SAINT JOSEPH HOSPITAL
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
RULES AND REGULATIONS 2023

I. PREAMBLE:

The goal of the Department of Obstetrics and Gynecology is to provide the utmost in quality of care for women and fulfill the Mission of Saint Joseph Hospital.

II. ORGANIZATION:

A. MEMBERSHIP: Eligibility for membership in the Department of Obstetrics and Gynecology will be limited to those physicians Board Certified by the American Board of Obstetrics and Gynecology, or comparably recognized Obstetrics and Gynecology Board, or current active participation in the examination process leading to certification. Failure to become Board Certified within five (5) years completion of formal training will be deemed a voluntary withdrawal of clinical privileges.

Should a physician's Board Certification lapse at recertification time, the physician will have three (3) years to successfully pass the Board recertification process.

B. OFFICERS/SELECTION: Responsibilities of the Chair will automatically revert to the Vice Chair if the Chair resigns or is unable to perform the responsibilities of the Chair. If the Chair resigns, the Vice Chair will be appointed by the Ob/Gyn Committee. Officers will be allowed to succeed themselves for a maximum of one additional term. (For additional information Refer to Section 8.5.2 of the MS Bylaws)

C. OB/GYN Committee: The Ob/Gyn Committee is appointed biennially by the Department Chairperson. Functions of the Committee include:

1. Review all medical issues and problems pertaining to the proper function of the Department and the quality of patient care.
2. Forward recommendations regarding the amendment or termination of member privileges to the Medical Executive Committee.

III. PRIVILEGES:

A. There are two classes of privileges in the Department of Obstetrics and Gynecology: Class 1a, Class 1

B. Class 1a: New staff member who are Board eligible or Board certified and require proctoring for advancement to Class I privileges (all proctoring must be done by a Class I physician with privileges in the procedure being proctored).

1. Gynecological Proctoring requirements:
   All major gynecological procedures done by Class 1a physicians must be done in the operating room with the assistance of a Class 1 gynecologist. Physicians must have a variety of at least six (6) cases prior to requesting Class 1 privileges. Of the six (6) gynecological cases,
   - one (1) should be a laparoscopy
   - one (1) should be a operative hysteroscopy
   - one (1) should be a laparoscopically assisted vaginal hysterectomy
   - Simple Diagnostic Cystoscopy: Proctoring: Three (3) cases proctored by anyone with a Class 1 privileges

- Maintenance (Reappointment): two (2) cases performed within the past 2-years (must be proctored again for the privilege if insufficient case requirement not met)

- Advanced Cystoscopy privileges are not open to gyn physicians who have not been formally trained in the procedure(s)

- Robotics: Successful completion of a training program which includes didactic and hands on laboratory training. Proctoring of 2 cases.

2. Obstetrical proctoring requirements:
Physicians must have six (6) obstetrical cases proctored to obtain Class 1 privileges. At least 2 vaginal deliveries and 4 cesarean sections. Until these requirements are met, all cesarean sections will require proctoring by a Class 1 Obstetrician.

   For proctoring purposes, surgical treatment of an ectopic pregnancy is considered a major gynecological case.

3. Obtaining Proctors is the responsibility of the Class 1a physician:
All evaluations must be written on the proper forms and forwarded to the Medical Staff Office.

4. In addition to the proctoring requirements, all Class 1a physicians must have a consultation with a Class I physician for the following conditions:

   a. Induction of labor by oxytocin or prostaglandin prior to thirty-nine (39) weeks gestation.
   b. Vaginal breech delivery.
   c. Vaginal delivery of multiple pregnancy.
   d. All primary cesarean sections.
   e. Any serious medical condition or complication of pregnancy placing the mother or fetus at risk for a poor outcome.

5. D&C and cervical cone biopsy do not require observation by a class I physician.

6. Class 1 privileges for genetic amniocentesis will be granted only after observation on five (5) occasions except for Perinatologists.

7. Class 1a physician must be observed on three (3) cases for :

   a. Amniocentesis >/=24weeks.
   b. Circumcisions.

C. Class 1: Department members granted Class 1 privileges are those who have maintained their active Board Status, completed all proctoring requirements, and demonstrated their ongoing aptitude and skill in patient care.

   Class 1: Physicians have unlimited privileges to consult, diagnose, proctor and treat all conditions, in obstetrics and gynecology for which they have the necessary qualifications and skills. When proctoring Class 1a physicians, Class 1 physicians must complete and file the required surgical or obstetrical evaluations forms.

D. Ultrasonography Privileges in Labor and Delivery:

1. Ultrasonography in L&D is limited to Basic Ultrasounds (fetal position, fetal heart rate, amniotic fluid index or deepest pocket, placenta location, biophysical profile and to monitor external cephalic version/twin deliveries).

2. Credentialing: Physicians will submit a certificate of attendance from an approved course in obstetrical ultrasound or a letter from their residency training program stating their proficiency in obstetrical ultrasound to the Medical Staff Office.

