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Labor and Delivery OB Faculty Responsibilities When on Call

Subject: Labor and Delivery OB Faculty Responsibilities when on call

Purpose: Clarify faculty role

Policy:

1. On-call faculty must be available within (30) minutes at the request of a resident.
2. On-call faculty will be in-house:
   - When a patient is admitted for induction of labor to confirm fetal presentation, cervical exam and induction management plan.
   - When a patient is in active labor (spontaneous or induction)
   - Patient with history of previous c-section admitted for TOLAC.
   - Patient on IV Pitocin.
   - Patient with postpartum complication.
   - Anytime upon the request of the resident.
   - Patient requiring epidural.
3. Faculty will have a supervisory role for residents. In case of having the 9024 resident busy with other on call responsibilities, the faculty will take care of patients in Labor and Delivery until resident is available.

Patients coming to L&D

1. When a patient presents to Labor and Delivery, the resident carrying the 9024 pager will be notified and will see patient. Upon initial evaluation, the resident will call the OB faculty on call and the patient's PCP if available.
2. If the patient is admitted in labor and is a resident's patient, the 9024 resident will notify the COC resident of patient's admission.
3. The 9024 resident will be the patient's provider until the COC resident is able to take over care.

Revised and approved by OB faculty at OB faculty meeting June, 2011

Resident Role in the Care of Obstetrical Patients

Subject: Resident role in the care of obstetrical patients

Purpose: The care of maternity patients is an integral part of resident training in the Family Medicine Program. As the primary care physician, the residents provide prenatal care, attend the labor and delivery, and follow the mother and infant in the postpartum and neonatal period. It may be necessary from time to time for the residents to leave their assigned services to attend to their patient in labor. In order to minimize confusion and stress on the assigned services, the following recommendations are made.

The residency goal is to provide core knowledge in obstetrical skills for all residents. According to RRC requirements, residents must have 40 deliveries, including 10 continuity deliveries, prior to graduation.

Staff Level to Perform: Resident

Equipment: NA

Assignment of Maternity Care Patients

A patient who is already under the care of a resident and who becomes pregnant will remain with that resident for maternity care.

A prospective obstetrical patient who requests an unavailable resident will be contacted by that resident as soon as possible. Obstetrical care with another resident will be discussed and arrangements made. (If the requested resident is on vacation, the resident that is covering for him/her will contact the patient).

The OB list will designate the primary physician as **OB CALL** for all patients who will be assigned to be covered by the resident carrying the 9024 pager.

Residents will be assigned for faculty patients when they are on the maternal-newborn rotation during the month the patient is expected to deliver. Special considerations may apply.

Third-year residents will share obstetrical patients who have an EDD close to one month prior to the completion of residency.

First year residents **will be able** to accept obstetrical patients **prior** to having completed their OB rotation.

Continuity Patient Definition and Responsibilities

In order for a patient to be considered a COC patient, the resident must:

- See the patient at least twice for prenatal visits,
- Participate in the labor management and delivery, and
- Either follows the patient for postpartum hospital care or for the postpartum outpatient visit.
- Continuity residents should be available to care for their patients when they are admitted in labor. They will be notified at time of patient admission. Residents must arrange coverage for maternity patients for planned absences. Residents may use a "team" approach for obstetrical care to provide coverage for vacations or may have the resident carrying the 9024 pager to cover for them.

When an initial OB visit is performed in clinic, the resident should add the patient information to the EPIC OB list.

When a resident sees the patient for the first OB visit, the resident will staff the patient and the **faculty will complete bimanual exam with the resident**.

When a resident is assigned as a continuity resident for a faculty patient, the resident's name will be added to the EPIC OB list. The resident should communicate with the faculty to assure that he/she will be able to see the patient for at least two prenatal visits.

The continuity resident should keep the EPIC OB list updated.

On the first day of a new service, the resident will notify the attending/supervising physician(s) that he/she has a maternity patient due during the month assigned to the service. The resident will provide estimated date of delivery and keep the attending physician updated regarding anticipated date of delivery.

Residents should see their own continuity patients as many times as possible. If the continuity resident is unable to see a patient, the patient should be scheduled with the maternal-newborn resident assigned to the month the patient is due.

