RESIDENTS AND INTERNS MANUAL FOR THE DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

I. INTRODUCTION:

This manual was prepared for the house staff in the Department of Obstetrics & Gynecology. In it you will find general and specific information which should answer many of the questions and help solve many of the problems which will arise while you are in the Department.

In caring for the female patient the successful physician must develop the practice of the Art of Medicine. He should demonstrate an attitude of sincere, gentlemanly interest, never appearing hasty or abrupt. He should maintain modesty and privacy, recognising the confidential and privileged nature of his relationship with his patients. He must be gentle and careful in examinations, explaining procedures and dealing with fear and anxiety with an attitude of assurance. It is as important that one develop these characteristics as that certain technical and scientific skills be learned.

This Department consists of three divisions. The Obstetrical unit is located on the B and D wings of the 3rd floor. There are two delivery rooms, and 4 labor rooms in the lying-in suite - (D-3). The B wing contains 26 postpartum beds and 4 beds for complicated antepartum patients. The Gyn division occupies the A wing of the 3rd floor. Available here are 29 beds, an examination room, and ward office. The OB-GYN Clinic is in the B wing of the first floor. It contains 8 office-examination rooms, an administrative office and waiting room. The Clinic is in operation four and one half days per week.

The Department office is located in C3-2. The Department Conference Room is located in C3-3. In this room is a mail box maintained for each individual assigned to this Department. Military communications, rosters, birth certificates, operative reports, narrative summaries, and other material which require attention will be placed there. The house staff is expected to refer to this box daily and attend to their duties promptly.

II. ADMINISTRATION:

The chairman exercises administrative and professional control of the department. The assistant chairman is in direct administrative charge of the training program. He will prepare the duty rosters, conference schedules, training reports, and effectiveness reports on interns and residents. Absences of twenty-four hours or more must be approved by him.

Each member of the house staff is expected to be at his assigned place of duty on time and ready to work. Being late for surgery, clinic, rounds, conferences, and other appointments is unfair to patients, insulting to colleagues, and harmful to himself.

The Gynecological and Obstetrical inpatient services each have a staff physician who serves in the capacity of a consultant. Directly in charge is a senior resident assigned to each inpatient service. He is responsible for the residents and interns under him and for all patient care. The senior resident will be kept informed at all times of ward activities, and in the event of an emergency, it is he alone who will determine whether the staff consultant should be called. In the event routine administrative problems arise, it would be well to check with the Department NCOIC who can be found in the Department office.

Ordinary leave will not be granted in June or July - Except during Christmas only one resident will be allowed leave at any one time. The two weeks may be divided or taken together - Thirty days notice will be required for ordinary leave. Leave will be arranged through the assistant chairman.

III DUTY ASSIGNMENT AND RESPONSIBILITIES:

1. INTERNS:

Six interns will be assigned to this department for a period of two months. Rotation between the three services will occur at approximately 20 day intervals.

	Clinic	OB	GYN	Nite Call
1st 20 days	A-B	C-D	E-F	CE/DF
2nd 20 days	E-F	A-B	C-D	AC/BD
3rd 20 days	C-D	E-F	A-B	EA/FB

One intern from each of the inpatient services will remain in the hospital at night. Prior to leaving the hospital in the evening the intern must have his work completed, brief the remaining intern and receive permission from his resident.

Specific duties will be outlined and explained on the various services by the senior residents. Each intern will have assigned specific clinic days. Full clinic participation is necessary and is expected of all interns who are not either scrubbed or involved in necessary ward duties.

It is only natural that many questions will arise as to the management of various problems encountered in the obstetrical, gynecological, and clinic divisions. Consultation will always be available to the intern. Probably more questions will arise in the routine prenatal clinic than on any of the other divisions. For this reason, there is appended to this manual a paper entitled: Prenatal Care, Standards and Routines. You are encouraged to read this carefully before answering any questions presented by a prenatal patient in order that you not commit this department to a course of management upon which it would not like to embark.

2. RESIDENTS:

FIRST YEAR:

The two first year residents will rotate between obstetrcs & gynecology on a 2 months schedule. They will be responsible for the interns under them and in turn will be directly responsible to the senior resident on their particular service. Both residents will have specific assignments in the clinic. The obstetrical resident is expected to attend all obstetrical clinics. The gynecological resident should make himself available to all clinics unless he has immediate duties which require his attention. The first year residents will rotate night duty with the second year resident.

