1933

The Technic

of the

Chicago Maternity Center

FORMERLY

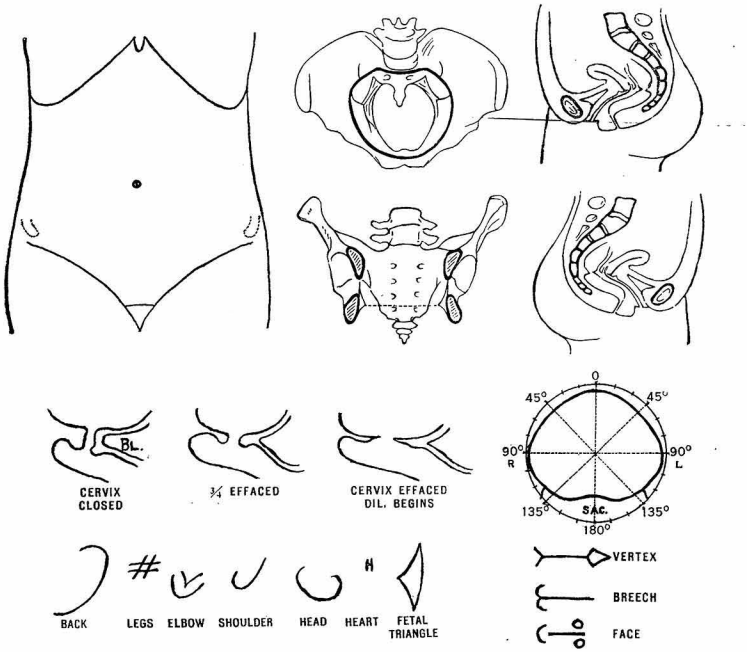
THE CHICAGO LYING-IN HOSPITAL

MAXWELL STREET
DISPENSARY

NAME_____

Date of Service_____

history-of-obgyn.com



To the Student: Our history sheets are designed to aid you in the development of habits of thinking. They teach the "Technic" of the Center and I cannot too strongly urge you to master them. Fill out the records in the presence of your patient. Even the best memory is fallible when one is rushed with work.

You should learn to visualize the conditions you meet in practice. This gives you correct impressions on which to make diagnoses and helps the mind to retain them.

Learn to draw what you see and feel, and, to help you, these sketches are recommended. A little practice with them will enable you to increase the accuracy of your mental concepts and to enrich your diagnostic ability astonishingly.

Make full use of all the opportunities for learning at the Center,—a life may hang on your possessing the knowledge at the right time.

Wishing you a pleasant and useful service. I am

Sincerely,

Aug. 1st, 1933.

J. B. DeLee, M.D.

history-of-obgyn.com

Copyrighted by
The Chicago Lying-in Hospital and Dispensary
July, 1921

Recopyrighted by
Joseph B. DeLee, M.D.
October, 1933

history-of-obgyn.com

PREFACE

THE Dispensary Technic described in this booklet was originally devised by Dr. De Lee, in 1895, to meet the conditions of obstetric practice among the very poor women of Chicago.

Although the essentials are the same, it has been modified from time to time to meet advances in our art, and many Residents, Interns and Nurses have helped with suggestions and improvements.

The principles of this system are very simple to learn, and, once acquired, will enable the doctor to care for labor cases, or even major surgical operations, with success, in the most discouraging environment.

The Hospital Technic and Standing Orders are those of standard hospitals, modified and refined for the purposes of a specialistic institution.

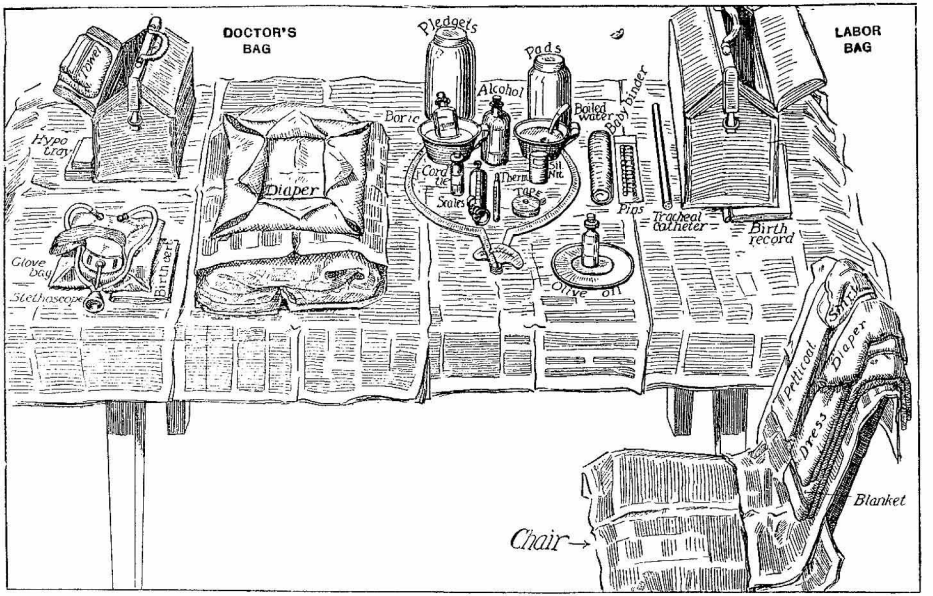
In these matters also, the Medical Staff, the Heads of Special Departments, the Superintendents and Head Nurses all collaborated to make a complete and practical system.

Naturally, the technic is changed as time goes on, and for this reason several blank pages are inserted on which these changes may be noted.

J. B. DeLee.

July, 1933

history-of-obgyn.com



history-of-obgyn.com

The Chicago Maternity Center

FORMERLY

THE CHICAGO LYING-IN HOSPITAL

MAXWELL STREET
DISPENSARY

DISPENSARY TECHNIC

ANTE-PARTUM CARE

Upon first visit and application, each pregnant woman is examined and the ante-partum record (Pink Sheet) is started, special care being taken with the previous history, the general physical examination, the blood pressure, and the urine analysis. Women should report at the Dispensary every two weeks, bringing a specimen of urine. About the seventh month, pelvic measurements are taken and recorded. All examinations and events are recorded on the Pink Sheet, which is kept on file in office.

Abnormalities are especially noted on the Application Card in red ink, and for cases to be sent to the Hospital, arrangements are made with the Social Service Department.

If the Intern makes the first call at the patient's home, the Pink Sheet is filled out with the same completeness. Take temperature, obtain specimen of urine. Diagnose presentation and position. Record findings.

Emergency cases are accepted at all times. Especially desired are calls for help from doctors and midwives and they should be encouraged to call as early in labor as possible.

CONDUCT OF LABOR CASE

Pink Sheet (Ante-partum Record) taken from file. Intern stamps "Out" on office card, using time stamp. Intern takes his bag. Student carries Labor Bag. Each pays own carfare.

On arrival at home of patient, ask members of family to clear kitchen table and to bring newspapers. If table is covered with oilcloth, remove it and cover table with newspapers. Place bags on table. Intern's bag placed on left, labor bag on right.

history-of-obgyn.com

Intern's Bag

Talcum
Safety Razor
Jar of Pledgets
Brush—Tin box of soap
Jar of pads with cord dressings and mouth wipes
Alcohol
Lysol
Hg Cl^2
Ergot, 1 dram
Boric solution
Hypodermic case
Tube of morphine
Box of ampoules
1 Ergot
1 Camphor in oil
2 Pituitrin, 1 cc.
2 Pituitrin, ½ cc.
Lubricant
Cord tie
2 prs. good gloves in boiling bag
Rectal gloves
Birth report book
Rubber apron
Stethoscope
2 towels
2 mouthpieces
1 small brush pan

Labor Bag

2 six-in. forceps
Scissors
Steel tape
Scales
Sterile douche can
Jar pledgets
Jar pads with cord dressing and mouth wipes
Tin box soap
2 brushes in boiling bag
1 pr. leggings
Tracheal catheter
Lysol, Hg Cl^2
Boric Solution
Ergot
Cord tie
Urethral catheter
Pelvimeter
4 Granite basins
(1 hand solution pan, 2 solution pans, 1 placenta pan)
1 apron (white)
2 towels
1 blue labor record
1 Pink Sheet (ante-partum record)
3 newspapers
2 capsules of Ag NO_3

Arrange articles as shown in **Fig. 1.** (Page 4)

Technic, Dispensary Method

Very different from the Hospital Technic is that practiced in the Dispensary Service. In the Hospital a large field is covered by sterile sheets and towels and is considered aseptic—clean. In the Dispensary service a small area around the vulva is disinfected and kept sterile.

N. B.—Only this small area and the things that come in contact with it are aseptic, clean. All else is infected, unclean.

The first may be called the extensive, the second the intensive method of asepsis. Anyone who has mastered the latter, the intensive method of asepsis, is competent to operate with success, no matter how unfavorable the environment. It would improve the results in the hospitals if more of the intensive methods of asepsis were practiced.

After becoming acquainted, ask the patient: 1, when pains began; 2, how often they come; 3, has the bag of waters broken; 4, when did the bowels move; 5, when did urination occur. Cover a chair with newspapers and deposit street wraps on it.

history-of-obgyn.com

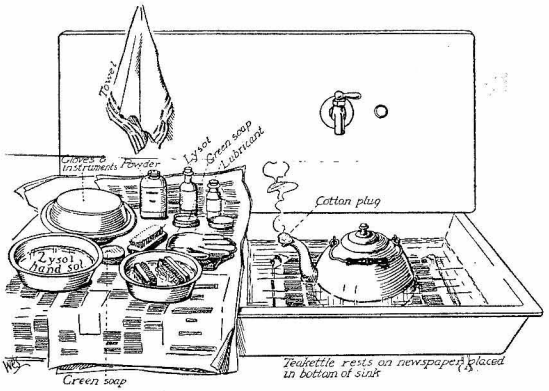


Figure 2. Sink Set-Up.

Now all wash the street dirt from hands, using a new bar of soap. Clean finger nails.

Take patient's temperature and pulse. If fever, search for cause, notify Dispensary, perhaps send to Hospital.

Fill 2 kettles with water and put on to boil, 10 min.

Whenever possible a bunch of newspapers is put in the oven to sterilize.

If Pink Sheet is incomplete, supply data.

Unless delivery appears to be imminent, give enema.

Ask husband or member of family to bring:

(1) Washtub, (2) two table boards (or an ironing board), (3) safety pins (two cards, large, one card small), (4) material for abdominal binder for mother, (5) baby clothes, (6) three cups, a spoon, and a saucer, (7) olive oil, (8) soup plate, (9) small pillow for baby.

If vermin or great poverty is found, exercise proper care without hurting feelings of family.

If in doubt whether patient is in labor or not, observe uterine action—make rectal examination. Even if case looks like a "false alarm," prepare just as for labor. Make abdominal and rectal examination; fill out Labor Record, complete the Pink Sheet if necessary, and teach student and nurse whole technic and obstetric care as if woman were going to deliver.

1.—SINK BOARD SET UP IS MADE. See Fig. 2.

Sink board cleaned and covered with newspapers.

Place on it: Soap, brush from Intern's bag, Lysol bottle, lubricant, powder, rectal glove.

history-of-obgyn.com

Hang rectal glove towel near sink so that the soiled side (or side on which rectal glove is wiped) is out.

Later will be added to this "set up"—

Hand solution,

Soap from labor bag,

Small pan with brushes in solution,

Pan with gloves and instruments.

2. NOW PREPARE PATIENT

Chair by side of bed on which patient is to be delivered is covered with paper. On it is placed:

Jar of pledgets,

Small pan filled with lysol solution (solution made by placing lysol size of a quarter in pan and then filling pan with boiled water),

Medium sized pan with 1/1000 bichloride solution,

Razor in brush pan,

Soap.

Place safety razor in brush pan; pour over it 2 drams lysol, fill pan with boiling water.

Line tub with paper and place it on floor under the bed.

Place patient across bed on the drainage pad, which drains into tub. Buttocks overhanging edge, each foot on a chair.

Cover her decently.

Draw gloves on dry hands. Wash gloves well with running water and soap.

Wet vulva and mons liberally with lysol solution. Place pledget of cotton saturated in bichloride solution in introitus.

Lather and shave field of operation, **taking care nothing gets into the introitus.**

Wash from umbilicus to near knees with soap, lysol solution, then bichloride 1/1000. Remove smegma gently. Dry with cotton.

Cover patient with clean sheet, and always remember to protect her feelings of modesty.

Lysolize and dry razor. Boil used pans 10 minutes.

3. START LABOR RECORD

after carefully reading Pink Sheet (Ante-partum Record).

Get ready for abdominal examination. Intern and student again wash and warm hands. Drape the patient decently.

Follow plan of examination shown on Labor Record, first the Intern and then the Student.

history-of-obgyn.com

In all cases the Intern should quiz student.

Be exact with pelvic measurements, and teach student to take them.

☞N. B.—Be sure not to miss a contracted pelvis and thus allow the good time for Cesarean Section to slip by.

Now examine patient's heart and lungs. Record findings.

Test urine for albumen by boiling in a spoon and acidulating with vinegar.