E. Laser Privileges:

1. Credentialing: For Class 1a privileges in laser surgery, a physician must submit a certificate of attendance from an approved hands on course in the use of the laser or a letter from their residency training program stating their proficiency in laser use to the Medical Staff Office.

F. Operative Hysteroscopy Privileges:

1. Credentialing: For Class 1a privileges in operative hysteroscopy (resectoscope, ablation), a physician must submit a certificate of attendance from an approved hands-on course in the various techniques and instrumentation of operative hysteroscopy or a letter from their residency training program stating their proficiency in operative hysteroscopy to the Medical Staff Office.

G. Operative Laparoscopy Privileges:

1. Credentialing: For Class 1a privileges in operative laparoscopy , a physician must submit a certificate of attendance from an approved hands-on course in the various techniques and instrumentation of operative laparoscopy or a letter from their residency training program stating their proficiency in operative laparoscopy to the Medical Staff Office.

H. Gynecologic Oncology: Gynecologic Oncologists are members of the Department of Obstetrics and Gynecology who have Class 1 or 1a privileges in Gynecologic Oncology.

1. Credentialing:

a. An applicant must be a member of the Department of Ob/Gyn.

b. As of January 1, 2005, new members must hold current subspecialty certification or active participation in the examination process leading to subspecialty certification in Gynecologic Oncology by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology with certification to be obtained within six (6) years after completion of the educational and clinical requirements. If certification is not attained within this time period, privileges will be re-evaluated and possibly denied or revoked.

c. The applicant must furnish documentation of procedures performed during their Fellowship and, if applicable, procedures performed since completion of their fellowship for the most recent one (1) year period. This documentation must also outline complications and outcome.

d. In order for a Gynecologic Oncologist to be granted Class 1 Gynecologic Oncology privileges, they must be proctored and reviewed by a Class 1 Gynecologic Oncologist on an adequate mix of six (6) sufficiently complex surgical cases that meet the following criteria.

I. Cases must be primary (i.e. previously untreated patients) invasive gynecologic cancer but will not include: stage Ial or Ia2 cervical cancer, stage 1 uterine cancer or stage 1 vulvar cancer.

II. The case list must include gastrointestinal and urologic cases

2. Until Class 1 status is attained, all cases involving surgical management of gynecologic cancer must be proctored by a gynecologic oncologist including “minor” cases (e.g. intravenous port insertion, cystoscopy, sigmoidoscopy etc.)

IV. ASSISTANTS FOR GYNECOLOGICAL AND OBSTETRICAL SURGERY:

A. Anyone who assists a staff member in surgery must be a member of the Saint Joseph Hospital Medical Staff or a staff applicant with temporary privileges.

B. Only surgeons holding privileges in laparoscopy will be allowed to assist in operative laparoscopic procedures.

C. The Department of Obstetrics and Gynecology strongly endorses the following Committee Opinion (Number 145) of the American College of Obstetricians and Gynecologist:

“The primary surgeon’s judgement and prerogative to determine the number and qualifications of surgical assistants should not be overruled by public or private third-party payers. Surgical assistants should be appropriately compensated.”

V. EMERGENCY DEPARTMENT CALL PANEL:

A. All members of the Ob/Gyn Department (Class 1A and Class 1) are required to take Emergency Department call with the exception of those excluded by the Medical Staff Bylaws.

B. Failure to comply with these rules will result in the immediate notification of Ob/Gyn Chairperson who may then recommend disciplinary action including suspension of Medical Staff privileges in accordance with the Medical Staff Bylaws.

C. A $1,000 fine will be imposed on those individuals who do not adhere to the current ED call requirements as noted in these department rules and MS Rules and Regulations. Physicians who fail to respond or refuse to respond to Hospital Emergency call coverage, or inpatient consultation requests may be subject to $1,000 fine 1st time, 2nd $2,000, 3rd $3,000. Each fine would have to be reviewed by the department chair before implementation of fine, as there may have been circumstances beyond their control. The Department Chair will investigate why the physician failed to show. If it is determined that a fine is warranted, the fine will be levied by the Department Chair. If the physician fails to pay the fine within 14 days, he/she will be suspended. The appeal process will be through the department with a recommendation to the MEC. Reports on offenders should be made through the Medical Staff office, which will inform the Department Chair. It was also recommended that every occurrence of a violation should be reported to the MEC as information.

VI. TRANSFER OF PATIENTS TO L&D WHO COME THROUGH THE EMERGENCY DEPARTMENT:

A. All pregnant patients equal to or greater than 20 weeks gestation who present to the Emergency Department with primarily a pregnancy related complaint will be sent directly to Labor and Delivery for evaluation, stabilization and treatment.

