DEPARTMENT OF OBSTETRICS & GYNECOLOGY
RULES AND REGULATIONS

Department membership and granting of privileges

A. Obstetrician – Gynecologist:

An obstetrician-gynecologist shall be defined as a doctor of medicine or a doctor of osteopathic medicine who has completed an accredited OB-Gyne residency program, is board eligible or board certified and is licensed to practice medicine in the state of Illinois.

Post residency applicants to the Department of OB-Gyne shall be board certified within five years of the completion of their residency by the American Board of Obstetrics and Gynecology.

Reappointment to the medical staff will be contingent on receiving board certification and/or re-certification in the required time frame as stated in the Medical Staff Bylaws. (Bylaws: Article III, Section 1)

Each obstetrical and or gynecological privilege must be applied for on an individual basis and must be approved by the OB/Gyne credentials committee.

The OB-Gyne Credentials Committee will review physician’s requests for new procedures and will consider the level of training, experience and current level of competence of the physician applicant.

The hospital credentials committee will review all requested privileges. If the committee determines that the number of cases performed within the previous cycle are insufficient for adequately assessing competency, it may recommend that the individual be proctored and evaluated for a designated period until competency is demonstrated. If the physician has privileges at another institution for the requested procedure, proper documentation will be sufficient to allow the procedure.

B. Consulting Medical Staff

The department chairman shall make recommendations to the medical staff for consultants which fulfill a special need within the department. Consulting members shall be governed by the Medical Staff Bylaws: (Article IV, Section 6)

C. Obstetrical and Gynecological Consultations

Aside from exceptional cases where other criteria may be considered, members of the department of OB/Gyne in good standing shall perform all OB/Gyne consultations.
D. Proctoring. Proctoring of a new or current member of the Department is required for those procedures which are beyond those included in their residency or fellowship training or for which documentation of training has not been provided. The Chief shall establish the number of cases to be proctored for each procedure.

E. Physician First Assistants. This is not required for any specific surgery. A physician first assistant may be requested at the discretion of the attending.

F. Medical Screening Examination by a Qualified Medical Person (Emergency Medical Treatment and Labor Act (“EMTALA”))

All laboring patients or obstetrical patients with an emergency medical condition presenting for care to the Emergency Department or Labor & Delivery will receive a medical screening examination by a qualified medical person as defined in the Hospital Bylaws.

The medical screening personal and the medical screening procedure will conform to the protocol as described in the Emergency Medical Treatment and Labor Act.

G. Emergency Room On-Call Responsibilities

All members of the Department with admitting privileges and privileges Obstetrics/gynecology, obstetrics only or gynecology only will be responsible to take ED call. Sub-specialties would be excluded from ED call (i.e. perinatology, infertility, gynae oncology and uro-gynecology). After 20 years of attending status, a physician can request to be removed from ED call responsibilities.

H. Ob-Gyn Hospitalist Program

1) The Ob-Gyn Hospitalist Program is designed to provide around-the-clock coverage, thereby improving the quality of care for patients on the Ob-Gyn Services.

2) The Ob-Gyn Hospitalist shall be a physician who has satisfactorily completed an Ob-Gyn residency and is a properly credentialed member of the medical staff and shall be board certified or become board certified in accordance with the Medical Staff Bylaws.

3) The hospitalist shall be hired by the hospital after approval by the medical director of the hospitalist program and the vice president of medical affairs.

4) The hospitalist may be asked to perform all Level 1 obstetrical and gynecological services through the proper chain-of-command. Such services may include:
   - Medical screening for EMTALA
• Monitoring laboring patients
• Amniotomy and placement of internal monitors
• Placement of cervical ripening agents
• Cesarean sections, assisting or performing when necessary
• Vaginal deliveries when necessary
• Confirmation of spontaneous rupture of membranes
• Ultrasound for confirmation of fetal presentation amniotic fluid levels, placenta ion, and demise
• Evaluation of trauma patients
• Evaluation and treatment of postpartum, ante partum, emergency department, and gynecological patients as needed

5. Role of the hospitalist for patients requiring evaluation by an Ob-Gyn is as follows:
   a) Patients with a physician currently on the Medical Staff or a certified nurse midwife with privileges on staff (a private patient) presenting to the Emergency Department (ED) or Labor and Delivery (L/D) may be evaluated at the request of the attending physician/certified nurse midwife. The hospitalist may also be requested to see admitted patients.