SECOND YEAR:

The second year residents will spend six months in the clinic and six months on gynecology. Rotation between these services will occur on a three month basis. Duties while in the clinic will include day to day administration, answering the telephone messages, insuring adequate clinic coverage, and seeing that emergencies are attended to. He will attend all special clinics.

Duties on the gynecology service will includepreparation of the weekly pathology review, work up and care of the patients admitted by the teaching staff, supervision of the work up of the cancer patients admitted for therapy or re-evaluation, and attendance at certain medical conferences and rounds. Both second year residents will rotate on night call with the first year residents.

3. THIRD YEAR:

The third year residents will rotate on the obstetrical and gynecological services on a six months basis.

OBSTETRICS:

The senior resident in obstetrics will have full patient-care responsibilities. He is directly responsible for the first year resident and interns under him. He is directly responsible to his staff consultant. It is required that he consult his staff on Cesarean Sections, sterilization procedures, and obstetrical emergencies. He will make daily delivery and postpartum rounds. He will report to his staff at 0800 hours and present his problem cases at this time. He will function as the administrative OIC of the obstetrical division. He will prepare for all OB grand rounds. He will present elective OB surgical patients at the preoperative conference. He will attend all obstetrical clinics. He will attend Gyn Clinics on Monday P.M. Tuesday A.M. and Thursday A.M. He will be on 24 hour call to the obstetrical unit except when excused by authorized leave. He will serve as instructor for the prenatal classes.

GYNECOLOGY:

The senior resident is directly responsible for the other residents and interns under him. He is the Gyn ward OIC. He will schedule all surgical cases in the operating room and be directly responsible for the preoperative clinic and scheduling of operative candidates in the surical book. All major surgery must be approved by a staff physician. He must seek consultation on all major Gyn problems. He is responsible for making daily ward rounds and reporting to his staff consultant daily. At this time he will present any problem cases for discussion. He will see all consultations directed to the department from other services. Obstetrical patients of 20 weeks gestation or more will be referred to the senior OB resident. He will prepare and present the preoperative conference. He will attend and present cases to the tumor board. He will be on 24 hour call to the Gyn service except when excused by authorized leave. He will attend the cancer detection clinic on Monday nights. Both senior residents are expected to make weekend ward rounds on their service.

IV RECORDS AND CHARTS:

The interns will be notified immediately by the nurse when a patient is admitted. A complete history and physical examination will be accomplished thereafter as soon as possible. On the obstetrical service the abbreviated clinical record may be used, however, all admissions for major obstetrical surgery, or those patients which will be hospitalized for more than 5 days must have a long form completed. All admissions to the Gyn service will have a long form accomplished. A junior resident's admission note will be made, with pelvic examination. The senior resident will make a note on all major surgical candidates, and on all problem cases. The resident or intern will establish a good habit if he will note in detail his plan of therapy for the patient. He will list: #1 Impression, #2 Plan of therapy, #3 Additional laboratory tests, #4 Consultations ordered, consultations necessary. #5 Diagnostic procedures advised, #6 Indicated definitive therapy. On routine obstetrical postpartum patients it is not necessary to enter a daily note, however, it is expected that on all complications or major obstetrical surgical procedures daily notes will be entered by the intern and resident on the ward. On the Gynecological service daily notes will be made on all patients by the interns and ward junior resident. These will indicate the postoperative physical findings, pertenient lab results as they are returned, complications which may arise, and additional therapy which may be necessary. On patients who must undergo extensive preoperative studies, it is wise to include in a progress note the exact schedule of these studies and the results as they are returned. It should be always borne in mind that from a professional, statistical and legal point of view, that complete and accurate charting is a necessity and moreover reflects conscientious care of the patient. Within this teaching program we cannot consider therapy complete until it is correctly recorded. At the completion of all therapy and at the time of the patient's discharge, it is the responsibility of the intern to correctly sign out the chart. This is accomplished by carefully coding, using the prepared Armed Forces Nomeclature Manual, AFR 160-13. The intern should be especially careful to include all complications since this is the only valid way for maintaining accurate statistics. The patient's chart should be signed out and the cover sheet coded the night prior to the patient's planned discharge. It is the responsibility of the junior resident to dictate a complete narrative summary well enough ahead of the planned discharge to allow for typing and signing prior to the patient's discharge. This is very important in that a copy of all narrative summaries on patients referred to us from distant bases must be mailed to the referring physician upon the patient's discharge. It is also the resident's responsibility to initial the chart, indicating that he has reviewed the chart and found it to be complete and accurate in all details.

