DEACONESS HOSPITAL, INC.
Evansville, Indiana

OBSTETRICS-GYNECOLOGY DEPARTMENT RULES AND REGULATIONS

I. ORGANIZATION AND DIRECTION

The Department of OB/GYN shall be properly organized, directed, and integrated with other services or departments of the hospital. The Department is responsible for reviewing and recommending approval or disapproval of the credentials and monitoring of all individuals providing OB/GYN care, assessing the quality of care provided, and recommending any corrective measures which may be indicated.

A. These articles shall be known and observed as the Rules and Regulations of the Obstetrics-Gynecology Department of Deaconess Hospital, Inc., Evansville, Indiana.

B. These Rules and Regulations shall govern all actions and activities of the Obstetrics-Gynecology Department. Their intent is to supplement the Bylaws of the Medical Staff of Deaconess Hospital, Inc., and in no way shall they be construed to violate any Article or Section in said Bylaws.

C. These Rules and Regulations will supersede all previous Rules and Regulations of the Obstetrics-Gynecology Department.

D. The OB/GYN Department will make recommendations for the conduct of obstetrics and gynecology services and will review the practice of obstetrics and gynecology at The Women's Hospital and Deaconess Hospital, Inc.

II. MEMBERSHIP REQUIREMENTS

A. The membership of the OB/GYN Department is defined by the Bylaws of the Deaconess Medical Staff. All physicians granted initial privileges after March 15, 2004, are required to achieve Board Certification in OB/GYN with five (5) years of completion of residency or fellowship training. Members are required to maintain board certification until such time as they reach Honorary Staff status.

B. As stated in AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges (Reaffirmed 2021), "A cooperative and collaborative relationship among obstetricians, family physicians, and nurse midwives is essential for provision of consistent high-quality care to pregnant women. Regardless of specialty, there should be shared common standards of perinatal care. This requires a cooperative working environment and shared decision making; therefore, a Family Medicine Representative and Nurse Midwife attend Department of OB/GYN meetings.

C. Requests made by Family Medicine Physicians for privileges outside of core OB will be reviewed by the Chief of OB/GYN Department.

D. Any requests for changes in privileges must be accompanied by supporting documentation of training and experience as outlined on the Delineation of Privileges form.

E. Upon reaching age 70, any physician must be credentialed on an annual basis and must submit to a physical and mental exam by a qualified, licensed physician who is acceptable to both physician and the Department of OB/GYN. The written report will be sent to the Chief of OB/GYN.

F. Active Staff Requirements for the Department of OB/GYN:

1. Practice at The Women's Hospital with at least one year's duration of active participation in the affairs of the Hospital and the OB/GYN Department.

2. Obligation to attend the clinical service patients on an impartial rotation in the Emergency Rooms within the Deaconess Health System as assigned by the Medical Staff Coordinator in Medical Affairs and approved by the OB/GYN Department.

3. It is recommended that each member maintain the required number of continuing medical education hours as recommended by the American College of Obstetrics and Gynecology.

4. Obligation to keep themselves informed and acquainted in the work of the Department and with developments and progress in OB/GYN medicine and to use the highest standards of care for those patients who they attend.

5. Shall abide by the Rules and Regulations of the Department.

G. Courtesy Staff Requirements for the Department of OB/GYN:

1. Shall meet requirements specified in the Medical Staff Bylaws for Courtesy Staff Membership.

2. May not be eligible to vote or hold office or serve on committees.

3. Not obligated to attend the clinical service patients in Emergency Rooms.

4. Required to maintain continuing medical education by the American College of Obstetrics & Gynecology.

5. Shall abide by Rules and Regulations of the Department.

H. Courtesy Provisional Staff Requirements for the Department of OB/GYN:
Same as Courtesy Staff membership but will be on probation for one year.

I. Senior Staff Requirements for the Department of OB/GYN:
Same as Active Staff membership but are not required to attend meetings or obligated to attend the clinical service patients in Emergency Rooms.

III. ELECTION OF CHIEF AND DUTIES

A. The Chief of the OB/GYN Department shall be elected every two years at the last meeting of the fiscal year. The Chief of the department shall serve a two (2) year term and may be re-elected to two additional consecutive terms. The immediate Past Chief shall serve as Assistant Chief of the department and shall be eligible to attend the MEC meeting in the Chief's absence.

B. In the event of a tie or no majority vote, a vote will be taken by secret ballot.

C. The Chief must be a member of the Active Staff and Board Certified by the American Board of Obstetrics and Gynecology.