Rectal Examination. Progress of labor can be watched by rectal examination. Use rectal glove with lubricant. Afterwards rinse thoroughly at tap, disinfect with lysol, rinse off lysol, dry on rectal glove towel, powder, turn, replace. Remember, infection can be carried to the vulva on the rectal glove.

Make examination gently. Record findings at once.

Restrict vaginal examination to the minimum required for teaching, or if rectals are unsatisfactory. Practice rectals freely but gently. Be sure that you learn all that is necessary for conduct of case—otherwise make a vaginal.

Student must learn how to make satisfactory rectal examination. Most labors can be conducted without vaginal touch. No rectal or vaginal examinations on bleeding cases!

VAGINAL EXAMINATION (when indicated) prepare as follows:

Fold two pairs of gloves carefully, cuffs down; place in glove bag, in placenta basin; cover with water; cover with a soup plate; boil vigorously ten minutes.

Make hand solution in large pan, ½% lysol; place on sink board.

Cover bedside table or chair or washstand with newspapers.

Place on it two basins, one with 1/1000 Hg Cl_2, one with ½% lysol solution. Between the two the jar of cotton pledgets with cover loosened.

Drape the patient with knees raised and spread, lying on a pad of newspapers.

Take clean towel, fold it, lay over soup plate, covering the boiling gloves, grasp pan and cover, invert, permitting the boiling water to drain off into sink.

Place the two on sink board next to hand solution, placenta pan uppermost, plate beneath.

Remove pan, exposing gloves in bag.

Now sterilize hands. Sleeves rolled up above elbows. Clean fingernails again and scrub with green

history-of-obgyn.com

soap and much water for ten minutes, paying special attention to fingernails and creases.

Rinse hands in water, then in the hand solution.

Put both pairs of gloves on **without touching the outsides with bare hands.**

Cuffs of outer pair are rolled down a little to facilitate removal.

Patient on table, same set-up as for operative.

Wash the vulva with lysol solution and then with bichloride solution, wiping from above downward.

Leave piece of cotton saturated with Hg Cl_2 solution between labia.

Have assistant draw off outer pair of gloves.

Part labia widely, as taught, and insert first two fingers deeply in vagina, **TOUCHING NOTHING ON THE WAY.**

Observe the points in order given on history sheet and have the one not examining write, after dictation, the findings, **SIMULTANEOUSLY,** in the proper blanks.

While Intern examines and dictates, the student writes and on occasion, vice versa.

Then the student, under supervision and minute instruction of the Intern, puts on gloves and examines the patient internally.

If the case is pathologic, fill out a "Report Blank" and send it or telephone it to the Dispensary at once. Do this also if complications arise, or if case drags on too long.

4. PREPARE BED. See Fig. 3.

Select best bedroom. Remove unnecessary furniture and litter.

Retain one chair, bedside table or washstand.

Arrange bed to obtain best light.

Put two table boards or ironing board crosswise under mattress, on top of springs.

Lay clean sheet over mattress—or failing a sheet, cover with newspapers.

Cover half of pillow and middle of bed with a piece of clean oilcloth, letting it hang over edge of mattress to protect it.

Pin oilcloth to pillow and mattress, inserting two rows of pins about 6 inches apart at the foot end and distal side of oilcloth.

Make two stiff rolls of newspapers and slip between mattress and oilcloth in space formed by two rows of pins.

This makes a drainage pad and should leave a space 30 by 36 inches. It is called a "pakelly pad."

history-of-obgyn.com

Cover with a thick pad of clean newspapers. These are removed one by one as they become soiled during the labor.

Cover foot of bed with newspapers.

Place abdominal binder for mother, diaper for receiving baby and leggings from labor bag over foot of bed.

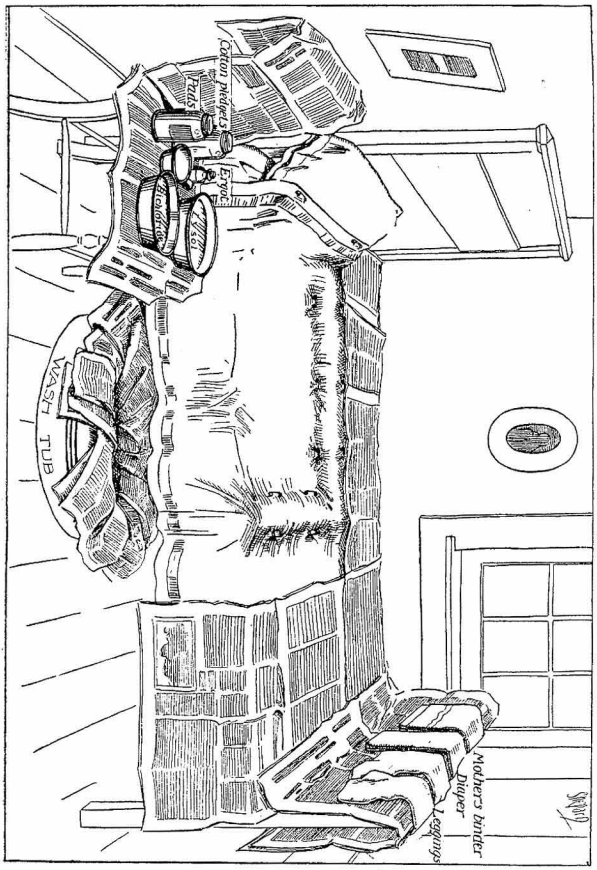


Figure 3. Bed Prepared for Delivery.

history-of-obgyn.com

5. SUPPLY TABLE—See Fig. 1.

To left of Intern's bag are placed:
Hypo syringe.
Box containing ampoules of ergot, pituitrin, camphor in oil and morphia.

To right of Intern's bag:
Empty good and rectal glove bags.
Birth certificate book.
Stethoscope.
Jar of pads and pledgets from Intern's bag.
Pelvimeter.
Scales.
Tape for cord.
Box containing ampoules of Ag NO^3.
Alcohol.
Bottle of boric is placed in glass of warm water.
Glass containing boiled water and spoon.
Rectal thermometer.
Card of small safety pins.
Olive oil and saucer in which to pour it.
A small pillow covered by newspaper and diaper.

To left of labor bag:
Tracheal catheter.

To right of labor bag:
History sheet and antepartum record.
Put folded Dispensary towel on left cover of Intern's bag, center of table.

6. PREPARATION FOR BABY

Cover a chair near the supply table with paper and place the baby's clothes on it in the order in which they are to be used, as: baby's blanket first, dress, skirt, shirt, diaper.

See that the clothes are dry and warm.

PREPARATIONS FOR DELIVERY

Take brushes from labor bag and put into lysol solution in brush pan on sink board.

Powder is washed from both pairs of good gloves.

Gloves are cuffed, fitted in pairs, placing the right glove of each pair underneath and with fingers rolled under left cuff.

Put gloves in brush bag and put in one of large pans.

Put cord clamp and scissors on top of gloves.

Fill pan with water and cover with soup plate.

Boil gloves and instruments for ten minutes.

After gloves have boiled for ten minutes, take clean

history-of-obgyn.com

towel, fold it, lay over soup plate, covering the boiling gloves, grasp pan and cover, invert, permitting boiling water to drain off into sink, and place on sink board.

Now make up hand solution in large pan from labor bag on sink board. (Lysol size of a half dollar is placed in bottom of pan and pan is filled with boiled water.)

Cover chair by bedside with papers. Put on it:

Jar of pledgets.
Glass containing a small amount of water.
Jar with wipes.
Bottle of ergot.
Two medium-sized pans, one containing lysol solution, the other bichloride solution.

Put on mouth cloth.

Same method of procedure as to sterilizing of hands, drawing on gloves and scrubbing of patient used here as when making an internal examination. See page—

The Conduct of Labor cannot be repeated here. Intern and Student should carefully study Chapter 21 in the Book. It may with advantage be taken and studied at the case.

Especially to be borne in mind by Intern (and taught the student) are:

1. Asepsis and antisepsis.
2. The presence of mechanical disproportion between the child and the mother.
3. Exhaustion of mother or child.
4. The possibility of rupture of the uterus.
5. Abruptio Placentae.
6. Eclampsia.
7. Study the mechanism of labor and discuss the causes of each movement.

☞N. B.—Remember the Great Principle of Asepsis: Gloves, vulva, inside of basins, and jars are sterile. **All ELSE is infected!** Learn how to preserve asepsis by not touching unsterile things!

If the Intern delivers, the student assists, and vice versa. The nurse assists as much as possible, but may not supplant the student, the Dispensary work being intended for the training of medical students. She should aid and instruct the student in certain nursing work.

Intern instructs student and nurse during delivery, wearing mouth cloth to avoid ejecting saliva on the sterile field and gloves, etc.

The child is laid on the diaper mentioned.

After a few minutes the cord is tied and cut.

The student takes the child and lays it in the place prepared for it.

history-of-obgyn.com

THE THIRD STAGE

The placenta basin is placed against left buttock by the student, who then guards the uterus.

Watch blood loss carefully and measure it.

Note on history sheet the phenomena of the third stage **simultaneously** with their occurrence.

Intern teaches student and nurse the mechanism and treatment of placental stage and explains the phenomena carefully.

When the signs are present that the placenta is separated and has descended into upper part of vagina, usually 25-30 minutes, student asks woman to bear down: failing which, he performs "early expression" **when the three conditions for same are fulfilled.**

Intern with sterile hands receives placenta, lege artis, inspects it carefully before dropping it into placenta basin handed by student or nurse.

Student administers dr. 1 of Ext. Ergotae fl. by mouth.

Intern inspects parts carefully for lacerations and cleanses them.

Soiled towels, pakelly pad and papers removed, clean ones put on, binder adjusted and patient made comfortable.

Count pulse and take temperature.

Make sure uterus is hard and no bleeding from vulva.

Remove board from under mattress. (Done by student under direction of nurse.)

CARE OF THE CHILD

Wash cord stump with Hg Cl_2, then put on cord dressing and belly band, on bed after birth.

Put one drop 1% Ag NO^3 in each eye.

Place on table near stove, oil with sweet oil, cleaning especially accumulations of vernix in axillae, neck, groins, vulva and hair; wipe with clean towel.

Lysolize gloves, rinse in sterile water.

Take temperature per rectum, then baby's weight and measurements, exposing it as little as possible.

Dress child neatly, and put it in its bed secure from flies, rodents, vermin, drafts, etc.

Now complete the Labor Record (Intern and student).

Fill out the child's birth certificate (Intern).

Gather all the belongings of the Institution.

Rinse out the towels and leggings (student), wrap them in clean newspapers.

Dry the gloves, pans and brushes—pack everything in the satchels in orderly fashion.

history-of-obgyn.com

Wrap wet clothes in newspapers, cover securely to avoid soiling bag.

Give definite instructions as to diet for the mother and the child.

Before leaving house see that the seven points have been attended to:

1. Uterus hard.
2. No hemorrhage from vulva.
3. Placenta complete.
4. Bladder empty.
5. Perineal tears attended to or arrangements made for later repair.
6. Child in good condition.
7. Mother in good condition.

WHEN TO CALL ASSISTANCE

If in doubt about a diagnosis and in absence of immediate danger to mother or child notify Dispensary.

If the mother has temperature above 100.5 notify Dispensary.

If any danger exists, notify Office at once, but be sure to fill out the Report Blank carefully.

If the second stage lasts over two hours.

If the fetal heart tones indicate a possibility of asphyxia in utero.

All breech cases (operative set-up).

Twins.

Notify Office immediately on discovering any present abnormality—even if you think the case will terminate happily. The Dispensary can thus save time in locating an Attending Surgeon.

SENDING PATIENTS TO HOSPITAL

All complicated labors, including those with fever, must go to the Lying-in Hospital if they are not treated at home.

These cases go when possible: Eclampsia, placenta previa (pack vagina only if dangerous bleeding), shoulder presentation; breech in primiparae; contracted pelvis; pathologic first stage; twins; complete laceration of perineum; fever in labor.

Telephone Dispensary for ambulance. While waiting, get patient ready—clean binder and pad; warm blankets; hot drink.

If case is for Cesarean Section, scrub belly with soap and water, dry and cover with clean towel.

Intern and student accompany patient to Hospital and remain until case is terminated.

history-of-obgyn.com

PREPARATION FOR OPERATION AT HOME

Select best room as to light and space. Fig. 4.

Table from kitchen or dining-room for operating table. Never use bed.

Fold a blanket on it smoothly, and cover with newspapers.

Next pakelly pad, pinned securely to blanket and draining into dishpan.

Side table at right of operator. If no table at hand, use two chairs with table board and cover with five layers of newspapers.

This table carries one basin 1% lysol solution, 1 basin 1/1000 Hg Cl_2; 1 jar of cotton sponges; instrument pan with room at its side for the inverted cover for same.

To make a pakelly pad, make a roll of newspapers with a string in center and bend this roll, tying the string ends together to make a half ring, and cover with newspaper and pin securely.

Open Operative Bag in clean place. Invert cover to act as temporary receptacle for unused supplies.

Keep all supplies in bag and covered until needed, but arrange them in same handily.

Have hypo. and medicines on top, in sight.

Select instruments for particular operation intended.