Since we must maintain separate inpatient and outpatient charts, a Form 600 Chronological Record of Medical Care will be accomplished at the time of discharge and will include the following: Discharge summary date, discharge diagnosis, operation date, procedure, anesthetic, tissue report, discharge medication, follow up plans, clinical appointments and a signature. This Form is then detached by the OB-Gyn secretary and forwarded to the patient's outpatient clinical records.

For those who are not familiar with the standard hospital forms and the format for completing a narrative summary, there are available on each ward and ward office a sample chart which has been prepared as an aid in accurate charting.

Each resident will maintain a personal procedure record. He must enter all deliveries and surgical procedures which he has performed or assisted. At the end of each month he will submit this to the OB-Gyn secretary.

An extremely important part of any surgical patient's chart is a carefully dictated operative note; and the frustrations of an improperly, sloppily dictated note is familiar to anyone who has attemped to assess the extent or degree of an operative procedure done by another surgeon on a patient who has no idea what procedure was performed. It is the responsibility of any physician operating in this department to dictate immediately after a case, a complete operative note. If the case is done by a member of the consulting staff, it would be well for the resident to offer to dictate this note if the staff man so desires. The completed operative note should be on the patient's chart within 72 hours of the surgery and should contain the following: 1. Preoperative diagnosis, 2. Postoperative diagnosis, 3. Pathology found in detail and procedure done, describing in detail any surgical misadventures or complications, 4. the surgeons, 5. anesthesia used, 6. estimated blood loss and replacement, 7. packs or drains left in, 8. correctness of the sponge count, 9. postoperative condition on the table and in recovery. It is the responsibility of the operating physician to complete or assure completion of a tissue report form, making sure that the necessary clinical information is available to the pathologist for adequate and accurate diagnosis.

V. TEACHING PROGRAM:

A great deal of care and thought has gone into establishing a program of formal teaching within this department. This is accomplished by various ward and hospital rounds and by clinical conferences. It is expected that all personnel will attend these teaching sessions.

1. ROUNDS:

Daily inservice rounds will be made by the resident and intern staff of each service at 0700 hours. Teaching rounds will be held on Obstetrics at 0730 hours Mondays and Wednesdays, and on Gynecology at 0730 hours on Tuesdays and Thursdays.

2. CONFERENCES:

Tuesday	0815	----	OB Grand Rounds	---- C3 Conference Room
Tuesday	1200	----	Residents Conference	-- Lt. Col. Gibbs Office
Tuesday	1300	----	Intern Conference	---- C3 Conference Room
Tuesday	1930	----	Consultants Seminar	--- T3 Conference Room
Thursday	1230	----	Staff Conference	---- C3 Conference Room
Thursday	1300	----	Preoperative Conf.	---- C3 Conference Room
Thursday	1400	----	Pathology Conf.	---- TB Conference Room

3. CLINICAL PROJECTS AND PAPERS:

Each intern will prepare a short typewritten paper on a subject related to this specialty; the length of the paper should permit it to be read in 10-15 minutes. The subject will be left up to the intern, however, these should be coordinated through the Training Officer so that duplication does not occur. A bibiography of the literature used will be included. These papers will be submitted to the Training Officer by the 20th of the second month on the service and the papers will be read the last Tuesday of the last month on the service. All residents are expected to begin a clinical investigation project early in their first year. Particular areas of interest

Should be discussed with the department Chairman and the Training Officer and the plan approved by them. Satisfactory papers resulting from these projects will be submitted for presentation in various clinical meetings. Superior papers can be entered in the various essay competitions.

