WITH THE RESIDENT OR STAFF BEFORE YOU DO THIS.** ***** Any patient with a question of ROM needs a sterile speculum exam. A slide should be made for ferning and the fluid tested on Nitrazine paper. (Please dispose of your slides in the sharps bin and turn off the microscope after use).

Antibiotics should be given to any patient who is at risk for Group B Strep. This includes:

- a. <37 weeks gestation
- b. Previous GBS bacteruria
- c. Previously affected GBS baby
- d. Ruptured membranes >12h and not likely to deliver in another 4h.
- e. Vaginal/rectal swab done which was positive for GBS
- f. Maternal fever >38 (oral)

Currently, a vaginal-rectal swab at 34-36 weeks of gestation is done to assess GBS status. If the patient's GBS status is known to be negative and they are at term, then they do not need prophylactic antibiotics.

Other Key Survival Hints!

1. Any house staff that asks for help when unsure or inexperienced is regarded as wise and is respected.
2. ALWAYS clean up after a delivery. Nurses appreciate this, as they are very busy caring for mother and baby after the delivery. Count all sharps and instruments and dispose of the sharps into the sharps container. Count all sponges before using any and count them after to ensure that all are present.
3. Hang out in L&D. Be VISIBLE. Out of sight is out of mind. When things get busy or an acutely ill patient arrives, you might miss on a great learning opportunity. If low-risk Ob is quiet, seek out the resident; he or she is rarely bored.
4. Participate in surgery in the OR as well as in C/S, so that you are familiar with the most common gynecological procedures. You should develop good assisting skills as you may be expected to do this for patients in your own practice in the near future. You may even find it interesting & a good supplementation to anatomy and pathology.
5. Introduce yourselves to the nurses so they get to know you and tell them whom you are (CC vs. PGY1).
6. Always go to L&D if you are assigned to it first thing in the morning. Introduce yourself to the patient you have been assigned to.
7. THE MOST RESPONSIBLE PHYSICIAN SHOULD BE NOTIFIED OF A PATIENT'S CONDITION WITHIN 15 MINUTES OF SEEING THAT PATIENT.

Documentation

Triage: write note on blue progress sheet

Admission to L&D

1. Admission note
2. Orders
3. Medication reconciliation form

After a delivery

1. Facesheet
2. Postpartum orders
3. Birth record
4. Delivery note

Preprinted Order sets

Many common order sets (admission, postpartum, induction) are available through Access HHS. Make sure you set up your printer preferences!

General OB/GYN

You are expected to see patients under these physicians and will be paged for these patients: Drs. Sibley, Lightheart, Chen, Sciarra, Hamoudi, Costescu

** Please note however that the ward should not page you directly for Antenatal patients or gynecology patients, however the resident on-call may still involve you in their care, but the resident should receive these pages directly and then contact you.

Subspecialties

The following physicians are the sub-specialists within the hospital and have a specific resident assigned to their patients. The resident is responsible for the day-to-day care of the patients. You should not be paged about patients under these doctors and if you are, please kindly ask the nurse to page the appropriate resident (subspecialty resident or on the weekends, the OB/Gyn resident on-call).

Reproductive Endocrinology & Infertility: Drs. Karnis, Amin and Faghih, Deniz. Fellow: Dr. Gurau.

Perinatology (MFM): Drs. Brennan, Smith, DeFrance, Winsor, MacDonald, and Dr. S. Sharma, Dr. M. Morais.

Fellows: Drs. Dagenais and Moramarco

Urogynecology: Drs. Best, Didomizio and Malabarey

Laparoscopy: Drs. Leyland and Scattolon

Fellows: Drs. Murji, Kuriya and Tafler

GAA (Gyne Assessment Area)

This is a new area off of L&D and next to the women's ICU where gyne consults are seen, now that MUMC has pediatric emergency department only. These patients cannot walk into the GAA, they need a referral from an ER, walk-in, or family physician to the gynecologist on-call to come for assessment. As well, our own post-op patients experiencing problems can present to the GAA. The GAA nurses will page the gyne resident or chief resident, then we will ask them to page an intern or clerk to see the patient if stable. After the patient has been seen, review with the resident and he/she will call the staff.

Obstetrics and Gynecology is a busy but fun rotation. You will be involved in one of the most intimate, sensitive, and memorable experiences with your patients and their families. Like in kindergarten, be respectful and enjoy yourself. Our involvement can be rewarding both for our patients and ourselves. Don't underestimate your influence and presence. These guidelines are by no means complete. If you find tidbits or pearls that would add to this package for future house staff, please let us know.

Thank you and we look forward to working with you.

Chief Resident
MUMC