Date: **September 03 2025**

To: **Community Health Care Providers**

From: **Thompson Region Family Obstetrics (TRFO) Clinic**

Re: **CLOSED to new referrals effective immediately (Sept 3rd 2025)**

It is with great sadness that we inform the community of Kamloops and surrounding areas that due to critical staffing shortages and lack of specialist care for high risk patients, effective immediately the TRFO Clinic will no longer be accepting new referrals. For the next six months, we will care for our current patients until six-weeks post-partum, and focus all other efforts on providing acute on-call obstetrical coverage on labour and delivery. After this period, the future of family practice obstetrics at Royal Inland Hospital remains uncertain.

As many of you know, we have faced significant challenges in recent years due to physician shortages. Since 2023, our ability to continue operating has been supported by locums and an alternative payment model. More recently the volume of unattached patients and acuity has increased as there are even fewer providers offering on-call coverage and the OBGYN group switched to a consultative-only role. The sheer volume and lack of support for high-risk patients has resulted in TRFO physicians frequently working beyond the normal scope of family practice obstetrics. Due to this unsafe work environment and lack of competitive compensation, several TRFO providers have resigned, locum coverage is minimal, and we have been unable to recruit new graduates as expected. The few remaining TRFO providers are no longer able to continue under the current circumstances.

We recognize the stress our closure will have on both patients and health care providers in the community. We are committed to continue working closely with Interior Health and the Ministry of Health to explore all options that may allow the TRFO clinic , which has been a cornerstone of obstetrical care at RIH, to continue to operate.

For any possibility of a future for TRFO, we urgently need an influx of new physicians and the establishment of a stable supportive OBGYN group capable of providing continuous coverage and managing high-risk obstetrical patients.

We sincerely appreciate your understanding and support during this challenging time.

On behalf of the Doctors of the TRFO Clinic

Alternative Resources to consider:

- First Steps Early Pregnancy Triage Clinic
- OBGYN specialists
- Mighty Oak Midwifery
- First Light Midwifery
- Kamloops Urgent Primary Care and Learning Centre
- Kamloops Primary Care Waitlist Priority Access Referral process
- Royal Inland Hospital Emergency Department for Emergencies only

Recommended investigations for routine care.

Ultrasounds:

- First trimester dating ultrasound for all pregnant women around 11 weeks
- 10w-13w3d gestation, fetal nuchal translucency for pregnant women 35 and over years old
- 20w-22w gestation, fetal anatomic scan for all pregnant women

Lab Work to consider:

- CBC, Ferritin, TSH
- Urine culture
- Blood Group and Antibody Screen
- Rubella titer
- HIV serology, HBsAg, HepC antibody, Syphilis serology
- Cervix or Urine screen for Chlamydia/Gonorrhea
- Current PAP
- Prenatal Serum Screening for fetal aneuploidy (SIPPS 1: 10 – 13 weeks; SIPPS 2: 15-20 weeks)
- If a woman has an abnormal SIPPS screen, you will usually receive direction from the screening program about next steps which usually includes a funded NIPT
- 50gm Glucose Screen to screen for Gestational Diabetes at 24-28 weeks
- Repeat Blood group and antibody screen in 3rd trimester
- GBS swab at 36 weeks

RhoGAM at 28 weeks for all RH negative women - can be ordered from RIH blood blank with a prescription. RhoGAM 1500 IU IM once.

For Patients diagnosed with Gestational Diabetes please refer to the Kamloops Diabetes Education Clinic and indicate GDM and Urgent

Additional prenatal supports and resources:

Perinatal Services BC has multiple resources available for patients and providers.
See Prenatal Primary Care Checklist:
https://cms.psbchealthhub.ca/sites/default/files/2023-12/2023-11-29_Prenatal%20Primary%20Care%20Checklist.pdf

BC Women's Hospital has excellent supports for complications that arise in pregnancy. Referral forms and criteria can be found here:
http://www.bcwomens.ca/our-services/pregnancy-prenatal-care/complications-in-pregnancy

RAMAC in Kamloops has excellent local IM doctors who have a special interest in obstetrics and can be referred via usual referral form (Dr Remy Wong, Dr Dayne Ortved and Dr Mary Malebranche)

Diabetes Education Clinic in Kamloops is an excellent resource for any patient diagnosed with GDM. Flag as urgent on the referral form and ensure estimated due date is included.