Do not boil craniotomy set as a routine.

Balance of instruments arrange neatly and accessibly in cover of bag.

Arrange instruments systematically in boiling pan.

Put in a little soda bicarb, 1 inch boiling water, and place over a hot fire.

Boil vigorously with cover on for ten minutes.

Slip towel through hooks on pan, pour off excess of water in sink, let cold water from tap flow over top of pan till cooled.

Put pan still covered on the right end of side table. When needed invert cover alongside of pan to act as tray.

Place new brushes in brush basin, replace empty green soap boxes.

Fresh leggings on patient.

Place new or reboiled basins on side table.

Reboil gloves as described in normal labor.

Place ether mask and ether at head of table. Fig 5.

Pillow covered with a towel, nearby for the baby.

Tracheal catheter placed near to pillow.

Intern on case assists Senior Intern, who assists Operator.

Students help prepare room and table. Extra Intern gives ether.

history-of-obgyn.com

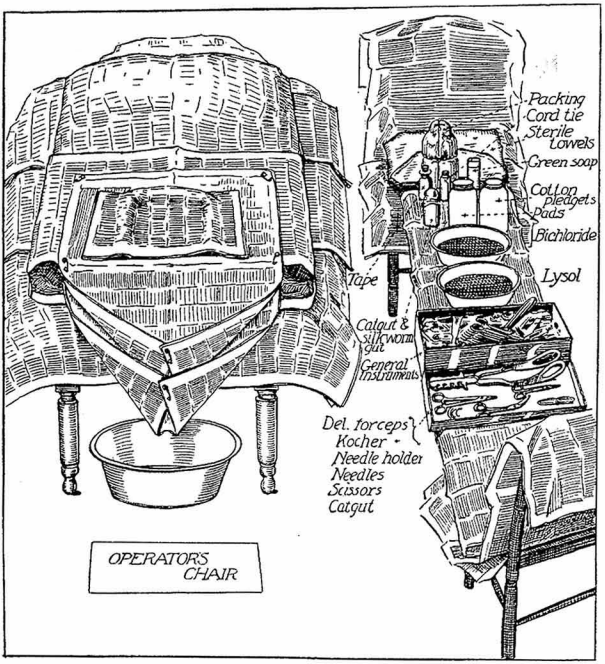


Figure 4. Table and Side Table for Obstetric Operation.

Head nurse instructs Intern and students in technic.

Students carry patient to table.

Lithotomy position, buttocks well over edge of table.

Senior Intern washes lower abdomen and operative field with green soap, 1% lysol solution and then with 1/1000 bichloride, ☛**taking care nothing is washed into introitus vaginae.** Hold sterile pad over introitus while washing.

Sterilized towel laid over belly.

Intern changes gloves or lysolizes them thoroughly.

Catheterize.

Flush out introitus and lower vagina with both solutions liberally.

N. B.—Remember that only the sterile towel, the area around the vulva, the gloves, the inside of instrument pan and basins are sterile—**all else infected.**

If unsterile object is inadvertently touched, lysolize gloves or draw on new ones.

history-of-obgyn.com

Child is handed to Intern on case who watches it, after putting it into place prepared for it. Uterus is guarded by the Senior Intern, through the sterilized towel.

Placenta received in placenta basin—is inspected before being taken away from the operation, and inspected again when the history sheet is being filled out.

Both Operator and Senior Intern examine the woman for injuries.

Catheterize, examine rectum for injuries.

Senior Intern cleans up patient—students carry her to bed.

Nurse instructs one student how to clean the baby, while Intern and students clean the instruments, as follows:

Scrub with brush in cold water; rinse; place back in pan; pour boiling water over them; add lysol; shake, and dry instruments out of this hot lysol solution. (This prevents rusting.)

Woman from house asked courteously to wash and rinse the bloody towels, leggings, etc. If refuses, student and nurse do it.

Wet and soiled articles are rolled in newspapers to protect the satchel from contamination.

Pack bag neatly.

Forget nothing. Remember to keep all Operative Bag supplies together, **in bags and covers,** but exposed in orderly fashion.

Now complete history sheet (Senior Intern on case).

Record the baby's measurements accurately.

Describe operation minutely, getting information from the Operator.

Discuss points of interest with the Operator.

Before leaving house see that the seven points are attended to, and give instructions as to diet, medicines, and general care.

PUERPERAL CARE

Intern visits puerpera 3rd and 10th day.

Senior Intern visits his own operative cases.

Student and nurse every day.

Both Interns and students should make as many post-partum visits as possible. Post-partum instruction is an important part of the Intern's duties. Both students as well as Interns lose much of value if this portion of their work is neglected.

Observe conditions and then fill out carefully all the blanks on the post-partum record for the day.

history-of-obgyn.com

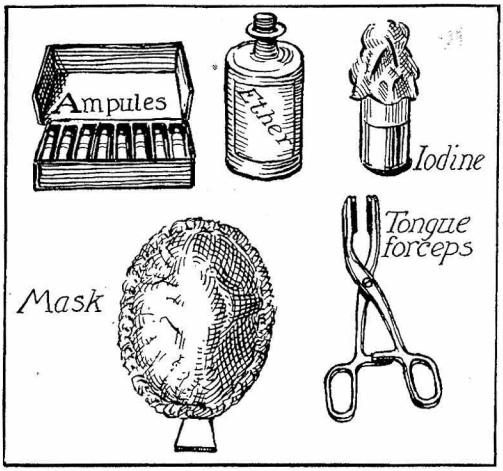


Figure 5. At Upper Corner of Table for Anesthetizer.

Nurse instructs students how to oil and dress the baby. Student teaches nurse physiology of puerperium and first days of the infant.

Cord is dressed only if necessary—(moist, smells, dressing displaced).

Mother is dressed by nurse, baby by student.

Nurse makes 1/1500 Hg Cl_2 solution (2 tablets), places it on a chair on newspaper beside bed with open jar of cotton pledgets beside it.

Sterilize hands.

Vulva is gently sponged with solution and clean pad and binder applied. **Pad to be very loose** (not to dam back the lochia).

Note condition of perineum.

Give accurate instructions regarding diet, bowels and urinating.

Warn patient against touching genitalia and breasts.

She is taught to use cotton as pads. On third morning give Ol. Ricini.

history-of-obgyn.com

EMERGENCIES

Intern must always be on lookout for anything abnormal, should study carefully the mechanism of labor and early recognize, so as to promptly treat, disproportion between fetus and pelvis, irregular mechanisms, and complications.

Do not give pituitrin before the third stage, unless ordered by Attending Surgeon. Breaking this rule is the same as a resignation.

RUPTURE OF UTERUS

Threatened. Painful Pains—no progress in labor in spite of good pains, nervous, anxious patient, complains of pain and soreness over hypogastrium, supports sides of uterus with hands. Rapid pulse. Uterus hard and drawn up above fetus. Contraction ring near navel. Round ligaments prominent, tight and tender. Cervix imprisoned, swollen, vagina hot and dry.

Actual Rupture. Symptoms of shock and internal hemorrhage. External hemorrhage. Uterus changes shape. Baby dies. Baby felt free in belly with empty uterus alongside. Pains cease. Vaginally, presenting part has receded or disappeared, may feel rent of intestine.

Treatment. If rupture is threatened send for help instantly and while waiting keep parturient deeply anesthetized with ether. Never send a patient to the hospital with a uterus threatening rupture. In actual rupture send for help at once and treat symptomatically in the meantime.

EXHAUSTION

Every labor must be watched for its effect on the strength of the woman. The Intern should examine the woman's heart and observe how it stands the strain. Remember we watch the woman to see, not how much she can **endure,** but how much she can **accomplish.** When progress ceases, we have to procure rest for recuperation or perform operative delivery.

POST-PARTUM HEMORRHAGE

During labor watch for exhaustion and guard against weak pains in third stage by proper conduct of first stage and second stage. If history of p. p. hem. use standard prophylaxis.

If hemorrhage **before placenta is born** massage uterus briskly. Catheterize, express placenta, and if need be, remove manually.

history-of-obgyn.com

Reboil or lysolize gloves, flush vagina freely with both antiseptic solutions, put hand in under drenching of lysol solution. Be sure to remove all of the placenta and the membranes. Massage uterus, ergot, pituitrin.

After placenta is born if too much flow, massage uterus; express clots; ergot and pituitrin; and if these are ineffectual, give a hot uterine douche of ½% lysol solution, inserting the hand and clearing the uterus of clots, etc.

In the meantime have husband or neighbor (not student) notify Dispensary to send Emergency Satchel and help.

After hemorrhage controlled, give hot coffee and salt solution per rectum, etc.

ECLAMPSIA

Watch for premonitory symptoms, headache, spots before the eyes, epigastric pain, edema, etc. Test urine by boiling in a spoon and acidulating with vinegar. Notify Dispensary at once. Patient will be sent to Hospital. Do only that which is needful to protect patient from injury until instructions come. Use covered clothespin to protect tongue. Watch patient carefully.

ASPHYXIA NEONATORUM

Watch fetal heart tones very carefully. Listen every 20-30 minutes in first stage, every three minutes in second stage. Gradual slowing or hastening of fetal heart requires redoubled attention.

Notify Dispensary if any signs of fetal distress begin, such as slow or rapid or irregular fetal heart, discharge of meconium, too active fetal movements, etc. Report too early rather than too late.

ABRUPTIO PLACENTAE

Sudden severe pain in belly, fetal motion ceases, belly hard, uterus boardlike, signs of internal and external hemorrhage. Notify Office at once; send to Hospital. Very tight abdominal binder, and if critical, ergot and pituitrin, half of usual doses.

PLACENTA PREVIA

Painless causeless uterine hemorrhage in latter months of pregnancy. Child alive, uterus relaxed or contracting normally. External hemorrhage compatible with patient's symptoms of blood loss. Notify Office at once. Elevate foot of bed, if flow too profuse, pack vagina temporarily; tight binder. Hospital.

history-of-obgyn.com

PROLAPSE OF CORD

Send for help at once.

Replace cord at once in vagina after disinfecting it.

Put patient in Trendelenburg position using a kitchen chair well padded with pillows.

Hold head or breech up out of the pelvis with gloved hand until help arrives.

See that hot and cold sterile water are prepared for the eventual operation.

If B. of W. intact be careful not to rupture it.

If pains too strong to permit above method have patient work her best to hasten delivery. Episiotomy if necessary.

TREATMENT OF ABORTION

Threatened Abortion as shown by uterine pains, uterine hemorrhage. Rest in bed; morphine gr. ¼ by mouth every 4 hours for three doses. Make no vaginal examination unless flow considerable. Rectal. If vaginal examination is to be made—prepare as for labor.

Inevitable Abortion, as shown by severe uterine pains, considerable hemorrhage, opening of the cervix, presentation of ovular parts. Prepare parts as for labor, pack cervix with piece of four inch gauze and vagina evenly and smoothly with dry 3X cotton. Notify Office.

Eighteen or not later than 24 hours after this, remove tampon, everything having been prepared as for any obstetric operation. If cervix open remove ovular mass with fingers, following with light curettage. Pack only if need be for hemorrhage. If cervix not dilated, pack again as before.

Next day prepare for dilatation and curettage on removal of tampon.

"REFUSED TECHNIC"

The rules of the Dispensary must be carried out, and by using tact, gentleness, and infinite patience, almost aways, they can be. ☞Remember that you are building your own character, and treat each poor woman as you would wish your sister to be treated. ☞Never forget your professional dignity and combine it with kindness.

If patient refuses and if you cannot get her husband or a good neighbor to persuade her, you must discharge the case, but must remain in the house until a doctor or a midwife arrives.

history-of-obgyn.com

DISCHARGE OF PATIENT

Obtain all information necessary to fill blanks on history sheet, and fill same.

Form careful opinion of patient's general condition and if it is proper to discharge her.

Advise to report at Dispensary eight weeks after labor for final examination.

FALSE ALARMS

Not always easy to tell if a woman is in actual labor or not. If regular pains at intervals of 20 minutes are present and the os is thinning, the patient is in labor. Intern may absent himself for a few hours, but student should stay at bedside. If uterine contractions are absent and os not dilating, the case may be "false alarmed." Leave instructions to call immediately upon the resumption of uterine pains. Order sample of urine brought to Dispensary.

REGARDING "PRECIPITATES"

If child and placenta are born before arrival of Dispensary officers, wash vulva with lysol solution, clip longest hair with scissors (do not shave), inspect for tears. Do not carry infection into fresh wound. If tears present arrange for operation later. Inspect placenta carefully.

If child born but placenta not, treat in same manner, being careful not to get hair, etc., into vagina.

If child not born but coming so rapidly that complete technic not possible, place patient on clean sheet, draw on gloves, lysolize them while student makes strong **lysol solution,** then wash vulva liberally with same, letting the child come without manipulation. If time, clip long hair, sponge parts liberally with lysol and bichloride solutions, keeping any kind of soil out of the vagina. In meantime boil up gloves for possible post partum hemorrhage. Don't hold head back forcibly.