Role of the Family Medicine Maternal-Newborn (9024) Resident

OB patients presenting to Labor & Delivery will be **triaged by the 9024** resident. The 9024 resident will decide whether the patient requires admission or discharge to home. The 9024 resident will call the responsible on call faculty and the primary continuity resident if the patient is admitted. The continuity faculty will be notified of admission.

Manage labor and delivery for all patients seen at non-FCC clinics (North Liberty, River Crossing, SE Iowa City).

Resident Expectations During Labor and Delivery:

Resident must notify faculty of admission and report any change of status. Faculty will be present if the patient is in active labor or anytime the resident requests supervision/assistance (see policy entitled "Labor and delivery Ob faculty responsibilities when on call").

The managing resident will assess the patient at a minimum every two hours. A note documenting patient status and plan will be written by the resident at this time. If there are any complications or changes in the plan, they will be documented in the chart by the resident.

A procedure note will be written after delivery to document delivery details.

Postpartum and newborn admission orders will be entered immediately after birth.

Resident Responsibilities for Postpartum Care

1. The delivering resident or the 9024 resident will round on patients with faculty and write notes each day while the mother and baby are hospitalized and will keep EPIC sign out list updated as well as communicating with the residents providing overnight coverage.
2. The delivering resident or the 9024 resident will arrange outpatient postpartum and newborn care appointments for mother and baby with him/herself or the continuity faculty or resident.
3. **Written**: 2001 by Dr. Sara Mackenzie

Reviewed:
Revised: July 2011 by Dr. Jill Endres, OB faculty meeting, 2011
Approved: OB faculty meeting, September 2011

Faculty Obstetrical Sign-out Policy

Subject:

Faculty obstetrical sign-out policy

Policy:

Procedure:

- Accurate hand-offs lead to improved patient care.
- FM OB Faculty day call runs Monday thru Friday 7:45 AM to 5:30 PM, except Holidays.
- FM OB Faculty night call is Monday thru Friday from 5:30 PM to 7:45 AM following day, except Holidays.
- The patient census can be found in Epic and is updated by the residents.
- Sign-out will occur at 7AM and 5 PM to allow the incoming person time to adjust their schedule as needed.
- OB day call faculty should sign out to next oncoming OB day call for better continuity of care. Examples of this would be when: 1) OB day call is split between two providers during the week 2) Sunday evening when weekend OB provider should sign out patients to on coming day call faculty on Monday in addition to the coverage Sunday night.
- Each shift will also be responsible to sign out to the next shift immediately following them.

Special Considerations:

- Faculty who delivers and follows a private patient should sign out to the OB Faculty on call to improve communication and patient care. The Faculty may decide whether he/she wants to be called with any issues regarding the patient or not. If this is the case, it should be specified in Epic.
- If at the time of sign out the faculty is in–house because of patient care responsibilities, he/she will wait until the faculty taking over is in-house.
- OB faculty only needs to be in house at the start of their shift if deemed necessary between the outgoing and incoming faculties.
- While sign-out to next provider is prompted by the outgoing provider, if a page has not been received for sign-out at the designated times (noted above), the incoming provider should check L&D board and page to see if they will be needed as acute situations on L&D could be preventing the outgoing provider from paging. This will help to ensure that providers are able to leave their shift as close to time as possible.

Revised and approved by OB faculty at OB faculty meeting June, 2011
Revised and approved by OB faculty at OB faculty meeting August, 2014

Faculty Notification of OB Patient in the Hospital

Subject: Faculty Notification of OB patient in the hospital

Purpose: Standardize communication and patient management between residents and Faculty

Procedure:

Faculty Notification when OB patient comes to L&D

OB patient in L&D

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Resident evaluates patient

No labor complaint

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1-Resident to talk to Faculty on OB call

2-Upon discharge or admission, resident to send message through Epic or e-mail to PCP

Labor complaint

↓

1-Resident to talk to Faculty on OB call

2-If patient is in labor, resident to send through text message FYI to PCP Faculty* of admission with phone number

3-If patient in labor is TOLAC, notify OB team of patient admission and FYI FP faculty with c-s privileges if available

* If PCP Faculty is coming, the PCP Faculty will call the resident at given phone number and notify resident of his/her decision. The on call resident will then notify the FM OB on call.

Department of Family Medicine and Department of Obstetrics and Genecology

Subject: Department of Family Medicine and Department of Obstetrics and Gynecology

Purpose:

1- To clarify the working relationship between Obstetrics and Family Medicine
2- To optimize patient care through timely and appropriate request and provision of consultation.
3- To educate residents regarding the process of requesting and providing consultation.