VI. CLINIC:

Reference to the Outpatient Clinic has been made several times. Attached on a separate sheet is a schedule of the OB & GYN Outpatient Clinics. You will support this clinic. If you are not scheduled for actual attendance and have completed your assigned duties, check with the clinic OIC to see if your services can be utilized.

PRE-OP CLINIC: (TUESDAY P.M. & THURSDAY A.M.)

Any patient considered to be a surgical candidate is sent to this clinic for evaluation and scheduling. Interns must have resident or staff approval before referring a patient to this clinic. You are encouraged to order any laboratory work which will aid the senior resident in making his decision. Emergency surgery is of course scheduled as the need arises.

INFERTILITY CLINIC: (THURSDAY A.M.)

The infertility clinic is established for the evaluation of sterility in patients who have been married for two (2) years or more, carrying on normal marital relationships and without the use of contraceptives. Should you encounter such a patient, you have only to send her to this clinic and adequate evaluation is assured.

ENDOCRINE CLINIC:

On the 2nd and 4th Thursday of each month a special joint clinic is held in the GYN clinic for the study of endocrinological problems. This clinic is staffed by the 2nd year gynecology resident, a medical resident, an endocrinologist, and the gynecology consultant in the clinic that day. Patients may be referred to this clinic on approval by the consultant. Patients with persistant amenorrhea, anovulatory infertility, and similar problems are candidates.

TUMOR CLINIC:

On the 1st and 3rd Thursday of each month from 1000 to 1200 hours a GYN tumor clinic is held in the examination rooms of the x-ray therapy unit. This will be staffed by the 2nd year GYN resident, the x-ray therapy resident, and appropriate staff physicians. Appointments for this clinic are made through the Tumor Board Secretary. All follow-up cancer patients are to be seen in this clinic.

CANCER DETECTION CLINIC: (MONDAY 1800 hours)

The cancer detection clinic performs routine physical examinations for the early detection of cancer. It is the responsibility of the clinic personnel to attend this clinic each Monday evening.

POST PARTUM CLINIC:

The Post Partum Clinic is held on Friday morning form 0730 to 1000 hours. A complete pelvic examination, including a PAP smear, will be done. Special attention will be given to the follow up of renal disease, hypertension, diabetes, and other medical problems. Questions concerning family planning will be answered. Referral to another physician will be done if religious considerations make it impossible to care for a patient's request concerning contraceptives.

PRENATAL CARE STANDARDS AND ROUTINES

1. HISTORY AND PHYSICAL: Including manual pelvimetry on all cases except:
   (a) Patient with good records from another installation acceptable to the Clinic Resident.
   (b) Patients in the last trimester with bleeding after the fifth month should not have a pelvic or rectal examination.

2. STANDARD LABORATORY PROCEDURES: Including a chest x-ray. These may be accepted from another installation. Husband's Rh factor from dog tags, Red Cross card, etc. is not satisfactory. Repeat Hb 36 weeks will be routinely ordered. Rh titers will be obtained at the initial visit,

32 weeks and 36 weeks. If a positive titer occurs repeats should be done about 2 weeks thereafter.
X-RAY PELVIMETRY will not be routine. Patients who show pelvic abnormalities requiring x-ray mensuration should be identified by a note on the chart and this procedure will usually be accomplished during labor. Indicated x-rays for twins should be done as soon as the diagnosis is seriously entertained after the 20th week.

3. SPECIAL OB CLINIC (Red Star on Chart) The following patients should be seen in the Special Clinic. (1) All patients requiring medical consultation, i.e., diabetics, hypertensives, cardiacs, (Grade II murmur plus), Pulmonary disease,etc. (2) Patients with, or with a past history of toxemia. (3) Previous sections (4) Twins, (5) Patients with an Rh antibody or previous erythoblastotic babies. (6) Patients with 3 previous consecutive abortions. (7) Patients with an unexplained anemia of under 10 grams of Hb. These and other patients are to be referred to this clinic after approval by the OIC of the clinic with a word of explanation to, but without alarming the patient. Patients for the medical consultant should have the words "Medical Consult" written on the jacket and a consultation request placed on the prenatal chart.