CLINICS AT DISPENSARY

One Intern, one student, and one nurse to each examining room, Senior Intern or Attending Physician gives a demonstration to the assembled students on the methods of washing gloves in preventing the carrying of contagion from one patient to the other

history-of-obgyn.com

PREPARATION OF HANDS

Wash hands with soap and water. Dry, powder, draw on gloves. Wash gloves thoroughly with soap and water, scrub in 1/500 bichloride, wash in 1/1500 bichloride, make examination.

After the examination, rinse the examining fingers carefully in running water, rinse the same hand, rinse the two hands well, then put soap on hands and rinse very thoroughly. Before next examination wash again as above.

Intern examines first, then the student, the Intern instructing him. Attending Surgeon then examines and lectures. ☞ Great gentleness and consideration of the sensitive patients' feelings.

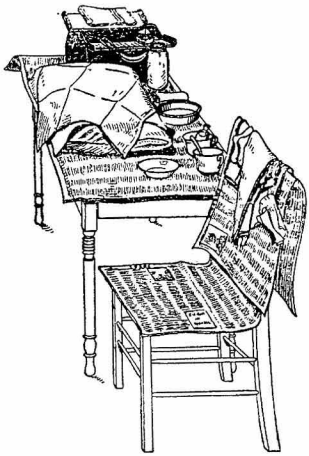


Figure 6. Set-up for Postpartum Call. To dress baby.

history-of-obgyn.com

POST PARTUM CALLS

Student and nurse visit patient daily for 12 to 14 days postpartum. The Intern visits her on the third and the tenth days and as much more often as is possible or necessary. The importance of postpartum visits is usually not appreciated by the Students and Interns. Both may learn much, and frequent visits also improve the Service.

Contents of Bags Used on Calls

WINTER BAG	SUMMER BAG
Boric sol.	Boric sol.
Bichloride	Bichloride
Cord-tie	Cord-tie
Jar of pledgets	Jar of pledgets
Jar of pads	Jar of pads
Brush	1 Brush
Box of Soap	1 Box Soap
Apron	Apron
1 Towel	1 Towel
1 Basin	2 Basins
	Powdered soap
	4 Sterile wash cloths

In winter olive oil and in summer castile soap and water are used for the baby's bath. If gloves are used, add two boiling pans.

PREPARATION IN THE HOME

Arriving in the home, place bag on kitchen table covered with a clean newspaper. Open bag—wash hands thoroughly, drying them on towel from bag. Put on apron.

Obtain the following articles from home:

Clean newspapers,
Complete baby outfit,
Olive oil, two tumblers, spoon, saucer.

See that kettle of water is boiling on stove.

history-of-obgyn.com

GENERAL SCHEME OF TABLE

Arrange table as shown in diagram. Place chair covered with clean newspaper to right of table, for the baby clothes and soiled linen.

Put 4 tablets of bichloride in small basin.

Fill basin full and tumblers half full with boiled water.

Remove tops from

a Thermometers
b Cotton jar
c Boric bottle
d Soap box

Place tops on lid of bag.

Arrange baby clothes on chair to right—

a Large blanket
b Dress
c Shirt
d Diaper
e Abdominal binder

CARE OF BABY

Wash hands thoroughly with brush and soap, dry on towel from bag, place cotton sponges in jar cover on lid of bag. Bring baby to table and put **Boric Sol. to the eyelids, face and scalp.**

Take piece of cotton, pull apart and saturate with Boric Solution.

Draw gently over eyes, beginning at inner angles, making one sweep to outer angles.

NEVER REWIPE OR WIPE BOTH EYES WITH SAME PIECE OF COTTON. USE FRESH COTTON.

Note and report any discharge. Office or Intern will order daily irrigations of $KMNO_4$, 1/6000.

Face and Scalp. Now gently sponge rest of face and scalp with Boric, dry head with towel underneath baby.

Take temperature per rectum.

Examine Cord and Navel.

Now remove all the baby's clothes, put on chair to right.

Redress navel stump only—**if soiled—if bleeding.** (In this case retie and report to Office.)

Watch closely for pus discharge; see if navel moist, purulent or fetid.

Office or Intern will order daily 50% Alcohol Dressings.

Olive Oil Bath

Oil baby all over, paying special attention to neck, axillae, and groins. Then rub off the oil gently, using a warm towel.

history-of-obgyn.com

Dress Baby

Binder.
Put on snugly and pin on side or front.
NEVER PIN IN BACK.
Place diaper under baby.
Bring up left corner over belly, hold with two fingers.
Turn up right corner.
Lower corner is brought up between legs.
Insert pin crosswise.
GIVE LEGS PLENTY OF ROOM.
Next the shirt and dress.
Put on neatly and fold back cuffs if too long.
Blanket.
Place baby diagonally on blanket.
Bring up lower end, then left end and right end in back.

Give Baby Two Teaspoonfuls of Boiled Water

Be sure water is not too hot.
(Test on back of hand.)
To open baby's mouth squeeze cheeks in a little.
Feed slowly.

CARE OF MOTHER

Put gloves on stove to boil for five minutes.

Preparation

Place following articles on chair covered with newspapers at head of bed:

Jar cotton sponges
Jar vaginal pads
Basin bichloride sol.
Remove tops.

Put "T" bandage at foot of bed.
Place pad of newspapers under patient.

General Observation

Countenance: happy, dull or flushed, as if feverish, pain, dry, moist, fetor ex ore.
Note tongue: clean or coated.

Take Temperature

Pulse. Rate and quality.

Examine Breasts

Consistency, engorged.
Tenderness.
Nipples: fissured or inverted.
Secretion: amount, colostrum or milk.

history-of-obgyn.com

Remove Abdominal Binder and
Palpate uterus.
Size and location.
Height above symphysis.
Consistency.
Tenderness.

Now Scrub as Follows:

Wash hands thoroughly with brush and soap.
Draw on gloves. (If no gloves, use bichloride sol.)
Put cotton sponges in bichloride sol.
Have patient pull up knees and push back bed clothes.
Beginning just outside vulva, gently sponge the secretions away, ☞ **allowing nothing to drip over the introitus.**
Stroke outward, using the cotton once only.
Then gently separate the labia majora and pour the contents of the pan over the introitus.
Put on vaginal pad.
Remove newspapers from under patient.
Put on "T" binder, pins crosswise, darts on sides.
Put on clean nightgown, arrange pillow and comforters.

CARE OF BREASTS

Engorged:
Put on tight binder.
Slip binder under shoulders.
Have patient hold up breasts.
Pin snugly, pins lengthwise.
Put in darts on side of first row of pins.
Restrict liquids.
Fissured Nipples
Office or Intern will order:
Mild cases—2% $AgNO^3$ applications.
Severe cases—Lead nipple shields, or dry method.

CLEANING UP

Wash thermometers with brush and soap.
Fill basins with water and boil on stove while filling out history sheet.
Make out history sheet. Fill out in detail, recording all abnormalities, so that Mother and Baby may be put under special care by Office.
Replace articles in bag. Be careful to keep bag clean and dry.

history-of-obgyn.com

GENERAL RULES FOR POSTPARTUM CALLS

When to Give Castor Oil

1. Mother—1 ounce on morning of 2nd day.
2. Baby—About 15 m. morning of 2nd day.
3. **Temperature 100° F. or Over.** If abdomen is tender also, put in Semi Fowler position.
4. No bowel movement since last post call.

Students must not prescribe for patients. Report abnormal conditions to Office. Intern will prescribe.

Student and nurses will carry out carefully all orders as noted on white slips attached to History Sheet.

Warn patients against touching nipples or genitalia.

Teach how to use cotton as Vaginal Pads.

BABY

If baby's breasts are engorged, protect with cotton and put on snug binder. Mother must not squeeze breasts.

Be alert at all times for peculiar crying and breathing, skin eruptions, discharges, paralysis, etc. Report same to Office so that baby may be put under special care.

STILLBIRTH

Care for mother as follows:
Cotton under arms, between and under breasts.
Hold up breasts firmly and apply binder **tightly.**
Give $MgSO_4$—1 oz. every other day.

STANDING ORDERS FOR SEPTIC CASES

To Be Carried Out Only by Order of Intern

Put patient in Semi-Fowler position.
Ice bag to abdomen.
Give cathartic (Saline).
Prescribe:
Fluid Ext. Ergot M XV
Fluid Ext. Hydrastis M XV } Every 6 hours.
☞ Be careful not to get hands or clothes infected.
Use red p. p. satchel and get special instructions.

history-of-obgyn.com

DUTIES OF THE INTERNS

1. They shall be regular graduates in medicine, and shall reside in Dispensary.

2. They shall be bound in honor to serve six months, and shall, if they leave before the completion of this period, refund the salary paid them.

3. They shall be present at the regular visits of the Obstetricians except when busy in the service of the Institution.

4. They shall visit each puerpera at least twice during her lying-in, and report to the Head Nurse all abnormalities in either mother or babe.

5. They shall attend to no other business than that of the Institution; shall not leave the Hospital or Dispensary without notifying the Head Nurse at the time of departure, and shall enter their time of arrival in a book provided for the purpose.

6. They shall, when notified by the Head Nurse or clerks, **immediately** respond to calls to cases, and take with them one pupil. The time of starting is to be recorded with the time stamp.

They shall gently, carefully and thoroughly examine each patient, making a full record of the same on the history sheets. Every case must have a record.

7. They shall instruct the pupils in the management of labor according to the plan adopted by the Dispensary, and taught by the Director, and shall attend the cases from beginning to end.

The student is to be allowed to examine every case to which he is assigned where such examination does not endanger the patient, but always in the presence of the Intern.

8. They shall report **immediately** any abnormal condition in a given labor to the Head Nurse, who will notify the Director and the Obstetrician on service, and, before the arrival of the latter, shall do only that which they consider necessary for the safety of the mother and child.

(a) They shall use the blanks provided by the Dispensary for this purpose.

(b) In the absence of the Head Nurse the report is to be made to one of the Attending Surgeons.

(c) They shall make a complete physical examination so as to be able to report fully to the Attending Surgeon.

9. They shall have two weeks' vacation during the middle of the six months' service, but must supply a satisfactory substitute.

history-of-obgyn.com

10. They shall be responsible for the treatment of all patients, must be ready to render a report of same to the Attending or Head Nurse at all times.

11. They shall superintend the writing of histories by pupils; also the urinalyses and blood pressures.

12. Leave of absence once each week, from 1 p. m. till midnight, is granted.

13. They shall report at the office on return from a case, stamp the time of return on the call card, and turn the satchel over to the Clerk complete and in good condition.

14. They shall write the histories of all abnormal cases or operations before leaving the patient's house, and make special analyses as the Obstetricians may direct.

15. They shall not prescribe for any one but the patient in the performance of their duties, and shall under no circumstances accept money or other gifts from patients for services rendered, and **shall not engage in practice** for their own account. Moneys given Interns by patients, belonging to the Institution, and must be turned over to the Nurse in Charge, who will issue receipts therefor.

16. The Succession of Cases. Patients will be assigned in rotation of seniority. After returning from a false alarm the Intern goes to the end of the list, but the student is sent out on the first call after reporting back. On recall the same Intern responds if possible. Precipitates and abortions count as cases for Interns. The anesthetic for an operative delivery is to be given by the Intern next on the list unless he is the senior, then the next Intern shall give it.

17. The Internes are responsible to the Head Nurse of the Dispensary, and, while at the Hospital, to the Superintendent of Nurses there, and should look to them for instruction regarding the work of the Institution.

This rule has been found necessary because of the frequent changes of Internes. The Head Nurses are permanent and know the policy and technique of the Institution. The Internes, if they give it a moment's thought, will appreciate the wisdom of this rule and aid in the conduct of the Institution.

18. The Internes shall keep a careful record of the work performed by them and give a copy of same to the Head Nurse on the completion of the service.

history-of-obgyn.com

RULES FOR PUPILS

1. Rooms will be assigned pupils on the payment of the fee for the two weeks' service, and after signing the rules for the government of students.

2. Pupils must devote their entire time to the Dispensary, and if wishing to leave before the completion of their service must give forty-eight hours' notice.

3. All pupils are under control of the Internes, and may be denied the use of the Dispensary by the Director for infraction of the rules governing it.

4. They shall obtain meals in the neighborhood at their own expense, and report to the Head Nurse upon leaving and returning to the Dispensary.

5. On assuming the service in this institution all students and physicians must carefully read and sign these rules for their guidance and profit and for the benefit of the Institution.

6. REGARDING ASEPSIS.

(a) For two days before coming on duty the pupil should not have had contact with pus, infectious matter, or contagious disease of any kind.

(b) He should notify the Head Nurse if he has been thus exposed and tell what precautions he has taken.

(c) He shall, during his service, most conscientiously and unremittingly carry out the precautions instituted by the Dispensary, for the prevention of puerperal infection and other puerperal accidents.

(d) HE MUST NOT during his service come in contact with pus, infected lochia, or any infectious matter, or contagious diseases of any kind, and if by accident he does so, he must notify the Head Nurse at once and not visit another case till permitted.

7. REGARDING HISTORY WRITING.

(a) The first duty of the student is to study a labor record, and learn the sequence of the points in the diagnosis and conduct of labor.