1.

Policy: This is a Guideline

1- Antepartum and intrapartum care at UIHC
   - Family medicine physicians and obstetrical providers benefit from a mutually supportive relationship.
   - Family physicians and obstetricians provide options for patients and provide alternative sites for prenatal care.
   - Consultation allows us to work together to reduce obstetrical complications and decrease the number of emergency consultations.
   - Responsive and respectful interactions optimize patient care.
   - The guidelines are intended to provide a minimum standard. The level of care and interaction will vary on a case to case basis.

2- Definition of terms
   - CONSULT: a single visit to OB/GYN clinic or one visit on labor and delivery. An official consult will be placed in Epic. Consultation is intended to facilitate a working relationship. When placing consult to OB, include in your consult question family medicine's comfort level for continuing as primary. For example: "Patient on therapeutic Lovenox during pregnancy. I would like to keep her in family medicine for her obstetrical care if this is appropriate." Consult from OB will include recommendations for either transfer to the OB clinic vs rest of care in family medicine.
   - CO-MANAGEMENT: an ongoing relationship for care between family physician and obstetrician will occur. A consultation will be placed and will state that "co-management of care" is requested. A clear plan delineating who is responsible for components of care is essential. If disagreement regarding responsibility exists, a faculty to faculty discussion should occur. From an education perspective, co-management of care is an important skill. As an institution that trains physicians who may choose to provide care in rural and other settings, physicians must be prepare to collaborate with other physicians in co-management of care.

TRANSFER: when an obstetrical patient's care is transferred from family physician to obstetrician. All further care will become responsibility of the obstetrician unless or until a transfer back occurs.

	CONSIDER CONSULT	CONSULT	CO-MANAGE	TRANSFER
ANTEPARTUM				
Fetal anomaly in vital organ system, documented	X			
Fetal demise, second or third trimester		X		
Hx of recurrent pregnancy loss (either 3 consecutive abortions or 2 consecutive abortions, depending on pt's age)		X		
Poly and Oligohydramnios	X			
Isoimmunization: --RH and other with potential fetal compromise				X
Isoimmunization -- Minor antibodies, no potential fetal compromise	X			
IUGR	(Fetal Diagnostic Consult done when discovered on ultrasound. No need for additional consult to HROB unless further concern)			
Prior c-section, requesting repeat c-section		X		
Hx of prior midline skin vertical incision with unknown uterine incision, desiring TOLAC	X			
Hx of previous fetal or neonatal death with ongoing cause		X		
Multiple gestation --Di/Di twin		X		
Multiple gestation -- mono/di -- mono/mono -- > 2 gestation				X
Malpresentation >34 weeks		X		
Hx of major operations in uterus/cervix (cerclage, septum resection, myomectomy)		X		
Malignancy requiring treatment during pregnancy				X
Severe chronic medical disease (heart disease, SLE, etc)		X		
Hyperemesis gravidarum not responsive to therapy	X			
2 prior C-sections, wants TOLAC	X: if OB recommends C-section, consult with FM high risk OB for repeat C-section; If OB OK TOLAC, transfer or co-management but OB to deliver			
Diabetes type I				X
Pre-existing DM type 2		X		
Gestational diabetes requiring insulin		X		
Cholestasis of pregnancy	X			
Prior history of major operations in uterus or cervix		X		

	CONSIDER CONSULT	CONSULT	CO-MANAGE	TRANSFER
INPATIENT				
Bleeding due to placenta previa				X
Bleeding due to placenta abruptio		X		
Manual removal placenta	X			
Outlet forceps (for those with training)		X		
Vacuum extraction	X (notify OB team)			
Repair of vaginal, cervical and labial laceration	X			
3rd and 4th degree perineal laceration:		X Unless have privileges		
TOLAC		Notification to the OB team		
Preeclampsia without severe features	X			
Preeclampsia with severe features/eclampsia intrapartum				X
Post-partum preeclampsia with severe features		X		
Anomaly in vital fetal organ system	(Fetal Diagnostic Consult done when discovered on ultrasound. No need for additional consult to HROB unless further concern)			
NO cervical change despite use of pitocin and/or no fetal descent in second stage of labor for 4 hours	X			
Preterm onset of labor (less than 34 weeks)		X		
STD active or other infection potentially affecting fetus (HIV, herpes)	X			
Postpartum hemorrhage unresponsive to medical therapy			X	
Unscheduled c-section		X if FM high risk OB not available		
Eclampsia				X
Umbilical cord prolapse		X if FM high risk OB not available		
Amniotic fluid embolus				X
Any other questions or medical conditions not covered		X		