4. APPOINTMENTS: Patients in the regular OB Clinic will be seen once per month in the first 28 weeks, once per 3 weeks at 28-32 weeks, every other week at 32-36 weeks, and each week thereafter. The appointments will be made at the desk prior to the patient seeing the doctor. These may be changed as necessary. Patients referred to the special clinic should have their appointments changed prn.

5. WEIGHT CONTROL: The patient at her optimum weight at conception should be allowed a gradual 15-20# weight gain. Non pregnant weight should be figured as: Ht 5'- wt 100#, 5'1-105#, 5'2"-110# etc. adding about 5 pounds for each inch. With this as a base the ideal term weight would be 5'-100 + 20 or 120#, 5'4"-120 + 20 or 140#, etc. An overweight patient should be controlled with efforts made to attain an optimum weight plus twenty pounds. An underweight patient may be allowed a gradual increase to a total of thirty pounds over weight at conception. No diet containing below 75 grams of protein should be prescribed during pregnancy. An increase in the vitamin supplement should be prescribed for dieting patients. Salt restriction should ordinarily be instituted on need, should be for salt used at stove or table only, and usually only in the last trimester.

6. MEDICATIONS DURING PREGNANCY:
(a) All immunizations are permissable after the 14th week and prior to the 36th week. Polio vaccine should be encouraged. Gamma Globulin should be used for Rubella prophylaxis prior to the 14th week. (0.1cc/lb body wt, up to 15cc). Exposure to mumps any time in pregnancy should be treated by an intra dermal mumps immunity test and, if not immune, 1cc of mumps vaccine in each of two doses a week apart should be given. These will be done by the shot room on a signed prescription.
(b) FeSO4 qv v tid & mullivits 1 d are given to all patients. Mol-iron 2 tid may be given if sensitivity to FeSO4 is encountered.
(c) Nausea & vomiting of pregnancy may be treated with Bendectine or Bonaminel-2 Tabs q 12 hrs. Compazine should not be routinely used.
(d) Avoid discontinuing any medication given the patient by another service, Obtain consultation if a serious question arises in this area.

7. BREAST FEEDING: Patients should be asked at their initial visit if they plan on breast feeding. Those who wish to should be encouraged, but effort should not be exerted to force the issue.

8. INDUCTION OF LABOR: Induction of labor will be done only for valid medical reasons. Prior to admission, approval by the senior resident should be secured. Such patients should be admitted at 0700 hours with no breakfast. The delivery floor should be notified the day previous to admission. The Pediatric Nursery resident should also be notified when Rh patients are to be induced.

9. CESAREAN SECTIONS: Primary cesarean sections shall be done only after adequate consultation. This is defined by the Joint commission on Hospital Accreditation as "Consultation by a specialist in Obstetrics including an examination of the patient and thorough assessment of the problem with findings and recommendations properly written and signed and placed on the chart". Repeat section is usually performed in this hospital. If a patient previously sectioned inquires she should be told that unless something very unusual should occur she will be sectioned again. Timing for a repeat section is determined by estimated fetal size and maturity and is not necessarily performed at 38 weeks.

10. ANALAGESIA & ANESTHESIA for delivery - This should be discussed with each patient sometime during her prenatal course and noted on the chart. A positive attitude toward saddle block should be manifested but no attempt made to talk a patient into it. Alternatives (pudendal, paracervical, trilene, and nitrous) should be mentioned. No promise should be made but preferences mentioned.

II. DEPARTMENT POLICIES

1. STERILIZATION PROCEDURES

DEFINITION: A surgical operation which changes the female genitalia in such a fashion that conception and/or implantation cannot occur. Such a procedure may be either incidental to the removal of overt pathology, or may be intentionally done to make impossible further pregnancies. No operation resulting in sterilization may be done without staff approval.

INCIDENTAL STERILIZING OPERATIONS:

1) It is generally better to perform a hysterectomy when removal of both ovaries (or a single remaining ovary) is required. 2) Likewise a hysterectomy is often preferable when a salpingectomy will result in absolute sterility. However, the patient's wishes to continue menstruation, and at times the urgency of the procedure, will often serve as contraindications. Hysterectomy at these times may be done only after prior discussion with, and written permission by the patient and her husband. 3) Repeat Cesarean Section patients should be prepared for possible hysterectomy, even if not contemplated, by a short discussion and a signed operative permit.