In the "Practice of Obstetrics" and "Obstetrics for Nurses" of Dr. DeLee and Dr. Bacon he will find other information of the technic practiced.

(b) Labor records must be filled out **at the bedside,** and finished as completely as the conditions allow, all possible information being obtained.

(c) Post-partum records also are to be accurately filled out, **AT THE BEDSIDE.**

(d) Each labor record must be carefully copied in full, and before leaving the student must see that all his history sheets are written up to date.

history-of-obgyn.com

This is part of the student's instruction.

(e) A birth return must be filled out at the labor and returned with the labor record.

(f) Ask the Internes or Head Nurse for further information.

8. Students are urged to pay particular attention to the post-partum calls, and make as many of them as possible. They are an essential and most important part of the service.

9. Students may not criticize the work of the Visiting Nurses. Suggestions regarding same may be left with the Head Nurse of the Dispensary.

10. Students are to ask information from the proper sources on all irregularities met with in the condition of the patients. THEY ARE TO TRUST NOTHING TO THEIR OWN SKILL, and must always remember that the highest welfare of the patients is vital to the conduct and growth of the Institution.

11. Students are not allowed to make internal examinations without permission.

13. SMOKING WITH ONE EXCEPTION IS ALLOWED IN NO PART OF THE BUILDING.

14. Card playing is not allowed. When not working, the student should be getting sleep, or reading. The service is so short that the student should not waste a minute of it. The opportunity is rarely repeated.

15. Students are responsible for the good care of the labor satchels, etc., and for their return to the office in good condition, and complete. Do not stain them with blood, etc. Wrap wet towels, etc., in newspaper.

16. Students are not to absent themselves from the Dispensary on other than Dispensary business, without the permission of the Head Nurse.

17. They shall attend cases in regular rotation with the Internes.

If absent on their own pleasure when they come "on turn" they lose their turn; but if on duty in the service of the Dispensary, they receive the next case coming in, after they report "back."

18. They shall visit each case twice daily for the first four days, then once daily till the ninth day, or longer if necessary. Should the case live more than thirty minutes from the Dispensary one visit daily is required.

19. They shall keep a record of the condition of mother and child on the history sheets provided by the Dispensary. They shall also fill out the records for the labors, a copy of which they may keep for future reference.

history-of-obgyn.com

20. Pupils must not prescribe for any member of the household of the patient they are treating, and shall not accept any money or other gift from the patient or friends, **nor shall they engage in practice for their own account.** Money given by patients belongs to the Institution.

21. They shall not visit a case in charge of another pupil, to which they are not assigned, except by special permission of the Interne.

22. In abnormal cases they should immediately notify the Head Nurse, who will notify the Director. They should always use the forms provided by the Dispensary and fill out all the items.

23. Each pupil shall, before going on duty, deposit with the Director the sum of $5.00 as a guarantee that he will serve his full two weeks and to cover the cost of breakage and loss. This deposit is forfeited if the students leaves before the time of service is completed or is dismissed.

24. The service of the student shall begin at 10 a. m. of the first day, and shall terminate at 10 a. m. of the fifteenth day thereafter, or after he shall have made and recorded his post-partum visits for that day, and shall have completed his history sheets up to date.

25. The student is to keep an accurate record on the blank provided of all the work he does and give a copy of same to the Head Nurse on the completion of his service.

26. Each pupil will receive a certificate at the end of his service (signed by the Directors), providing he has done his work faithfully, and to the satisfaction of the Medical Board.

history-of-obgyn.com

HOUSE RULES

1. Smoking, spitting, card playing and the use of alcoholic beverages are prohibited in all parts of the Hospital and Dispensary. Students during the two weeks are guests of the Board of Directors and are expected to act as such.

2. Rooms must be kept in order, no cooking, etc., being permitted in them.

3. Articles of value must not be taken to the Dispensary, as it will not be responsible for their loss.

4. Pupils are requested to be economical with electric lights and with supplies of the Dispensary.

5. Wet preparations shall not be kept in the house longer than thirty-six hours, unless put into hardening fluid.

6. All preparations, placentae, etc., belong to the Institution, but may be given away at the discretion of the Director.

7. Students are admonished to be quiet, in their rooms, going up and down stairs, at all times, because of others who may be sleeping.

8. Students are not allowed to sit or loiter about the door of the Dispensary, or about the office.

9. Students may use telephone booth in Social Service Room.

10. History sheets are to be in the rack always, except when being copied or at a case.

history-of-obgyn.com

history-of-obgyn.com

history-of-obgyn.com

history-of-obgyn.com

(As of 1931. Many changes of detail have been made since then, but the principles remain the same.)

ADMISSION OF PATIENTS

Women may engage beds in advance, but with the understanding that it is not always possible at the time of admission to assign the room engaged.

Women who occupy private rooms must employ a private physician or engage a member of the Staff. These paying $5.50 a day or less may have the Intern's services.

Emergency cases admitted at all times, and every patient entering the Hospital does so with the understanding that should complications arise needing special treatment, she will go to the Mother's Aid Pavilion.

Immediately upon entry the receiving clerk fills out the large administration card, obtaining the information from the husband or near friend. If the admission card is found in the file, it is completed and sent with the patient to the ward, otherwise a new one is filled out. This card is attached to the history sheet, and accompanies the patient throughout the Hospital. It goes with her to the Birth Room or Operating Room and comes back to the ward. The Intern or attending physician writes her discharge upon it. ☞The Antepartum Record (Pink Sheet) must also be sent up with the patient.

When a child is born, the Office is at once notified. A blue Child's Admission Card is filled and the entry number inscribed. These two cards accompany the patient and baby throughout the Hospital and to the door on their leaving. Unless the discharge is written and signed, patients may not leave the Hospital.

The large cards are filed by the clerk in numerical order for administration purposes. The admission cards are filed alphabetically for the registrar of medical histories.

The clerk must see that entry numbers are properly inscribed on both admission cards, the blue and white, and on the history sheets.

history-of-obgyn.com

The Registrar must see that the history sheets are properly numbered, and that the diagnoses are written, and that the records are completely filled out, including the graphic temperature and pulse charts. Notable features of each case are to be recorded on the physician's history. The nurses' records are tied in bundles of 100, the physicians' records are prepared in bundles of 200, ready for the book-binder.

RECEPTION OF WARD PATIENTS

As soon as these cards are written (and before, if the case appears urgent) the clerk notifies the floor to which the patient is assigned, for a nurse to come for her, and at the same time informs the Intern on Birth Room duty.

If a House case, the patient goes to the Receiving Room. Here the nurse takes the temperature, pulse and respiration, and asks if there is sickness in patient's home, and examines for vaginal discharges. If there is fever or skin eruption, or pus, etc., nurse summons Intern, and patient is sent at once to the Mothers' Aid Pavilion.

Patient is undressed (nurse watches for pediculi and cimex), shaved, bathed—dressed in clean clothes and sent to the North Birth Rooms; specimen of urine to laboratory. If in labor, the urine is sent to Birth Room with patient.

Her clothes are carefully listed, packed, labelled, and sent to the locker room.

PRIVATE ROOM CASES

Nurse from floor is summoned. If patient is in active labor she goes direct to the East Preparation Room on the 6th floor. Specimen of urine goes with her. If not, she goes to bedroom, undresses, and is observed for a while, then goes to Preparation room. Nurse takes temperature, pulse and respiration, observes suspicious discharge; colds; inquires about infection at home; sends speciment of urine to the laboratory. If anything suspicious is found nurse notifies Head Nurse, who calls Intern.

Aseptic Technic

This is the same as in the surgical operating rooms of the best general hospitals. We emphasize the dangers of spit and air infection, and carry out the details of asepsis painstakingly and consequentially in all labors just the same as for laparotomy. If a case is the least suspicious of being infected, it is at once isolated in the Mothers' Aid Pavilion.

history-of-obgyn.com

All physicians and nurses in the Hospital are cautioned against any letting down of the severity of the aseptic technic. An occasional unavoidable error may be pardoned, but no change of the prescribed technic will be permitted. If any alteration of the methods appears desirable to either physician or nurse, the suggestion should be put in writing and given to one of the Attending Physicians or Superintendent of Nurses, who will present it to the Staff.

Head and mouthpieces are worn by all attendants on a woman in active labor. White suits are also provided.

Anyone who must combine active attendance upon infectious cases and work in our Hospital should use extraordinary precautions to preserve his hands, clothes and person from being the carriers of contagion.

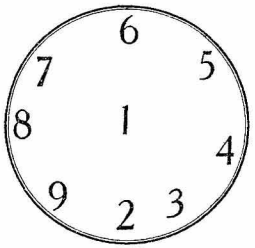
Interns on duty at the M. A. P. are not permitted in the Hospital except by special permission from the Attending Physician.

All the material used at labors and operations is sterilized under high steam pressure in copper drums, the sterilization being controlled by the Diack tubes.

history-of-obgyn.com

CONTENTS OF THE DRUMS.

Labor Drum.



1. 2 Placenta basins
2. 1 sheet
3. 1 abd. binder and pad holder
4. 2 vulva pads
5. 2 pkgs. of 6 drawn gauze sponges
6. 4 towels
7. 3 towels
8. baby receiver, weighed and noted
   (binder with safety pin
   (cord dressing
   (1 cord tape
   (2 tapes with number
   (for mother and
   (baby *
   (4 mouth wipes
   (1 small towel
9. 1 pr. muslin leggings

On top of these is placed in order from below up, the following:

10. 1 small turkish pad
11. 1 large turkish pad
12. sterilizer control
13. safety pins
14. 1 sheet
15. 1 quilted table pad
16. small towel placed immediately beneath drum cover.

* The same number is written on tag on outside of drum.

Gown Drum.

The gowns are folded small, with sleeves and outside turned in, and packed around the outside of the drum.

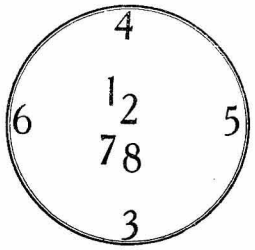
1. (
2. (
3. (gowns
4. (
5. (

In the center are placed in order from below up, the following:

6. 4 hand towels
7. 1 gown
8. 2 towels

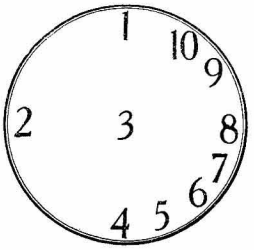
history-of-obgyn.com

Laparotomy Drum No. 1.



1. 1 small lap sheet
2. 3 sheets
3. 1 sheet
4. 1 sheet
5. 1 large lap sheet
6. 1 instrument table cover
7. 1 sterilizer control
8. 1 quilted table pad

Laparotomy Drum No. 2.

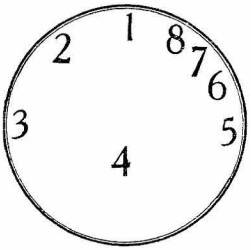


1. 6 towels
2. 1½ doz. large lap. sponges
3. 1½ doz. small lap. sponges
4. (in packages of 6)
5. 1 abd. binder and pad holder
6. 2 vulva pads
7. 2 combinations
8. 2 compresses
9. 1½ doz. drawn gauze sponges (in pkgs. of 6)
10. powdered salt (for salt sol. for lap sponges)

On top of these is placed in order from below up, the following:

11. 1 long narrow lap. sponge
12. safety pins
13. sterilizer control

Vaginal Drum.



1. 6 towels
2. 2 pkgs. of 6 drawn gauze sponges
3. 1 sheet
4. 3 sheets
5. 1 sheet
6. 1 fundus binder and pad holder
7. 2 vulva pads
8. 1 pkg. (6) drawn gauze sponges

On top of these:

9. safety pins
10. sterilizer control
11. 1 quilted table pad

history-of-obgyn.com

INSTRUCTIONS FOR INTERNS

On assuming his Hospital service, the Intern presents himself to the Superintendent, then makes rounds with his predecessor and is introduced to and informed of the condition of each patient on his service—also he is instructed in the duties of his office.

He shall read these rules. In general the rules applying to the Dispensary Interns apply to those at the Hospital.

He shall wear white suits when on duty and must always present a neat and clean appearance.

The Intern has charge of the medical conduct of all the cases, directly under the jurisdiction of the Resident Physician, who is next to the Private Attending and Staff Surgeons, respectively. The nursing of cases is under the jurisdiction of the Superintendent of Nurses and her assistants. The Resident Physician or Senior Intern acts as leader or adviser.

DUTIES OF BIRTH ROOM INTERN

Intern on Birth Room duty may not leave the 6th floor except in emergency and then only if no cases are on.

He shall see that a urinalysis is made and blood pressure taken and recorded of every patient on the floor, within two hours of her arrival. Reagents tubes, etc. in Doctors' Room.

He is responsible for the history writing of all cases on the floor during his hours of duty, and if the delivery occurs during these hours the case must be written up completely before he leaves the floor.

Upon completing his turn, he will introduce his successor to all the patients, explaining the nature of the cases and the treatment to be given.

Intern should study carefully the Conduct of Labor (Chapter 21) in the Book. Especially to be borne in mind by Intern (and taught the Student).