Written: Dr. Sara Mackenzie, November 2001 **Approved:** November 2001 by Dept of Family Medicine and Dept of OB/Gyn
Reviewed: November 12, 2014 at the OB Faculty Committee Meeting
Reviewed and approved: Reviewed and updated with OB January 14, 2016, approved by FAM OB faculty meeting 2/11/2016

Admission to the Maternal-Newborn Service

Subject: Admission to the Maternal-Newborn Service
Purpose: Identify patients that will be admitted to the Maternal-Newborn Service.

Staff to perform: Resident and Faculty

Procedure:
Any **pregnant patient** or **patient with postpartum complication** whose PCP is from the Department of Family Medicine and who requires inpatient care for any obstetrical and/or medical condition consistent with Family Medicine privileging will be admitted to and cared for by the resident and faculty on the Family Medicine Maternal-Newborn Service.

1- If patient is in the clinic or L&D, the provider will call 9024 pager and senior resident answering the page will notify OB Faculty.

2- If the patient is in the Emergency room, the Admission & Transfer Center will routinely contact the Faculty and senior resident (pager 8096) on Medical-surgical call. Once the patient is identified as being pregnant the senior resident will take down information and inform the ATC that they will contact the maternal-newborn team on call (9024 pager) to evaluate the patient. During the night and on weekends and holidays, the senior resident is on call for both teams and will merely confer with the maternal-newborn family Medicine Faculty on call prior to evaluation.

All **infants up to 3 months of age** will be admitted to the Maternal Newborn Service.

1- All infants up to 3 months that are seen in UI Family Medicine Clinics at the FCC, North Liberty Clinic, Southeast Clinic, River Crossing clinic and Muscatine clinic will be admitted to the Family medicine Maternal-newborn Service.

2- For infants up to 3 months of age that may require admission from clinic or emergency Room, please page the Family Medicine faculty on OB call that day. Alternatively, the Family Medicine resident on OB call can always be reached on the 9024 pager. If the Faculty on Med-Surg call is contacted for admission, they will assist in transferring the call to the physicians in the Maternal Newborn service.

Approved at OB Faculty Meeting May, 2011

Obstetrics or Newborn Criteria for OB faculty case presentation at OB Faculty Meeting

Subject: **Obstetrics or Newborn Criteria for OB faculty case presentation at OB Faculty Meeting**

Criteria for case presentation

- Maternal or fetal death.
- NICU/ICU admission.
- 1 minute Apgar of 4 or less; 5 minute Apgar of 7 or less.
- Unexpected labor complication (abruption, etc)
- Delivery complications (manual removal of placenta, 4th degree lac, postpartum hemorrhage, failed operative delivery, etc)
- Severe postpartum complications either with mother or with baby (fever, preeclampsia, postpartum hemorrhage, etc)
- C-sections (excluding scheduled c-sections)
- C-sections complications.
- Concern raised by Department of Obstetrics and Gynecology or family medicine faculty or resident.
- Newborn readmissions during the first seven days of life, excluding hyperbilirubinemia.

Procedure:

1. The 9024 resident, following this criteria list, will remind the OB Faculty involved in the case that it needs to be presented at the OB faculty Meeting. The communication should be by e-mail. This e-mail will also be sent to Barbara Bollinger who will make sure that all the cases are discussed at the meetings.
2. These cases are also going to be presented by the 9024 resident at the monthly OB M&M presentations.

Revised and Approved by OB faculty at OB faculty meeting June, 2011

Criteria for Review

- Maternal or fetal death
- NICU/ICU admission
- 1 minute Apgar of 4 or less; 5 minute Apgar of 7 or less
- 4^{th} degree tear
- Severe post-partum complications either with mother or with baby
- Unexpected cesarean for unanticipated breech, fetal distress, or other maternal complication (failure to dilate or failure to descend would not automatically trigger a review)
- Concern raised by Department of ObGyn or Family Medicine faculty or resident
- Concern raised by nursing staff

There will be 2 tiers of review

1. Initially cases meeting these criteria, will be presented by the faculty member who supervised the case, at the regular monthly meeting of ob faculty. The supervising faculty member will present the case, make recommendations/provide education for how the case might have been handled differently, and the group will decide whether a more formal review should be undertaken.