B. Patients less than 20 weeks gestation will be evaluated in the ED unless the OB feels that the clinical situation warrants evaluation in l&D

C. Pregnant patients greater than 20 weeks gestation with primarily a non pregnancy related complaint will remain in the ED for evaluation with OB consultation as indicated
D. If pregnant patient greater than 20 weeks has both ob and non ob complaints the complaint felt to be more acute or urgent will dictate where a the patient will be evaluated
E. See policy PC-343 for further details

VII. EVALUATION IN LABOR AND DELIVERY WILL BE PROVIDED BY ONE OF THE FOLLOWING QUALIFIED MEDICAL PERSONNEL:

A. LABORIST
1. Laborist will evaluate all patients without a designated physician on staff at SJH
2. Laborist will see private patients with urgent needs at the request of a RN until the private MD can be reached and resume care
3. Laborist will see patients at the request of the private MD as the activity on the L&D deck permits

B. Registered Nurse
1. A Labor and Delivery Registered Nurse who is permanently assigned to the unit and has successfully completed orientation and annual unit standards may initially evaluate the patient. The nurse will then notify the appropriate physicians of the patient's status. If the patient has had no prenatal care a physician will do an evaluation of the patient. The final decision regarding admission or discharge will be made by the physician.

C. Private Obstetrician

VII. CATHOLIC HOSPITAL ASSOCIATION:

A. Tubal ligation will not to be performed at SJH
B. The following 5 conditions must be met in order to induce or augment labor in a patient with a living pre-viable fetus:

1-The fetus is less than 24 weeks verified by an OB ultrasound
2-The intent is not to end the life of the fetus, even though the death of the fetus may be foreseen
3-Patient has been counseled about options/risks/benefits of remaining pregnant and requests induction or augmentation of delivery
4-If applicable, Class 1A physicians must obtain full written consultation with a Class 1 physician
5-Either A or B

a-The mothers health/life is imminently threatened by heavy vaginal bleeding/hemorrhaging or premature rupture of membranes with signs /symptoms of chorioamnionitis (i.e. fever or uterine tenderness or leukocytosis or malodorous vaginal discharge)

OR

b-The miscarriage is inevitable with fetal parts or cord in the cervix (i.e. beyond the internal cervical os) or in the vagina

C. An ectopic pregnancy, with or without fetal heart motion, can be treated surgically or medically as indicated.

D. An incomplete abortion (no fetal heart motion, but retained products of conception) can be evacuated surgically or medically as indicated.

E. METHOTREXATE FOR ECTOPIC PREGNANCY

1. Patient is sent from an outside OBGYN, not affiliated with St. Joseph (has no privileges at St. Joseph), with a diagnosed ectopic pregnancy: The ECC MD will work up the patient and consult the OBGYN on-call, who will come to the ECC and evaluate the patient. If methotrexate therapy is appropriate, the OBGYN will order the methotrexate and discuss disposition of the patient with the ECC MD. Disposition options include observation or discharge and, if discharged, appropriate follow-up will be secured by the OBGYN.

2. Patient is sent from a St. Joseph-affiliated OBGYN with a diagnosed ectopic pregnancy: The sending OBGYN is expected to call the ECC MD or send a note with the patient describing the work-up and expectation of methotrexate therapy. The ECC MD will evaluate and work up the patient as appropriate. The sending OBGYN will order methotrexate in EPIC and discuss disposition of the patient (as above) with the ECC MD.

3. Patient is diagnosed by the ECC MD with an ectopic pregnancy: The ECC MD will consult the OBGYN on-call or the patient's OBGYN (if prenatal care is established with a St. Joseph-affiliated OBGYN). The appropriate OBGYN will evaluate the patient in the ECC, order methotrexate, and discuss disposition (as above) with the ECC MD.

VII. ADDITIONAL RULES AND REGULATIONS:

A. Video recording and still photographs are not permitted during the delivery process. There will be time for photographs before and after the delivery.

B. Initial prenatal records must be on file in Labor and Delivery by 28 weeks gestation and updated by 37 weeks gestation.

C. All non-emergent cesarean sections, both primary and repeat, must have the standard hospital history and physical examination dictated 30 days or less before admission and ~~(~~must be in the chart prior to the c-section~~)~~. If the H&P is dictated before the patient is admitted an update to the H&P must be done before the patient is moved to the Operating Room.

A. Physicians are to clearly note in the chart if vaginal pack or drains have been placed. Their number and type are to be noted immediately after surgery before the patient leaves the Recovery Room.

B. Before a tocolytic agent is administered for an external cephalic version, a confirmatory ultrasound must be done by a physician or qualified labor and delivery nurse.

C. Whenever oxytocin is administered to a patient for induction or augmentation of labor and the routine protocol established by nursing policy and procedures is not followed, the attending obstetrician or a qualified alternate must be present on the hospital campus.

D. Emergency D&C's for incomplete abortions without clinical signs of infection may be performed in the Labor and Delivery area at the discretion of the nurse in charge during that time.

E. OB GYN Morbidity & Mortality (M&M)

The OB GYN M&M Conference is a conference in which members of the OB GYN Department and health care team participate in impartial review of adverse outcomes, care trends and other OB GYN related cases in an effort to improve the quality of care at St. Joseph Hospital. The M&M will be a safe, open and respectful atmosphere for discussion and education. M&M meetings are confidential and subject to peer review protections.