1. Asepsis and Antisepsis.
2. The presence of mechanical disproportion between child and mother.
3. Exhaustion of mother or child.
4. The possibility of rupture of the uterus.
5 Abruptio Placentae.
6. Eclampsia.
7. Study the mechanism of labor.

Immediately upon being notified of the admission of a private patient, the Intern visits her. He demands and reads the Pink Sheet (the antepartum record), then

history-of-obgyn.com

obtains the main facts of her present condition, temperature, pulse, character of the pains, or nature of the case, unusual symptoms, and at once communicates with the Resident and Attending Surgeon. He must learn from the latter what is desired, e. g., shall the intern make abdominal, rectal or vaginal examination? What diet should the woman have? What attention to the bowels? When does he wish to be called to the labor? and any other instructions. He may not examine a private patient vaginally or rectally without permission.

Intern should consult the "Doctors' Permission Card," to be found on Work Room Desk, for instructions as to what he may do in individual physicians' cases.

On the admission of a Staff case, the Resident and Attending Surgeon are notified only if it is pathologic.

In both cases, before the arrival of the Surgeon, he shall do all in his power to maintain or to improve the patient's condition. If time allows, and the patient's condition permits his absence from the bedside, he shall make (or see that they are made), all necessary laboratory examinations, urine, blood, blood pressure, bacteriologic or pathologic investigations, and present the findings to the Surgeon in charge, together with all obtainable information, upon his arrival.

The Interns are in charge of the cases in labor, and are expected to watch them. Nurses are not responsible for watching the fetal heart tones, or for determining the time to summon either Intern or Attending Surgeon for delivery. The Intern must watch the fetal heart tones, recording the results of his observations frequently on the history sheet. He should watch also for exhaustion, threatened rupture of the uterus, threatened eclampsia, etc., etc. This is not nurses' work except incidentally.

See that the Observers and Students are notified in time for all cases.

Always get permission from Attending Surgeons for the Observers and Students to see their private cases.

Emergencies

If delivery is imminent before the arrival of the Attending Surgeon, he shall summon the Resident Physician, who shall take full charge of the case, but shall immediately relinquish such charge upon the arrival of the Surgeon. If the case is serious in character,

history-of-obgyn.com

and the patient's own physician cannot be reached, the Resident Physician shall call the member of the Medical Staff on service.

When emergencies arise in Staff cases, the Resident will communicate at once with the member to whom the case was assigned after obtaining complete information regarding the patient. Failing to reach that member of the Staff, the Chief or any other member is consulted. In the meantime, the Intern does only that which is required for the safety of the mother and child.

In a Gynecologic case, a "General History" is filled out with great care.

An attending Surgeon or the Resident must be present at all operations, breech deliveries, repair of 3rd degree lacerations, and all complications.

WARD DUTY

The Resident, or Senior Intern, shall each morning, inspect and sign the day report in the office, and take notice of the patients—mothers and babies—in his service that require special attention. He shall at once visit such patients, determine their condition, and, if in his judgment, it is necessary, he shall at once telephone the Surgeon in charge, giving him all the necessary data and request instructions. The Senior Intern shall each morning confer with the Head Nurse on the floor regarding the clinical course of any patients requiring attention.

The Intern shall visit each mother and baby TWICE DAILY, in addition to the rounds made by the Surgeon in charge, taking with him two students to see the ward cases, and teaching them what to observe. All abnormal conditions determined during these visits shall be entered on the record and the attention of the visiting Surgeon shall be called to the same during his visit.

At all times, abnormalities developing in the condition of either mother or child are to be referred to the Attending Surgeon without delay. The Superintendent of Nurses and, during the night, the night Supervisor, are to be notified.

GENERAL

Orders must be carried out to the letter, but if in the judgment of the Intern conditions prove later on to be such as to contra-indicate the measure prescribed, permission must be obtained to countermand the order.

history-of-obgyn.com

The Intern may have a half day's absence each week, providing a substitute before he leaves the house. At no time may the Hospital be without half of the Intern Staff.

There are standing orders for the routine treatment of the mothers and babies—as regards diet, baths, bowels, etc., also for laparotomies and Cesarean Section. These the Intern must always consult for guidance. All special orders must be written in the order book on the Nurses' Table.

Interns may prescribe simple remedies for private patients only when the Surgeon in charge cannot be conveniently consulted. Important changes of treatment may only be made by the latter. The rule is to give as little medicine as possible.

DUTIES OF INTERN AT M. A. P.

He may not visit the Main Hospital (excepting the first floor) without permission and then must change his dress.

He has charge of all cases in the M. A. P. under the supervision of the Resident and Attending.

He is responsible for the history writing (and all that includes), all laboratory tests, blood pressure, etc., all bedside notes during the progress of the case; he assists at dressings, labors and operations and does such as are assigned to him.

In general the same instructions are for him as for the other Interns.

CONDUCT

Interns shall be under the direct supervision of the MEDICAL STAFF. In the medical care of House cases, that member of the Staff having the case in charge shall exercise full jurisdiction over the same. Attending Surgeons have direct charge of their own cases. In all matters regarding House routine, the Intern shall be under the jurisdiction of the Resident Physician and the Superintendent. In the medical care of House cases or of private emergency cases, the Attending Surgeon being absent, the Resident Physician shall have full charge.

In this connection, the MEDICAL STAFF desires that each Intern take notice of the fact that they wish to work in harmony with him to the fullest extent possible, that this union of forces may result in safeguarding the interests of the patients, the betterment of the service, the good name of the Hospital, and, to the Intern individually, a larger obstetric experience,

history-of-obgyn.com

and an improved obstetric judgment. The MEDICAL STAFF realizing that the Intern enters the service to obtain a better insight into the obstetric art, wishes to aid him in every possible way and whenever advisable will assist him, in return for good service, in acquiring a wider practical and theoretical knowledge in this important branch of the healing art.

The Intern shall not speak in disrespectful terms of the ability or technique of any attending Surgeon, to any patient residing in the Hospital. The service of the Hospital and the Intern should always be the best and such good service will often guard the patient from technical errors on the part of her physician. Likewise the Intern shall not recommend the employment of another physician nor speak of his good qualities or superior ability, or in other ways prejudice the patient against her own physician. During the presence of the Attending Physician, the Intern shall not give orders or directions to the patient respecting her conduct or action. All such suggestions or directions shall come from the physician in charge. The Intern shall not make any suggestions regarding the treatment of any patient of an outside physician except upon his request.

In all disagreements between the Interns and Nurses or hired help, complaint shall be made only to the Superintendent of the Hospital.

The Superintendent is amply able to correct or reprove all errors of conduct, or lack of technical ability on the part of the Nurses. On the other hand, if any error of routine or technic is discovered by the Intern on the part of the Nurses, he should consult with the Superintendent of Nurses, who will make the necessary corrections and the individual nurse will benefit by the report, and thus harmony, good feeling and improvement will result.

Any complaints, or suggestions as to the improvement of the House routine, are welcomed by and should be reported to the Chief of the MEDICAL STAFF, the Resident Physician, or Superintendent of the Hospital, who will adjust all differences with impartiality and justice.

The Intern must remember that he is with us only a few months—too short a time to learn all the details of the technic. The Head Nurses are here for many years, and know the technic. Therefore, the Interns should get instructions from the latter when in doubt what to do. In many ways, the Interns will find the Head Nurses very helpful in their work.

history-of-obgyn.com

The Intern, during his term of service, shall not accept any money from any patient or friends in payment for services rendered.

In all, the Intern's deportment should be quiet, dignified and professional, and his dress always neat and orderly.

DISPENSARY

When many cases are on at once, the Birth Room Intern should summon assistance from the Dispensary, and in Staff cases coming to operation, as many as possible should be brought from the Dispensary to attend.

HISTORY WRITING

A labor case requires a Pink Sheet and Labor Record. The nurse keeps her own record and the Time Book.

A Gyne case requires a General History Blank. A Gyne operation is described on the sheet carrying the Graphic Temp. Chart.

Each patient has a Progress Sheet with Laboratory Blank.

Be careful not to waste printed matter. It is very expensive.

House cases require a full history, begun on the admission of the patient, supplemented during the progress of the case, and completed immediately upon its termination. During labor, the Intern delivering dictates to another Intern or Student (the Scribe), who writes the facts on the history sheet as they occur. The results of each examination must also be entered without delay. In private physician's cases, only essential points in the history may be obtained and these most tactfully—but observations during the progress of the case must be written down by the Intern. These may be supplemented by the Attending Surgeon, telling the Intern what to record. Operations must be written up accurately and completely, also all unusual complications, within two hours. The weight and measurements of the child must be carefully taken and recorded.

☞Admission Card and Antepartum Record (Pink Sheet) must accompany patient to the Birth Room. After delivery the child's admission card (blue) is filled out, and history completed and all sent down to the room with the patient.

history-of-obgyn.com

DUTIES OF RESIDENT PHYSICIAN

He shall reside in the Hospital and shall receive board, lodging and laundry and a salary. His term of service shall be not more than five years.

He shall have charge of and shall instruct the Interns and the Students, acting as next in authority to the Medical Staff.

He must know the condition of all the patients in the Hospital and M. A. P. and shall visit them at least once a day. While attending septic cases at the M. A. P. he shall wear a cap, gown and rubber gloves.

He shall assist the Staff and the private physicians at operations where needed, and shall supervise the operations assigned to the Interns. Special operations he shall demonstrate to the Interns and nurses on the mannikin.

In cases of emergency he shall do only that which in his judgment is demanded for the safety of mother and child.

He shall co-operate with the Superintendents in all that pertains to the administration and nursing departments.

He shall lecture to the nurses once and to the students three times each week.

He shall have a daily conference with the Interns regarding the patients.

He shall not accept money or other gifts in payment of service rendered while in the Hospital, nor may he, during the first year of his service practice on his own account. Subsequently to the first year he may accept cases in the Hospital, providing they do not interfere with his duties.

Should infection develop in any patient he shall immediately isolate her, shall permit no one but himself and her nurse to care for her, shall notify the Attending Physician immediately, and have the needful laboratory examinations performed.

He shall co-operate with the Registrar and see that the Interns write their history sheets properly. On his rounds he shall make notes of the condition of the patients on the records.

He shall instruct the Interns to be quiet, dignified and professional in their relations to all people in the Hospital, bearing always in mind that the welfare of the patients is the supreme object of the Institution.

He shall have direct charge of the students.

history-of-obgyn.com

DISCHARGE of PATIENTS

The Intern writes the discharge of the patient on the admission card, filling in all the blanks and signs his name. Without this the patient may not leave the Hospital. Intern also fills out the Registrar's Card.

Ward cases. if well, are discharged on the 11th to 15th day, operative cases later.

Private cases are permitted to leave only when the Attending Surgeon decides it.

DUTIES OF STUDENTS AT HOSPITAL

In general, these are the same as at the Dispensary.

Students are to make rounds with the Interns, visiting ward cases only, and they must not visit the wards at other times without permission from the Intern. Students wear gowns.

Students not on duty in the Birth Rooms may not loiter on the sixth floor.

Students may not visit the M. A. P. except with the Resident Physician.

While on duty on the sixth floor, students wear white clothes supplied by the Hospital. They shall not visit the East Wing (Private Patients' Department) without permission. They shall not examine any case to which they are not assigned.

Students assist at all deliveries occurring in the clinic rooms, and are permitted to witness operations in the Gyne. Operating Room. Most perfect decorum must be maintained in every part of the Hospital.

ANTEPARTUM CLINIC

On Monday and Saturday, from two to three-thirty P. M., House patients awaiting confinement, both within and without the Hospital, are to be examined. The pelvis is measured, blood pressure taken, urinalysis made, etc., etc., all of which is recorded on the Antepartum Record (Pink Sheet), in the Main Office.

Abnormalities are to be specially noted, and indicated with an arrow.

The Interns on Ward duty with the Students make these examinations, with the Attending Surgeon.

Cases referred by the Dispensaries must be entered in this manner also, unless the Pink Sheet is available. If not, phone Canal 123 for the information.

All patients are to be given careful instruction regarding diet, etc., and furnished with the "Rules for Pregnant Women," in the language they know.

Eight weeks after delivery House cases are to return for final examination. At these visits the involution

history-of-obgyn.com

and position of the uterus, and the presence of lacerations should be noted on the proper blanks and the patient given treatment and advice.