2. If the ob group feels that a formal review is desirable, then Dr. Levy, the supervising faculty member, and 1 to 2 other ob faculty will independently review the case and meet to go over the findings. It is expected that all ob providers will make time to participate in these reviews as needed.

Procedure for Review

1. If a case meets one of the criteria above, the faculty involved should notify Dr. Levy (Obstetrics Coordinator) within 3 days. If Dr. Levy is unavailable, then either Dr. Wolfe (Clinical Coordinator) or Dr. James (Department Head) should be notified.
2. The case should be presented at the next regular ob faculty meeting by the supervising ob faculty involved with the case. Pertinent fetal strips and copies of all pertinent records should be available (with copies made if needed). (Copies will be placed in the shredder at the conclusion of the meeting, unless keeping certain documents for teaching purposes.)
3. The faculty member presenting the case should make recommendations for how to prevent a similar case in the future (if applicable) and provide the group with educational strategies if needed.
4. The group will decide whether the case should be presented at the Family Medicine monthly Morbidity and Mortality conference or one of the Family Medicine Ob/Gyn conferences. If it is decided to present the case, then the faculty member who supervised the delivery will make arrangements for this.
5. The group will also decide whether a formal review should be undertaken.

If a formal review is needed

1. Dr. Levy and an ad hoc committee of one to two other Family Medicine faculty members will independently review the medical record and meet within 14 days, along with the faculty member(s) involved in the case. If Dr. Levy was involved in the pertinent case, a third faculty member will be identified to participate in the review. Barb Bollinger or Laurie Wallace will arrange a convenient time for the review.
2. If the opinion of an Obstetrics/Gynecology trained physician is felt to be desired, Dr. Levy, Dr. Wolfe, or Dr. James will request this and arrange to have someone from Ob/Gyn attend the group meeting with the 3 Family Medicine faculty reviewers, plus all faculty involved in the perinatal care of the patient(s).
3. The purpose of the review will be educational.
4. In most instances, the supervising faculty member would be expected to arrange to have the case presented at one of the monthly Morbidity and Mortality conferences, so that residents and faculty can learn from the experience.
5. All deaths or significant morbidities of obstetric, fetal or newborn patients under the care of the Department of Family Medicine will continue to be presented at the regularly scheduled monthly Morbidity and Mortality Conference. Arrangements for the date of the presentation will be made by the faculty member supervising the case.

Dr. Levy will keep a track of the cases to be presented and Barb Bollinger will remind faculty when a presentation is due. Roze Murphy can assist with requesting the needed

Revised 11/21/06
Approved by Ob faculty at meeting on 11/22/06

Postpartum Rounds/Newborns Following with Family Medicine

Subject: Postpartum Rounds/Newborns following with Family Medicine
Purpose: Clarify staffing responsibility for postpartum and newborn rounds.
Definitions: OB faculty refers to the Family Medicine faculty member on OB call
Staff Level to Perform: Faculty
Equipment: NA

Policy:

1. Whichever resident delivers a baby, will round postpartum on the mom and baby until both are discharged from their respective units. Residents will generally round about 8 am.

2. In some cases, the parents of newborns delivered by one of the obstetricians wish to follow with one of the family physicians in the Department of Family Medicine or at one of the Community Medical Service sites. If it is determined that the parents wish to have a family physician at any one of our outlying clinics --- Lone Tree, South East, North Liberty, Belle Plain or in the Family Care Center, the nursery staff will page 9024.

   The resident carrying the 9024 pager will admit the infant to the Nursery and will let the OB staff on call know that the baby is now a patient on the FPS. If the infant is healthy and born between the hours of 5 pm and 8 am, the 9024 resident will alert the OB faculty on call and the infant will be seen by one of the Department of Family Medicine Day Call staff physicians in the morning. If the infant needs assessment by a staff sooner, the 9024 resident will page the OB staff.

3. A family medicine faculty member who delivers one of their own continuity of care patients usually will round on both mom and baby for their entire stay. They must "sign out" to a Family Medicine faculty member if they are unable to perform post-partum rounds. This will usually be the Day Call faculty. If the Day Call faculty is not available, then the patient will be rounded on by the OB faculty.