Healthy From The Start is IH's prenatal phone program for all pregnant women. Healthy From The Start receives self-referrals through our website (www.interiorhealth.ca/HealthyFromTheStart), by phone (1-855-868-7710) and referrals from physicians and midwives from across IH. **Nurse Family Partnership** is a free public health program for women under the age of 24 having their first baby. Womenenrolled in the program are visited by a public health nurse throughout their pregnancy, continuing until their child reaches two years of age. Over this time, a woman and her NFP nurse may explore topics such as: how to have a healthy pregnancy, preparation for childbirth, nutrition, exercise, parenting, child development, future life planning and accessing community resources. Eligibility screening for the NFP program is offered to women through the Healthy From the Start Program.

SmartMom is a free and innovative prenatal text messaging program intended to increase access to evidence-based prenatal health information for all moms in the Interior region, particularly those who have limited or no access to prenatal education or live in rural or remote communities. Moms-to-be receive text messages tailored to their gestational age up to three times per week. Links to websites, phone numbers, and videos on topics such as fetal growth and development, options for screening in pregnancy, and preparation for labour and delivery are included. Messages can be customized to include resources about a patient's personal health concerns. Expectant women in the Interior region can enroll with SmartMom via text message or by visiting the SmartMom website.

ANTEPARTUM AND POSTPARTUM OUTPATIENT CONSULTATION

(Previous recommendations we have from OBGYN group)

Indications for Outpatient Antepartum Consultation

The following conditions should prompt referral for OB Antepartum Consultation. (* suggests OB/GYN could be MRP / consider transfer of care; (#) consider early OB IM referral)

- Pre-pregnancy Diabetes (Type 1 or 2) */#
- Placenta Previa / Accreta / Patient high risk of Morbidly Adherent Placenta *
-Significant maternal chronic medical conditions, specifically the following conditions:
    - Antiphospholipid antibody syndrome */#
    - Lupus */#
    - Other significant autoimmune condition (mixed connective tissue disease etc) #
    - Maternal cardiac disease */#
    - HIV */#
    - Prior history of thrombosis, (particularly if complicated / recurrent) (# early!)
    - Chronic hypertension #
    - Paraplegia / significant physical disability */#
    - Inflammatory bowel disease – on medication or severe/unstable *
    - Grave's disease (even if stable / remote – still a fetal risk) */#
    - History of stroke */#
    - Epilepsy / seizure disorder #
- 1 preterm birth prior to 32 WGA, or 2+ preterm births prior to 37 WGA
- History of Eclampsia
- History of severe preeclampsia remote from term
- History of cervical insufficiency / cerclage *
- Known significant genetic concerns (parents are carriers and/or previous child affected) - Multiple gestation *
- 2 or more Prior C-Sections
- Previous classical C-Section / T scar / Myomectomy / Uterine surgery
- Isoimmunization *
- Oligohydramnios / polyhydramnios
- IUGR
    - Early onset and/or moderate to severe IUGR consider OB MRP / transfer of care*
    - History of significant IUGR / SGA in a prior pregnancy
- Extremely elevated BMI (Prepregnancy >45)
- Problematic substance use
- TOLAC counselling suggested for all women with prior CSx as per community standard
- Poor obstetric history (severe adverse outcome in prior pregnancy)
- Significant anomaly / structural issues with maternal reproductive organs (ie clinically significant fibroids, bicornuate uterus, uterine (*) or vaginal septum, persistent adnexal cyst >5 cm)

A referral as early as possible in pregnancy is recommended for each of these conditions. The OB will triage and then see at an appropriate time in pregnancy (ie after T2 u/s).

Transfer of care requests must be submitted in writing to the OB/GYN's office. The OB/GYN will review the request and accept it if indicated by clinical scenario. (They may choose to remain in a consultative role, in which case they will communicate a plan to the referring MD/RMW). Referring MD/RMW is to provide ongoing primary care until date of transfer of care. A pre-conceptual consultation would also be ideal for high-risk women.

<u>Outpatient Postpartum OB Consultation Indications:</u>

- Retained Products of Conception, U/S Proven → Consult OB on call
- Moderate - Severe Endometritis / pelvic infection (Complicated / Inpatient management required) → Direct patient to ER if severe, +/- OB on call consultation
- Postpartum acute hypertension management → direct patient to ER if severe, +/- Consult OB on call, consider OB IM as appropriate
- Any ARO Surgical Site Infection - Consult CSx Surgeon and ID on call. (Contact OB on call if CSx surgeon not available.)
- Poor healing of perineal laceration / objective anatomic concerns - Consult delivering OB
- Complex / surgical contraception (IUDs, Nexplanon, Tubals)

Conditions that are not optimal for postpartum OB/GYN consultation: (However MD evaluation is encouraged where appropriate).