RULES FOR PREGNANT WOMEN

1. Make arrangements at Hospital as soon as you believe pregnancy probable.
2. Dress warmly. Avoid circular constriction at any part of the body. As soon as the child's motion is felt lay off corsets; wear a maternity waist with breast supporter.
3. Take plenty of mild exercise in the open air and sunlight, especially walking, stopping short of fatigue. Avoid violent motions, golf, tennis, swimming, long trolley or automobile rides, etc. Traveling is permitted only when really necessary.
4. Take no hot nor cold baths, only tepid, with cool sponging. In the last three weeks before delivery, no tub baths, use the shower and sponging. Take no douches, unless ordered, and, especially in the last month allow nothing to touch the internal genitalia.
5. Intercourse should be avoided if possible, always restricted, and absolutely forbidden during the last six weeks.
6. The bowels must move every day.
7. Eat your usual amount of food, restricting the meats or their equivalent, fish and eggs, to four ounces a day. Drink freely of water, milk or butter-milk. No alcoholics. During the last six weeks reduce the diet generally, and especially the sweets and fats.
8. Keep the breasts free from pressure. Bathe the nipples once a week with tincture of green soap, and anoint them daily with sterilized albolene.
9. Send a four ounce specimen of the morning urine for examination every three weeks; after the seventh month, every two weeks. Once every week measure the amount of urine passed in twenty-four hours. It should be three pints or more.
10. The blood pressure should be taken every three weeks up to the seventh month, and every two weeks thereafter. Send the urine one week and appear for the blood pressure reading the following week.
11. Report to the Hospital when you are troubled with nausea, vomiting, headache, swelling of the feet or eyelids, or other abnormal symptoms. Report also any marked reduction in the amount of urine and if there is hemorrhage from any part of the body.
12. At the first consultation a careful examination must be made, and near term, another.

history-of-obgyn.com

13. When labor-pains begin, or if the waters break, or if the show of blood-stained mucus appears, go to the Hospital.

14. Six to eight weeks after delivery the patient should come to the Hospital for final examination, to determine if the womb is in place and if there has been any excessive injury to the parts.

STANDING ORDERS

RULES FOR CARE OF OPERATING ROOM WHEN SURPRISED BY AN INFECTED CASE

1. Be very careful not to drop anything infected on the floor—limit the area of infection the utmost possible.

2. Procure a large tub of 1% lysol into which to throw infected linen.

3. Procure a large basin of 2% lysol into which to throw instruments and gloves of operator and nurses, and sponges that are infected. All these must soak 30 minutes before being handled.

4. Two large wash rugs soaked in 1/1000 bichloride must be placed near the door so that pus is not tracked through the house on the feet.

5. Nurses wear rubber gloves for cleaning up room and rinsing linen and instruments.

6. Floor is mopped with 2% lysol. ☛Use a special mop and bucket. Tables and utensil stands also washed with 2% lysol solution.

7. Room aired as long as possible, and walls washed.

Preparation of Patient for Operation

Temperature, pulse, and respiration every four hours. Complete blood count, urinalysis, and systolic and diastolic blood pressure, all carefully recorded. Full bath and hair shampoo. Wash teeth and mouth with peroxide every six hours.

Generous diet of foods which leave no residue, such as eggs, milk toast, sugar (very freely), gelatine, jellies, rice, much water. If operation is in morning, no food after 5 a. m. At this time give a glass of hot malted milk, or coffee with cream and sugar. If in afternoon, no food after 10 a. m., when liquid food is given.

℞. Ricini once, two days before operation, not later. Enema of milk and molasses ãã ounces VIII, night before operation.

By Nurse. Night Before Operation. Shower bath Shave field of operation and vulva for all cases. Scrub

history-of-obgyn.com

with soap and water thoroughly and wash with 1/1000 bichloride. Let dry in. No abdominal dressing.

Before patient goes to Anesthetizing Room, pleat hair in two braids, put on clean operating room jacket, warm stockings; have her pass urine; send history sheet and admission card along.

By Operating Room Nurse. A. Just before anesthetic, put on gloves, scrub abdomen with tr. of green soap, and wash with bichloride 1/1000 and 65% alcohol, cover abdomen with sterile towels. Before rubber laparotomy sheet is adjusted paint abdomen with 50% tr. iodi. Excess wiped off with 65% alcohol.

B. Lithotomy position; wash vulva and introitus with tr. green soap and water.

By Intern or Operator: Wash vagina with lysol with 50% tr. iodine applied on swabs. This part is **not** for Cesarean Sections.

Catheterize if ordered.

During anesthetic take care that (1) patient is not chilled, (2) does not lie in the wet, (3) that the arms do not hang over side or table (place arms in the double sheet), (4) that her respiration is free.

POST-LAPAROTOMY CARE

Floor nurse or special assumes charge of patient as soon as she is back in bed. Until then, Junior Operating Intern is in charge. Intern must visit patient every hour for three hours and oftener if suspicion of danger.

Pulse is taken and recorded every fifteen minutes for four hours. Watch for shock, asphyxia, vomiting, external hemorrhage, developing pallor. (If there is a question of internal hemorrhage, take blood pressure every twenty minutes. Intern.)

Give per rectum 2 liters of salt solution containing 20 grams of sodii bicarb, by the drip method at the rate of 1 liter per hour.

Temperature, pulse and respiration every four hours. Specimen of urine to the Laboratory every morning for first week, and then every fourth day.

As soon as stomach is settled, water and liquid food with much sugar. Semi-solids on the second day. Light diet third day. May have lemonade or grapefruit juice with sugar.

No cathartics or enemata unless ordered. Routine is—milk and molasses enema āā oz. VII on morning of third day, and repeated daily.

For gas pains—milk and molasses enema; glass dumbbell; rectal tube; get order from physician. No pituitrin after classic Cesarean.

history-of-obgyn.com

For distension, same as above. See that straps and binder are loose. Ask doctor.

Back rest on the second day. Frequent change of position. Consult doctor.

If vomiting is excessive, stop food per mouth. Give salt solution per rectum. Consult doctor.

For dilatation of stomach. Prone position, gastric lavage, pituitrin (not after classic Cesarean), nothing by mouth for 24 hours. Begin with dry diet. See that patient is not dehydrated!

CESAREAN SECTION

Usual ante-operation orders if there is time. If not, at least give M. and M. enema, and have patient urinate.

For low cervical Cesarean section place a clamped catheter in bladder, after it is emptied and leave in position. Catheterize every six hours for five times post-partum.

Give hypodermic of aseptic ergot just as anesthetic is begun. Have ready hypo of pituitrin to inject when required. Have ready sterile syringe with pituitrin for uterus. **Don't boil pituitrin.**

Instruments for Cesarean Section

12 Artery Forceps.
4 pair Scissors.
3 Scalpels.
3 Stick Sponge Holders.
3 Tissue Forceps with Teeth.
2 Tissue Forceps without Teeth.
1 Uterine Packing Forceps.
2 Obstetric Forceps.
2 Medium Retractors.
1 Vaginal Cesarean Section Retractor.
1 DeLee's Curved Knife.
2 Needle Holders.
6 Tubes No. 2 Med. Hard Catgut 20-day.
4 Tubes No. 1 Med. Hard Catgut 20-day.
2 Tubes No. 0 Med. Hard Catgut 20-day.
1 Tube No. 00 Med. Hard Catgut 20-day.
Waxed Silk. (Not to be boiled).
Silk Worm Gut and Skin Clips.
Skin Clip Forceps.
Needles.
Lap Rings 18.
Rubber Dam.
2 Hypo Needles.
Glass hypo.
Ampoules Ergot and Pituitrin (sterile).
6 Allis Forceps.
4 Vulsellum Forceps.
4 8-inch Forceps.
2 Ribbon Retractors
Balfour Retractor.
Rubber Lap Sheet.
Thimble.

history-of-obgyn.com

BOOKING OPERATIONS

Operations for the Gyne. Operating Room must be booked with Chief Operating Room Nurse at least 12 hours in advance.

Precedence given in order of bookings.

Circumcisions. All circumcisions must be booked, and written permission obtained as for any operation. Be careful that the right infant is operated.

Operating Room hours 8 to 12:30. Other hours and Sunday none but emergency operations.

Anesthetics. Anesthetizer or Intern gives anesthetic to Staff cases, unless special order.

Anesthetizer must have 12 hours notice, except in emergency.

SPECIAL PERINEORRHAPHY ORDERS

Also for Third Degree Lacerations

1. No enemas nor rectal tubes.
2. Do not take temperature per rectum.
3. No cathartics until ordered by doctor.
4. Don't touch the stitches.
5. For the first bowel movement, be sure to obtain special instructions from doctor or head nurse.
6. DIET: No food containing woody fibres, such as fruits, lettuce, seeds, vegetables, bran, etc.

MAY HAVE: Strained vegetables and cream soups, oyster stew, plain custards, gelatines and jellies (no seeds), strained gruels, milk eggnog, grape juice strained, strained orange juice, well toasted white bread, wheat crackers, meat in small amounts, ice cream and ices. After first b. m. general diet.

Usually beginning about the fifth day, patient is given one ounce of Squibb's petrolatum t. i. d., on the sixth or seventh day one ounce of castor oil is administered and at the same time eight ounces of sterile olive oil are given per rectum, followed if necessary by soap suds enema. Stitches are removed the tenth or eleventh day.

After first b. m. regular post-partum orders for bowels except on special order from physician.

NURSES' STANDING ORDERS—MOTHERS

If patient, on admission, is having labor pains, she should be sent to birthroom for preparation.

Specimen of urine to be sent to the Laboratory on admission of patient, and at end of first week. To be sent daily if albumen is found.

Specimen from waiting patients to be sent each Monday morning.

history-of-obgyn.com

Private room patients to have bath each day. Semi-private patients every other day. Ward patients on first, fifth and tenth days.

Enemas and morning irrigations to be given before the bath.

House patients are given Ol. Ricini 1 oz. on second morning following delivery, one hour before breakfast. If patient has no result from the oil by 11 a. m., give an enema.

After second day give soap suds enema each day while patient is in bed. Poor results from enema to be recorded.

Ol. Ricini is not to be given to a patient having packing or to one who is on Special Perineorrhaphy orders.

Patients with third degree lacerations **do not get Ol.** Ricini or any cathartic or enema until ordered. (See Special Perineorrhaphy orders.)

All patients should void 12 hours after delivery. Urine should be measured for first 48 hours.

Any temperature over 100 to be reported and special irrigator tray to be provided.

Diet. Light tray until third day.
Full tray after third day.

Back rest for normal cases on fifth day.

For temperature during puerperium with tenderness in abdomen Intern will order Ol Ricini 1 oz., ice bag to abdomen, Fowler's position, and ergot M 20 every 6 hours, until discontinued.

For temperature with pain in breast, saline cathartic, ice bags to breasts constantly for 24 hours, tight binder, stop nursing.

Normal cases out of bed ninth day, walk around room tenth day. Discharge eleventh to fourteenth day.

No patient is allowed up without an order, nor allowed out of room first day up.

Patient going to toilet for self care, to be provided with two small sterile basins, one containing pledgets in lysol sol., and one containing vulva pad. See that she is dressed warmly.

GENERAL ORDERS

Floor nurses are not to use special nurses' dressing cart. Paper bags are not to be left in patients' rooms, nor thrown away while useful.

Gray blankets for cart. Plaid blanket for special nurses' cots.

No wool blankets to be put in laundry chute.

Clean linen dropped on floor to be put in laundry.

history-of-obgyn.com

Drinking tubes to be washed, boiled and returned to locked closet.

Medicine glasses not to be left in patients' rooms.

Catheters used for catheterization must not be taken for other purposes.

RULES FOR THE HANDLING OF INFECTED CASES

Nurses and Interns should always be on the lookout for the very first evidences of infection in either mother or babe. As soon as an infection of the genitals, or of the babies' eyes or skin is detected, or suspected, smears and cultures from the affected part must at once be sent to the Laboratory. The Resident Physician and Attending Physician must be notified and the patient isolated.

Points for Isolation

Patient in Observation Room (402-502).

Baby in Observation Nursery.

Nurse uses rubber gloves each time either is treated.

Dressings, etc., burned at once.

Bed clothing soaked in 2% lysol for 5 hours before being sent to the laundry.

History sheet kept in Observation Room.

Bed pan, thermometer, douche can, etc., kept in room.

All instruments, pans, etc., used for dressings, are kept in the room and sterilized in the sterilizer there provided.

The doorknob kept covered with cloth, frequently moistened with antiseptic solution.

Should nothing further develop, the patient may return to her room, or go home from the Observation Room.

If infection is established, the patient goes to the Mothers' Aid Pavilion for special treatment.

The Observation Room is then fumigated; walls, etc., washed with 3% crenasol solution (not dried), and left open to air for at least two days, winter or summer.

RULES FOR NURSERIES

NO VISITORS. FRESH AIR. CLEAN HANDS.

Babies must be weighed, oiled, tagged, dressed and have their footprints taken before leaving Birth Room. A baby received in the nursery minus any one of the identifications must be reported at once.

After baby is put in nursery, it must be watched carefully for bleeding from cord, choking on mucus, discoloration of the skin, etc.

history-of-obgyn.com

All babies born by the use of instruments must have abrasions cleansed with tincture of iodine, a dry dressing applied, and kept in place by bonnet made for that purpose.

Do not use hot water bags unless absolutely necessary. To fill bag draw water in pitcher, test with thermometer. Temperature not to be above 130 F. Bags must be put into covers, and must not come in direct contact with the baby's body. The nursery nurses will be held responsible for injury with hot water bags.

Before commencing to bathe the babies the nurses will see that they have everything ready for the morning work. Make out nursery blank, recording on it the weight of each baby on the previous day. If there is a difference in weight of more than 30 grams under or 60 grams over, the weight must be verified by the Head Nurse on the floor.