   b) OB patients with no physician currently on the Medical Staff or a certified nurse midwife with privileges on staff (an unassigned patient) will be evaluated by the hospitalist first. The hospitalist can evaluate and discharge the patient (pre-delivery) to be followed by i) the patient’s own OB physician not on staff, ii) the OB on-call at the time of discharge or iii) OB physicians at the (FQHC) Access Clinic proximate to the hospital. The hospitalist may evaluate and admit the patient and manage the patient through delivery and post-partum care. Upon discharge post delivery, the patient will be followed by the OB physician on call at the time of discharge. The hospitalist shall have admitting privileges, shall be responsible for managing the delivery, and may be the primary surgeon for these patients.

   c) Gynecology patients with no physician currently on the Medical Staff (an unassigned patient) will be evaluated by the hospitalist first. The hospitalist can evaluate and discharge the patient to be followed by the Gynecologist on call at the time of discharge. If the patient is in need of surgery, the hospitalist shall consult the on-call Gynecologist who shall assume responsibility for any necessary surgery and then assume care of the patient as the patient’s attending.

   d) In the event of an emergency, the hospitalist will intervene for both private and unassigned patients as a member of the “rapid response team” without the request of the attending physician/certified nurse midwife. The private attending physician, if any, shall be immediately notified of the situation requiring the intervention by the hospitalist.

   e) The primary responsibility of the hospitalist shall be coverage of the L/D unit. Emergency Department evaluations, inpatient evaluations, and
assist at surgeries are not to interfere with the responsibility. The attending physician is responsible for caring for any patient that the hospitalist is unable to see.

I. Allied Health Professional: Certified Nurse Midwife

**Sponsorship and Hospital Activities**

i. A Certified Nurse Midwife (CNM) shall be defined as an individual who has an Advanced Practice Nurse degree, is accredited by the American College of Nurse Midwives (ACNM), and is licensed to practice midwifery in the state of Illinois.

ii. The individual shall be guided by the Core Competencies for Basic Midwife Practice, the Standards for the Practice of Nurse Midwifery, and the Code of Ethics promulgated by the ACNM and the ACNM Certification Council, Inc. (ACC)

iii. CNM practicing at NCH shall be under the sponsorship of an attending physician who is board certified and is a member in good standing of the Department of Obstetrics and Gynecology. A CNM is an agent of the physician sponsor who shall be ultimately responsible for all activities of the CNM.

iv. The sponsoring obstetrician requesting CNM clinical privileges will follow the request procedure as outlined in the Medical Staff Bylaws (Article VI, Section 4)

v. Any physician covering for the sponsoring physician must have the same credentials as the sponsoring physician.

vi. If a physician has had restrictions placed on his/her practice, he/she cannot oversee a CNM’s practice in the area of restriction.

vii. The CNM will undergo the credentialing process for Advance Practice Nurses (APN) as outlined in the APN Credentialing Policy and the Medical Staff Bylaws. The Department Chief can request that the CNM be interviewed by the OB Credentials Committee on an individual basis.

viii. All CNMs will be monitored by the OB/Gyn Audit Committee and will be on probation status for the first 12 months of their appointment. The CNM must reapply for obstetrical privileges every two years.

ix. CNMs will not be granted vacuum privileges.
x. Activities of the CNM within the hospital shall be governed according to the rules and regulations as set forth by the Department of Obstetrics/Gynecology and consistent with the clinical privileges issued pursuant to the Medical Staff Bylaws

a. The CNM may manage the labor, birth, and postpartum care of low-risk obstetrical patients provided that the sponsoring physician reviews the patient’s records during the pregnancy and this is documented in the record. Higher risk pregnancies will be collaboratively managed or referred for physician care.

b. Determination of risk status must be assessed prenatally and again at admission.

xi. The physician who is overseeing the CNM must arrange for adequate backup coverage to perform the monitoring functions in the event his/her ability to adequately oversee CNM is compromised by his/her involvement in providing direct patient care.

xii. The OB/Gyne hospitalist may not act as the supervising physician except for emergency consultation and assistance. The OB/Gyne hospitalist may direct the CNM to ask the sponsoring physician to come to the hospital to assume management of the care of a patient based on clinical judgment. All instances will be reviewed by the OB Audit Committee to insure consistency.

xiii. Admissions and discharges to and from the hospital must be at the advice and consent of a physician member of the department of OB/Gyne. The CNM will not have admitting privileges.

xiv. A collaborative agreement must be on file with the hospital.

xv. The sponsoring physician overseeing the CNM is to be notified of all patients under the care of the CNM as soon as the patient is admitted to the hospital.

**Guidelines for Co-Management of Patients**

Privileges of the Certified Nurse Midwife (CNM) will be granted based on their training and experience. The CNM will consult, collaboratively manage and refer patients in accordance with the collaborative agreement with their collaborating physician.