ELECTIVE STERILIZATION:

INDICATIONS: There are no situations where sterilization is absolutely mandatory. Conditions in which sterilization may be indicated are:

1) 3 or more Cesarean sections
2) Grand multiparity (8 or more 28 weeks gestation)
3) Intercurrent disease in which pregnancy will predictably result in a decreased maternal life expectancy and/or progressively ill health.
4) Repeated perinatal mortality, untreatable and predictable for further pregnancies.
5) Certain psychiatric disorders in which the psychiatry department has so recommended and the approving authority has concurred.

The principle to apply is this: Will a sterilization procedure predictably and definitely result in a healthier more emotionally stable woman, is it the best answer to the problem; and if it is not done will the patient's life and health be predictably and definitely threatened? If yes to all three, than the procedure should be considered.

S. O. P.

For 3 or more C. Sections, Grand multiparity, repeated perinatal mortality:

a) Do not offer sterilization
b) If requested by the patient discuss the subject and its pros. and cons.
c) Procure informal consultation with the senior resident or staff man.
d) The patient will be interviewed by the senior resident or staff man, and a note to this effect will be entered in the prenatal record.

FOR INTERCURRENT DISEASE:

To be suggested to the patient by the senior resident and only after a note so recommending has been written on the prenatal chart by the staff obstetrician.

REQUESTS BY OTHER SERVICES:

For consultation regarding sterilization should be answered with the following points covered:

a) Presence or absence of OB/Gyn indications
b) Presence or absence of operative contraindications and/or operative risk if other than normal.
c) Whether or not we will perform the procedure if approved by the authority.
d) Avoid making comments (for or against) regarding other than the OB/Gyn situation.

PAPER WORK

To be completed by the 28th week of gestation by the Clinic OIC or resident. Following the suggested interviews and consultations:

1. Narrative summary dictated. Include:
   a) Historical and Physical Data of significance
   b) Reasons for recommending sterilization
   c) If the patient requested the procedure, so state
   d) Do <u>not</u> discuss methods

2. The case record and N.S. will then be presented to the weekly pre-op conference. If approved, the necessary signatures will be affixed by the staff and the N.S. and signature sheet submitted to the Board.

3. If approved the signatures of the patient and her husband will be obtained by the senior resident. It must be made clear to the patient at this time that the approval does not guarantee performance and that we reserve the right to change our mind. It must be realized that circumstances change and that the permit is not a contract. The fully signed sheets then should be placed in the prenatal record.

METHODS

1) Immediate puerperal patients may be treated by tubal ligation. Abdominal or vaginal hysterectomy at a later date may be the best choice.
2) Tubal ligation or hysterectomy may be employed at time of C.Section. Factors to be considered are:
   a) Age, education, emotional stability, and the wishes of the patient
   b) Operative risk
   c) Life expectancy
   d) Experience of the operator
   e) Indications in addition to the C. Section

Generally, the younger, (under 30) patient should have tubal ligation and the older patient, a hysterectomy. No mention of the method to be used should be made to the patient until late in the pregnancy (32 weeks) and after adequate assessment of her as a person has been made. If it is believed more suitable, hysterectomy may be offered. She must not be persuaded or talked into it. The only honest reason for the procedure is to avoid further trouble with the uterus. Fear of cancer and fear of failure of tubal ligation should not be used as motivating forces.
The method will be discussed with the patient by the senior resident and a note to this effect placed on the prenatal chart.

1. ADMISSION OF PREGNANT PATIENTS:

(a) Patients admitted in labor will be admitted to the OB unit if the pregnancy has advanced past the 20th gestational week or if in the judgement of the admitting physician a viable child is possible. Patients other than this are admitted to the Gynecology Service.
(b) Patients with primary obstetrical complications such as toxemia, unusual genital bleeding, etc., are to be admitted to the OB Unit if past 20 weeks gestation. Those with primary medical complications are to be admitted to Medicine until close to the end of the pregnancy. These would include such diseases as diabetes, heart disease, pneumonia, etc. The same rule applies to surgical problems.
(c) No patient with a potential or actual infection will be admitted to the Obstetrical Unit unless in labor. Patients with infectious disease in labor will be delivered in the Labor Room and may be kept on the OB Unit for a short period of postpartum observation.