- Non obstetric infections, including:
  - Mastitis, breast health concerns → Primary care provider / ER or urgent care if severe / Gen Surg if abscess
  - UTI → Primary care provider
  - C. diff → primary care provider +/- Infectious Disease
- Acute DVT → internal medicine on call
- Postpartum depression / mood → primary care provider /psychiatry
- Nonspecific generalized fatigue, non surgical pain, gastritis, renal / biliary colic, joint pain, carpal tunnel, thyroid dysfunction, etc
- Patient is in need of routine pap smear → primary care / well woman's clinic
- Routine contraception discussion → primary care clinic, Orchard's Walk
- Consider pelvic floor physiotherapy referral if mild SUI / pelvic floor dysfunction post delivery

COMMUNICATION:

- Preferred communication is:
  - Page / phone call to OB on call if an acute / emergency issue
  - If non-emergency: Office fax requesting urgent / semi-urgent evaluation
  - Informal communication such as emails and texts not encouraged for medicolegal reasons, we cannot guarantee prompt reply, etc

BREECH REFERRAL PROCESS - Department of OB/GYN RIH November 2021

Recommended for every pregnant woman approaching 36 WGA:

- Clinical confirmation of fetal presentation at 35-36 weeks.
    - POCUS (point of care ultrasound) evaluation suggested where resources permit.

Unknown or questionable presentation to be assessed via formal ultrasound or POCUS on LDR.

Breech presentation at 35-36 weeks GA:

FP-OB / Midwife (Herein after termed PCP / Primary care provider) to perform the following actions:

- If anticipated/ clinically suspected diagnosis arrange for formal 36 +0 fetal growth, fluid in radiology department in advance
- discuss the diagnosis of breech presentation with the patient
    - 2 management options at our site: ECV or Elective CSx
- After ultrasound confirmed breech --- request urgent consultation with OBGYN on call to discuss options.
- PCP to directly call the on-call OB/GYN to set up a consultation time within 24 hours (goal to see in same trip to the hospital or book for next day if patient outside of hospital).
    - Please minimize learners on these phone calls – direct PCP to OB discussion
    - PCP to call LDR to notify charge nurse to add the patient to the book for OB consult and possible ecv
    - PCP to fax a copy of updated antenatal to LDR
- Consulting OB/GYN is to meet with patient and set up for ECV or CSx as per patient preference.
    - Consulting OB/GYN to clearly document discussion of benefits / risks / informed consent.

- If patient is only interested in a breech trial of labour and declines ECV / CSx, PCP to arrange growth, fluid, fetal head attitude ultrasound and liaise directly with a centre supporting breech planned trial of labour (not supported at our site)

Practices surrounding ECV:

- Exclusion criteria:
    - Low-lying placenta / placenta previa
    - IUGR / oligohydramnios / fetal monitoring concerns
    - Abnormal uterine cavity
    - Multiple gestation
    - Recent APH (antepartum hemorrhage)
    - Significant maternal comorbidities (ie preeclampsia)
    - 1 prior C-Section is NOT considered a contraindication

- Optimal timing: 36+0 to 37+0 WGA
- Pre-procedure:
    - NST
    - Consent process performed and documented
    - Formal radiology u/s preferred, POCUS accepted if a totally low risk patient
    - NPO status / IV saline lock / pre procedure labs are NOT considered

  mandatory ▪ should NOT be automatically performed as a routine

    - OB to coordinate with holding OR / ensuring available OR room as per their

  usual practices

- Post procedure:
    - Fetal monitoring x 1 hour
    - All **Rh NEGATIVE** women should receive Rhogam
        - Consider Kleihauer to guide Rhogam dose (UK RCOG)

OB/GYN who performs the ECV will then:

- SUCCESSFUL VERSION: Document and discharge patient back to referring PCP if successful
    - POCUS recommended on subsequent visits to be confident about presentation

- UNSUCCESSFUL VERSION: ECV OB to arrange to book CSx for as close to 39 + 0 weeks if possible
    - ECV OB must document and consent patient for CSx and for ANY OB to be the primary surgeon due to late booking date for CSx
    - Fax OR package with 3 best dates to OR Booking
    - OR booking is responsible for finding OR time
    - Surgeon is by default the OB whose OR day it is
        - If a long term patient of a particular OB / significant relationship, they may request to borrow time to perform surgery
        - PCP the assist if certified (MD or certified RMW)
    - When we go to separate OR CSx time, this process will change where OB on call is anticipated to be default surgeon

- Day of OR: Surgeon will meet with patient and perform a POCUS and/or abdominal palpation prior to the surgery to confirm persistent breech presentation