(i) **Consultation** – Process whereby a CNM, who maintains primary management responsibility for the woman’s care, seeks the advice or opinion of a backup physician in person or by telephone

Consultation is required and must be documented in the medical record for the following conditions:

1) Sustained maternal temperature (100.0 degrees for over 4 hours)
2) Parity >6
3) Rupture membranes over 12 hours without labor or over 24 hours even if in labor.
4) Abnormal labor patterns
5) Amnioinfusion
6) Abnormal bleeding
7) Category II or III fetal heart rate tracings
8) Signs of pregnancy induced hypertension
9) IUFD
10) Prolonged second stage of labor (2 hours for a multiparous patient and 3 hours for a primiparous patient) regardless of active maternal pushing.
11) Any other abnormality thought by the CNM to constitute a high risk factor.

(ii) **Collaboration** – Process whereby a CNM and physician jointly manage the care of a woman or newborn who has become medically, gynecologically, or obstetrically complicated.

The scope of the collaboration may encompass the physical care of the patient, including delivery by the CNM, according to the mutually agreed upon plan. When the physician must assume a dominant role in the care of the patient, due to increased risk status, the CNM may continue to participate in physical care, counseling, guidance, teaching and support. The sponsoring physician must evaluate the patient, document the plan of care in the medical record, and be present in-house for the second stage of labor and delivery (with the exception of VBAC-TOL patients for which the physician needs to be present for the active phase of labor) or for the postpartum emergency.

Collaboration is required and must be documented in the medical records for the following conditions:

1) Excessive vaginal bleeding.
2) Previous uterine surgery/single prior low-transverse c-section. Sponsoring physician present in-house beginning with the active phase of labor.
3) Gestational age between 35-36 weeks
4) Management of post-delivery emergencies
5) Morbid obesity
6) Post maturity greater than 42 weeks gestation
7) Gestational diabetes (diet-controlled) well controlled.
8) Any other abnormalities thought to constitute a high risk factor.

(iii) **Referral** – Process by which the CNM directs the patient to a physician for total management of a particular problem or aspect of the patient’s care. Care cannot be referred back to the CNM for postpartum care unless the patient is medically and obstetrically stable.

Referral is required and must be documented in the medical record for the following conditions.

1) Acute and chronic maternal disease placing mother or infant a risk
2) Diabetes: gestational (insulin requiring or patients on oral hypoglycemic medication), pre-existing diabetes, poorly controlled or unstable diabetes even if diet-controlled
3) Preeclampsia, eclampsia, HELLP, hypertensive disorders of pregnancy.
4) Medical indication for induction of labor
5) Abnormal presentation including breech, unstable lie
6) Category 2-3 fetal heart tracings that do not resolve with corrective measures
7) Gestational age less than 35 weeks
8) Multiple gestation
9) History of dystocia, suspected feto-pelvic disproportion
10) Suspected macrosomia, history of excessively large previous infants (over 4500 gm)
11) History of hemorrhage/blood dyscrasia/Labor and Delivery Hgb <9
12) IUGR
13) Placental abnormalities/cord accidents
14) Abnormal active phase of labor/Abnormal labor patterns
15) Prolonged second stage of labor (3 hours for a multiparous patient, 4 hours for primiparous patient) regardless of active maternal pushing.
16) Chorioamnionitis
17) Abnormal conditions developing during pregnancy or any other abnormality thought to constitute a high risk factor.

J. Perinatal Affiliation Agreement – Patient Care Services – Level III with Extended Capabilities Facility
The Departments of Obstetrics and Pediatrics of Northwest Community Hospital have agreed upon the following categories of high-risk maternal and neonatal patients for whom consultation and/or transport should be considered, as required by regulations of the Illinois Department of Public Health, 77 Illinois Administrative Code Section 640.42.

Consultation Referral and Transport Guidelines - Maternal
a. The following maternal patients are considered to be appropriate for management and delivery by the primary physician at Level II with Extended Capabilities Facilities without requirement for a maternal-fetal medicine consultation:
1. Normal current pregnancy although obstetric history may be suggestive of potential difficulties;
2. Selected medical conditions controlled with medical treatment such as: mild, chronic hypertension, thyroid disease, illicit drug use, urinary tract infection, and non-systemic steroid dependent reactive airway disease;
3. Selected obstetric complications that present after 32 weeks gestation such as: mild pre-eclampsia/pregnancy induced hypertension, placenta previa, abruptio placenta, premature rupture of membranes, or premature labor;
4. Other selected obstetric conditions that do not adversely affect maternal health or fetal well-being, such as: normal twin gestation, hyperemesis, gravidarum, suspected fetal macrosomia, or incompetent cervical os;