2. CRIMINAL ABORTIONS:

The Base Legal Office has advised us that criminal abortions are not reportable to any Police Agency. Such a term will not be used in the diagnostic nomenclature.

3. ADOPTION:

(a) Infertile couples who desire to adopt should be referred to the various Agencies suitable for this purpose. Statements concerning the medical examination and infertility status will be requested by these Agencies and should be supplied.
(b) Inquiries by a patient concerning placing an unwanted child should be referred to the Chaplain, who will arrange the necessary papers with local Agencies. Under no circumstances should the physician undertake to arrange placement of an unwanted child. Such a child, when born, must be discharged from the hospital in the custody of the mother or the Chaplain.

4. CONTRACEPTIVES:

Patients requesting contraceptive advice should be advised. Rhythm control should be explained. Diaphrams and/or jelly techniques should be fitted and explained. Experience with oral contraceptives is limited as yet, but, if the patient requests such assistance, Enovid (5 mgm day 5 thru day 25 of the menstrual cycle) may be prescribed. The patient should have a preliminary pelvic examination and PAP smear prior to begining and should be seen in the clinic the 1st month or two of administration. Light bleeding is common during the administration of the drug and the menses are expected each month on with-drawal. All contraceptives must be purchased by the patient. Diaphrams and Enovid are available at any drug store. Jellies are stocked in the Base Exchange. Enovid prescriptions should have the word "contraceptive" written on the face of the prescription.

5. CONSULTATIONS:

(a) Consultations requested by the OB/Gyn Department of other Services in the hospital should be prepared and signed by the resident or staff physician concerned with the case. It is necessary that consultations prepared by interns be approved and initialed by a resident or staff member.
(b) Consultations requested of the OB/Gyn Department by other Services in the hospital will be answered promptly by the Senior Resident of the Service from which consultation is requested. Consultations on outpatients directed to the OB/Gyn Clinic will be answered by the residents or staff. Requests for specific physicians will be honored insofar as possible. Completed consultations may be dictated or handwritten. For the purposes of Clinic dictation, use recorder #501 so that the dictated material will return to the Clinic office. Dictations on inpatients, either consultation, narrative summaries, etc., should be accomplished on recorder #475.

7. CORRESPONDENCE:

(a) Routine Certificates of pregnancy giving EDC etc, may be prepared at the patients request.
(b) All statements leaving this hospital making recommendations in relation to medical care (TDY, PCS, change in orders, etc.) must be prepared in accordance with AFM 35-11, for the Chairman's signature.
(c) All correspondence with other physicians relating to a patient must be written and signed by a staff medical officer. When necessary obtain a record release from the patient when sending to or requesting from a civilian physician or hospital.

Reference AFM 35-11, 1 July 1960, as amended:
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Par. 27 a.
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An application based solely on the medical condition of a member of the applicant's family need only be substantiated by a statement of the physician attending the person in ill health. The statement should include the physician's diagnosis, history of illness, present condition, prognosis and contemplated therapy.

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MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
0745 - ROUTINE PRENATAL CLINIC 1000 - SPECIAL PRENATAL CLINIC 1200	0730 - GRAND ROUNDS 0900 - GYN CLINIC 1200 1205 - RESIDENT'S CONFERENCE (Col. Gibbs office)	0745 - NEW OB CLINIC 1200	0745 - GYN CLINIC INFERTILITY CLINIC 1000 - TUMOR CLINIC 1st & 3rd THURSDAY ENDOCRINE CLINIC 2nd & 4th THURSDAY 1200	0745 - POST-PARTUM 1000 - GYN CLINIC 1200
1300 - GYN CLINIC 1600 1800 - CANCER DETECTION CLINIC 2600	1300 - INTERN CONF. (C-3) GYN CLINIC & PRE-OP CLINIC 1600 1930 - DEPT. CONF. (T-3)	1300 - ROUTINE PRENATAL CLINIC 1600	1230 - STAFF & PRE-OP CONF. (C-3) 1400 - PATH. CONF. (TB)	1300 - ROUTINE PRENATAL CLINIC 1600