4. **In general,** the day call faculty will do postpartum rounds on family medicine resident patients Mondays through Fridays **(see 5. below).** If they are unable to do so, they may "sign out" to the OB faculty. The faculty member on OB call will always be available to the day call faculty for staffing complicated post-partum patients and for directly staffing a circumcision if needed.

5. OB faculty will perform postpartum rounds on Saturdays, Sundays, and University holidays.

6. The delivering OB Faculty will call day call faculty **before morning report** and verbally notify day call faculty of postpartum/newborn patients. The OB faculty is responsible for patient care the patient is "signed out." Once signed out, the day call faculty is responsible for rounds until discharge or until day call becomes "too busy" as defined by the day call physician. **The OB faculty should be contacted the day prior (if possible), given that the rounding faculty will usually have to round prior to clinic to make an 11 am discharge goal.** The day call faculty must verbally notify the OB faculty **directly** and sign out to pass off responsibility for care.

7. If a day call faculty is rounding on a mom and baby, but the weekend is approaching, the day call must call the OB faculty on call for the weekend if they plan to have the OB call faculty perform postpartum rounds.

8. A billing card or e-mail detailing care given should be turned in to **Roze Murphy** by all faculty who provide care for the patients.

9. The **most upper level resident on the FP hospital service not seeing patients in the clinic** is responsible for always knowing who are the family medicine patients in the hospital. The upper level resident on call at night should **directly and verbally** notify these residents about all admissions to L & D or postpartum at the beginning of the next day's shift (at morning report). The OB pager carried by the senior resident is 9024.

Procedure:

- **Special Considerations:**
- **Related Information:**

References:

Written: 2/28/02, Dr. Sara Mackenzie
Reviewed: 2/28/02, Dr. Sara Mackenzie
Revised: 6/03/02 Dr. Sara Mackenzie and Rick Dobyns
Approved: June 2002, Drs. Sara Mackenzie and Rick Dobyns
Updated: 6/29/04, Drs. Barcey Levy, Lauri Lopp, and Rick Dobyns
Approved: 6/30/04, DFM

Guidelines for Shared Prenatal Care

Subject: Guidelines for shared prenatal care.

Family Medicine prenatal care is currently performed at the Family Medicine clinic at UIHC location and many of our affiliated clinics.

Some providers provide prenatal care but do not participate in hospital care of obstetric patients.

Goals:

1. Provide optimal OB prenatal care for all patients.
2. Maximize communication between prenatal care only providers and prenatal care and hospital maternity care providers.
3. Promote continuity of care experiences for residents and patients from outlying clinics.

Definitions:

- Prenatal care only provider: provider does not provide in hospital maternity care
- In hospital maternity care provider: provider does in hospital maternity care (takes OB call)
- Shared care: Patient is seen by the prenatal care only provider and also seen by one of the in hospital maternity care provider at least once (after 32 weeks).

Procedure for pregnant patients seeing a prenatal care only provider:

1. At 18 weeks gestation, one of the following shall occur (according to patient/provider preference) to ensure that medical and social issues have been appropriately addressed and managed:
   a. The patient will be seen in the same clinic by one of the hospital maternity care providers. Provider will ensure that pt is on shared OB list in epic.

   b. If a visit with an in-hospital provider is not possible, the prenatal care-only provider will a chart review by one of the in hospital maternity care providers in the same clinic. If none available, the prenatal care only provider will ask the OB day call faculty to review the chart. Provider will ensure that pt is on shared OB list in epic.
2. Beginning at 30-34 weeks gestation until delivery, patient care will be managed in one of the following ways:
   a. Transferring the patient to one of the in hospital maternity care providers in the same clinic or at UIHC (such as a Family medicine resident).

   b. By sharing care with one of the in hospital maternity care providers from the same clinic or from the UIHC. This entails scheduling alternate visits with a provider who provides in hospital maternity care until the patient delivers.
3. In the event that a patient needs to come to the hospital for evaluation, the prenatal care only provider will communicate with the OB faculty physician on call.
4. The medical director of each clinic will be responsible to oversee the compliance with these guidelines.

Date written: February, 2014
Date reviewed: OB faculty meeting February 2014, March 2014 and February 2017.
Date approved: OB faculty meeting March 2014.