5. Gestational diabetes, Class A1 (White’s criteria).

b. For the following maternal conditions, consultation with a maternal-fetal medicine subspecialist (specify MFM source for Referral Hospital) with subsequent management and delivery at the appropriate facility as determined by mutual collaboration is recommended:

1. Current obstetric history suggestive of potential difficulties such as: intrauterine growth restriction, prior neonatal death, two or more previous preterm deliveries less than 34 weeks, a single previous preterm delivery less than 30 weeks, birth of a neonate with serious complications resulting in a handicapping condition, recurrent spontaneous abortion or fetal demise, family history of genetic disease;

2. Active chronic medical problems with known increase in perinatal mortality, such as cardiovascular disease Class I and Class II, autoimmune disease, reactive airway disease requiring treatment with systemic corticosteroids, seizure disorder, controlled hyperthyroidism on replacement therapy, hypertension controlled on a single medication, idiopathic thrombocytopenia purpura, thromboembolic disease, malignant disease (especially when active), renal disease with functional impairment, human immunodeficiency viral infection (consultation may be with maternal-fetal medicine or infectious disease subspecialist);

3. Selected obstetric complications that present prior to 34 weeks gestation such as: suspected intrauterine growth restriction, polyhydramnios, oligohydramnios, pre-eclampsia/pregnancy-induced hypertension, congenital viral disease, maternal surgical conditions, suspected fetal abnormality or anomaly, isoimmunization with antibody titers greater than 1:8, antiphospholipid syndrome;

4. Abnormalities of the reproductive tract known to be associated with an increase in preterm delivery, such as uterine anomalies or diethylstilbestrol exposure;

5. Insulin dependent diabetes Class A2 and B or greater (White’s criteria).

c. For the following maternal conditions, referral to a maternal-fetal medicine subspecialist for evaluation shall occur. Subsequent patient management and site of delivery shall be determined by mutual collaboration between the patient’s physician and the maternal-fetal medicine subspecialist:

1. Selected chronic medical conditions with a known increase in perinatal mortality such as: cardiovascular disease with functional impairment (Class III or greater), respiratory failure requiring mechanical ventilation, acute coagulopathy, intractable seizures, coma, sepsis, solid organ transplantation, active autoimmune disease requiring corticosteroid treatment, unstable reactive airway disease, renal disease requiring dialysis or with a serum creatinine
concentration greater than 1.5 mg%, active hyperthyroidism, hypertension that is unstable or requires more than one medication to control severe hemoglobinopathy;

2. Selected obstetric complications that present prior to 30 weeks gestation such as: multiple gestation with more than two fetuses, twin gestation complicated by demise, discordance, maldevelopment of one fetus or by fetal-fetal transfusion, premature labor unresponsive to first-line tocolysis, premature rupture of membranes, medical and obstetrical complications of pregnancy possibly requiring induction of labor or non-emergent cesarean section for maternal or fetal indications such as severe pre-eclampsia;

3. Isoimmunization with possible need for intrauterine transfusion;
4. Insulin-dependent diabetes mellitus Classes C,D,R,F. or H (White’s criteria);
5. Suspected congenital anomaly or abnormality requiring invasive fetal procedure, neonatal surgery or postnatal medical intervention to preserve life such as: fetal hydrops, pleural effusion, ascites, persistent fetal arrhythmia, major organ system malformation/malfunction, or genetic condition.

K. Department Voting
   a. Voting Privileges:
      Members of the Department with attending, associate, consulting or provisional staff status is eligible to vote at any meeting of the Department.

   b. Quorum:
      The presence of 15 of the total membership of the Department shall constitute a quorum.

   c. Proxy:
      Eligible department members, who are not present, may vote by proxy. A proxy is valid only if it is in writing and duly signed and dated.

L. Department Committees
   a. Credentials Committee. Three members including the Chair, appointed by the Chief for two year terms; meets once a month if needed.

   b. Steering Committee. Open to all members of the department and appropriate hospital staff; meets monthly; Chaired by the Chief.

   c. Audit/Quality Committee; Chief appoints at least six members for two year terms; members may include hospitalist and CNM; meets monthly; Chaired by the Vice-Chief of the Department

M. Department Meetings—every other month

N. Meeting with the Medical Executive Committee:
   Each member has the right to request an audience with the Medical Executive Committee. In the event a member is unable to resolve a difficulty working with his/her department chief that member may, upon two weeks written notice, meet with
the Medical Executive Committee to discuss the issue upon agreement of the president of the medical staff or the members of the Medical Executive Committee.