Sponge the babies carefully with warm water each day, expose the baby as little as possible while doing so, and be careful not to touch the cord. Apply clean, dry cord dressing when necessary, and clean binder each day. Use fresh sterilized basin for each baby. Dry baby with towel provided for that purpose. Do not use diapers for towels. If there is any odor to cord, or any redness or pus, report to Head Nurse immediately.

The skirts and gowns must be sewed, no pins to be used except in diapers.

Babies clothing must be clean and dry at all times.

Babies diapers must be changed as soon as soiled, and buttocks washed off with cool water each time.

BABIES

New babies go to breast every 8 hours for first 24 hours then every 4 hours.

Babies nurse only three minutes until milk comes, then not longer than 20 minutes.

All babies on 3 hour schedule must go to breast by 11:30 A. M.

For babies under six pounds, get instructions.

Babies not gaining after five days, are to be weighed before and after feeding, and records made of amount of food obtained.

Babies food not to be supplemented without order.

Temperatures are taken a. m. and p. m.

Take temperature of all babies showing 100° or above every 3 hours. Give sponge bath and colonic flushing.

Cord dressed with 95% alcohol.

history-of-obgyn.com

First circumcision dressing to be done by Supervisor on floor at end of 24 hours unless otherwise ordered.

Engorged breasts of infants to be strapped with adhesive under direction of floor Supervisor, or padded with cotton and binder applied.

Give water between feedings; ℥ ss to ℥ I according to age and weight.

Icteric babies need more water.

Give Castor Oil M XII on second day.

If bowels do not move for 18 hours, give normal saline flushing.

Watch for and report immediately discharge from eyes, or vagina, skin eruptions, moist cord, engorged breasts, and any abnormality. Report and record without delay.

Smears are taken of all discharges, and the Supervisor orders the infant isolated.

Bottles and nipples boiled after each use.

BREASTS

Nursery nurses are responsible for care of the breasts and the recording of their condition.

BE SURE YOUR HANDS ARE CLEAN

Before and after putting babe to breast, wash nipple with boric sol. Follow with albolene and sterile dressing. Adjust and pin binder after each nursing.

Lead nipple shields, dry shields, silver nitrate, etc. are to be applied for tender or cracked nipples, under the direction of the Supervisor.

Ice bags are applied to painfully engorged breasts over snug binder.

Do not massage or pump breast unless ordered.

Glass and rubber nipple shields are to be boiled after each nursing. Lead nipple shields are to be scrubbed and boiled before using, keeping them in bowl of sterile water while babe nurses. Lead nipple shields are used for 24 hours, then left off for 24 hours.

If breast pump is used, wash thoroughly, sterilize without putting bulb under water. Do not detach bulb.

RULES FOR ISOLATION NURSERY

Nurses must wear gowns and gloves while on duty here. Lysolize gloves thoroughly after caring for each baby. Do not wear gowns outside of nursery.

Wash feces from soiled diapers in white basin—NOT in sink. Feces to be disposed of in utility room.

All linen must be put in Lysol Solution in can provided for that purpose.

history-of-obgyn.com

Soiled pledgets, etc. in paper bags to be burned.

BED AND MATTRESS TO BE STERILIZED AFTER EACH BABY LEAVES NURSERY.

Keep room in good order.

Articles must not be taken from the cubicles. Do not exchange things. ☞Each cubicle must be strictly isolated from the others, in every respect.

Do not forget that these babies need EXTRA ATTENTION.

FEEDING ORDERS FOR FULL TERM NEWBORNS

Infant should be put to the breast 8 hours after birth, and should receive two additional breast feedings at 8-hour intervals during the first 24 hours.

Infants weighing less than 3,000 grams are to receive breast feeding every three hours after the first twenty-four hours. Those weighing 3,000 grams or more shall be placed on a four-hour feeding interval.

The three-hour feeding interval shall be: 6 a. m., 9 a. m., 12 M., 3 p. m., 6 p. m. and the last feeding at 10 p. m.

There shall be no milk feedings during the night unless so ordered in individual cases.

Four drams of boiled water shall be given each baby between the two morning feedings, and between the noon and afternoon feedings. Babies shall receive all they will take of two ounces of water from a bottle during the night if they waken.

Infants still losing weight after the sixth day are to be weighed before and after each nursing, and the amount received put on the record. Complemental feedings shall be given following the breast in an amount up to three ounces at each feeding. A baby who receives one ounce from the breast will therefore be given two ounces from the bottle.

Complemental Feeding

When complemental feedings are necessary, the following formula shall be given unless otherwise ordered:

Milk, 480 cc. (16 oz.)
Water, 480 cc. (16 oz.)
Dextri Maltose, 30 grams, 1 oz.
Boil for two minutes.

Other formulae: Larosan Milk (Calc. Caseinate).

A—Milk, 300 cc., water, 480 cc., Dextri Maltose, 33 grams.

Boil **A** for 2 min. and while still boiling add **B** (which is cool milk and larosan) and continue boiling 5 minutes.

B—Milk, 180 cc., larosan powd., 22.2 grams (1 pkg.).

One-third milk. Milk, 300 cc., water, 600 cc., Dextri Maltose, 30 grams; boil for 2 min.

Dryco Milk. Dryco powd., 1 tablespoon, water, boiled and cooled, 60 cc.

history-of-obgyn.com

As breast milk increases the amount of complement is to be reduced or discontinued. Frequently only one or two days of complement feedings are necessary.

The milk must not be too easily obtained from the bottle. Babies soon learn to prefer an easy flowing bottle to the breast.

While the mother is still in bed she is to lie on her side with head supported and the baby allowed to nurse the dependent breast.

FEEDING ORDERS FOR PREMATURE INFANTS

During the first twenty-four hours the premature should receive breast milk as follows:

8 hours after birth.....1 dram
16 hours after birth.....2 drams
24 hours after birth.....2 drams

Beginning the second twenty-four hours and thereafter the feedings shall be determined according to the following schedule:

	Under 1800 Grams		1800-2000 Grams		2000-2500 Grams	
Day	Drams	Num. Feedings	Drams	Num. Feedings	Drams	Num. Feedings
1	15.5	10	30.0	10	41.0	10
2	27.5	10	43.0	10	61.0	10
3	31.5	10	61.5	10	74.0	9
4	40.0	9	70.0	9	84.0	9
5	45.5	9	77.0	9	92.0	9
6	51.0	9	85.0	8	95.0	8
7	57.0	9	90.0	8	97.0	8
8	63.5	8	96.0	8	103.0	8
9	66.0	8	102.0	8	105.0	8
10	70.0	8	108.0	8	110.0	8
11	75.0	8	112.0	8	116.0	7
12	80.0	8	116.0	8	120.0	7
13	86.0	8	120.0	7	124.0	7

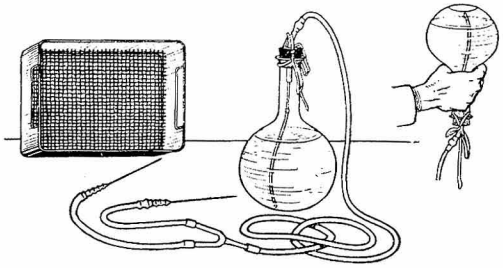
To obtain these amounts in cc. multiply each by four, (4). One dram=4 cc.

The method of feeding shall be determined by the ability of the infant to take his feedings. Infants under 1800 grams should be fed with a medicine dropper during the first four days. Infants weighing more than 1800 grams, and those weighing less, but who have passed their fourth day, may be fed from the special bottle unless symptoms of exhaustion appear—(cyanosis, great fatigue).

Gavage to be instituted at once when babe takes food poorly. Infants weighing less than 1800 grams are to receive gavage feedings seven times daily; those weighing more than 1800 grams may receive six catheter feedings daily.

No premature infant is to be put to the breast until his weight is 2000 grams.

history-of-obgyn.com



PREPARING SALT SOLUTION FOR HYPODERMOCLYSIS

Apparatus Consists of

1. One liter flask, sterile, containing sufficient sterile salt for one liter of saline. Neck of flask has tape to secure the cork.

2. A wire bottom tray containing, Y glass tube and rubber tubing; rubber cork with metal tube and one short rubber tube to be attached to it; 2 needles, 2 handles. These have been sterilized, dried and wrapped.

3. A sterile funnel with gauze filter.

To Prepare for the Operation

1. Nurse unwraps tray and resterilizes for a few minutes.

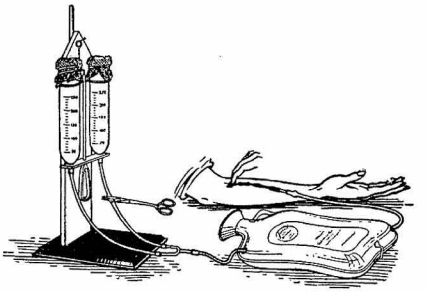
2. Nurse fills flask with sterile water of proper temperature (rather too cool than too hot) filtering through the funnel.

3. Doctor with gloved hands connects rubber tubes as per illustration, fastens cork in neck of flask securely with the tapes. Paints skin with tincture of iodin.

4. Nurse inverts flask, tests heat of solution.

5. Doctor inserts needles.

history-of-obgyn.com



THE ADMINISTRATION OF GLUCOSE INTRAVENOUSLY

Apparatus Consists of:

1. A double cylinder salvarsan instrument hung on a convenient support, 14 inches above arm of recipient.
2. A Y glass tube and rubber tubing 4 feet long. Two artery clamps.
3. One salvarsan needle (sharp).
4. Glucose solution as ordered.

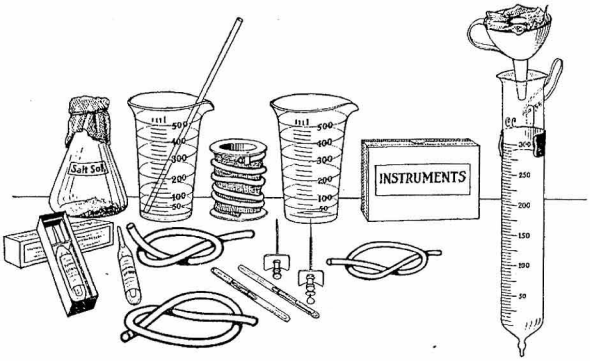
Preparation of Glucose Solution

C. P. Glucose (made especially by the Corn Products Refining Co. of New York) is dissolved in sterile distilled water in liter flasks, stoppered with gauze, autoclaved 40 minutes. Usually one liter of 10% glucose is given—but always as per doctor's order.

The Operation

1. The solution is warmed to about 105° F.
2. The apparatus is assembled as in the illustration. The tubes are clamped.
3. Both cylinders are filled to the 150 cc mark.
4. The tubes are now filled, the needle attached, and inserted into the vein.
5. Solution is allowed to run out of only 1 cylinder, at the rate of 8 cc in one minute. The rate of flow is easily regulated by raising or lowering the cylinder.
6. The tube is immersed in a basin of hot water, or covered with hot water bag, to keep the solution passing through it, warm.
7. The cylinder from which the solution flows into the vein should be kept about one-half full all the time, by admitting to it solution from the other cylinder. The latter is filled from the flask.

history-of-obgyn.com



CITRATE METHOD FOR BLOOD TRANSFUSION

Apparatus

Two 500 cc graduates. One thick glass rod.

One Burette with three feet of tubing.

Two needles, one of which has 6 inches of rubber tubing attached.

Three fine cambric needles.

One-half liter flask containing 4½ grams C. P. salt.

Ten Ampoules P. D.'s sodium citrate solution.

One set of blood vessel instruments in separate package.

Two rubber constrictors.

Method

Put 2½ ampoules of citrate solution in each graduate.

Fill burette one-fourth full of salt solution.

Insert needle in donor's vein and take as much blood as is necessary, first into one graduate and then into the other. Mix gently by stirring with glass rod.

Lift receiver's vein with cambric needle, insert large needle, and allow salt solution to run in slowly.

Burette to be nearly empty before blood is put in it.

Inject mixed blood into the receiver by means of the burette.

Let a few cc salt solution follow blood into vein. Constrictors are used on both donor and receiver as usual. Arms are sterilized with soap and water and 65% alcohol. For each 100 cc of citrated blood use one ampoule of the 2% citrate solution.

history-of-obgyn.com

STANDARD TECHNIC FOR TAKING BLOOD PRESSURE.

In order to have uniform blood pressure records, proceed as follows: The patient should be seated or semi-reclining and the instrument (if mercury, the reservoir) should be on a level with the heart. The patient's arm should be naked and relaxed, as any tension of the muscles make 10 to 15 mm. difference in the reading. The cuff should be placed smoothly above the bend in the elbow. The stethoscope is put over the brachial artery, which is about 3 cm. from the inner side of the arm at the elbow.

The cuff is to be inflated to a point above the estimated systolic pressure. The air is then gradually released and the reading is taken at the point where the first pulse sound returns (first phase). More air is released until the loud thumping sound (third phase) is just disappearing. This reading is noted, and also when the sound disappears (fourth phase). The three readings are recorded, the first is called the systolic, the last the diastolic.

In a few cases the pulse sound will not disappear until well below the diastolic level. In these cases, the second reading is recorded as the diastolic pressure.

history-of-obgyn.com

INDEX

history-of-obgyn.com

history-of-obgyn.com

history-of-obgyn.com