D. The Chief will have the following duties:
1. Overall administrative responsibility for the department.
2. Assess quality and safety of OB/GYN care rendered by all providers throughout the hospital including recommendations of any corrective measures which may be indicated.
3. Assist in the development of evidence-based policies and practice.
4. Appointment of members or subcommittees as he/she sees fit.
5. Serve as medical staff leader during emergency management activations.
6. Attend the following Committee meetings:
    a. Medical Staff Executive Council
    b. Appropriate Quality Committee
    c. Interdisciplinary Medical Staff Quality Improvement Committee

IV. SUB-SPECIALITIES OF DEPARTMENT

A. Within the Department of OB/GYN the following sub-specialties are recognized:
1. Reproductive Endocrinology Infertility
2. Maternal Fetal Medicine
3. Gynecological Oncology
4. Urogynecology
5. OB ED Medicine

B. The OB-GYN Emergency Department at The Women's Hospital specializes in obstetric and gynecologic evaluations prior to admission or transfer and antenatal testing. The goal of this unit is to provide assessments and screening within the hospital's capabilities. The OB-GYN Emergency Department RN is deemed by the hospital Board of Managers as a qualified medical person (QMP) and is responsible for assigning the acuity level when patients present to the Emergency Department.

They are also responsible for completing the Medical Screening Exam (MSE) as required by the Emergency Medical Treatment and Labor Act (EMTALA). The OB Hospitalist/ED Physician is also identified as the Qualified Medical Personnel on site and communicates with the patient's physician(s) for final disposition based on EMTALA regulations.

C. Hospital may appoint a sub-specialty medical director as appropriate.

V. STANDARDS OF PRACTICE

A. In keeping with evidence-based current practice, the department has oversight for the following hospital policies:

C-10 Cervical Ripening of Labor Induction with Prostaglandins
C-19 Guidelines for Placement and Care of Obstetrical Patients
C-26 Magnesium Sulfate Administration
C-27 Monitoring Fetal Heart and Uterine Activity
C-33 Oxytocin Induction & Augmentation of Labor
C-48 Trail of Labor After Cesarean Section
C-54 High Dose Oxytocin Administration
C-57 Scheduling Induction of Labor/Cesarean Section
D-29 Post Partum and Post Surgical Patient Comfort Orders
D-40 Maternal Insulin Infusion
D-41 Diabetes Insulin Pump
F-18 Skin Prep of Patient
F-22 Surgical Site Verification
G-3 Discharge Criteria from PACU
G-5 Patient Classification/Staffing Guidelines
I-22 Methotrexate for Ectopic Pregnancy
I-29 OB-GYN Department Service Call Patient Assignment Process
F-37 Power Morcellation

B. It is the physician's responsibility to provide informed consent to the patient, including risks and benefits, prior to surgery or procedure except in the case of an emergency.

C. A History and Physical will be documented prior to the performance of surgery regardless of whether the patient is an inpatient or undergoing surgery on an outpatient basis. If a history and physical performed within the last 30 days is used, it must be updated within 24 hours and prior to surgery. When the history and physical examination are not recorded before an operation or any procedure requiring anesthesia services, the procedure shall be cancelled unless the attending medical staff member states in writing that such a delay would be detrimental to the patient. In an emergency, the medical staff member shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

D. A prenatal office history will be part of the obstetrical patient's medical record.

E. An immediate post-operative note must be immediately completed by physician after procedure before patient leaves post anesthesia care area (including procedure, EBL, complications). A complete post op note should be completed within 24-48 hours post procedure. Daily progress note should be completed for each day the patient in the hospital.

F. In the event a physician leaves the facility, a new set of hospital provided scrubs will be donned prior to performing any surgical or obstetrical procedure.

G. Standard terminology for Cesarean Section scheduling is as follows:

STAT: Imminent danger for mother or fetus. Delivery should occur within 30 minutes. Examples (not an exclusive list):

- Category 3 fetal heart rate tracing
- BPP 4/10 or less
- Cord prolapse
- Uterine rupture
- Placenta previa with bleeding
- Maternal cardiopulmonary collapse
- Hypertensive urgency

URGENT:

- An urgent case will be performed before a scheduled case. However, physician-to-physician communication is required when a scheduled case will be delayed.
- Delaying the case for the 8-hour NPO status would increase maternal and/or neonatal morbidity/mortality.
- The cesarean should occur as soon as possible and ideally within 2 hours of making the decision to proceed with cesarean. There may be situations where there is more than one expedited case in queue or an emergent case develops prior to proceeding with the expedited case(s). In these situations, it is required that all physicians, including an anesthesiologist, directly communicate with each other to discuss the prioritization of patients to safely accomplish the deliveries.
- Patient does not need to be NPO for 8 hours.
- Examples (not an exclusive list):
  - Category 2 fetal heart rate tracing
  - Failed induction of labor
  - Arrest of dilation
  - Arrest of descent
  - Chorioamnionitis
  - Active herpes simplex virus infection with rupture of membranes/active labor
  - Planned cesarean with painful, regular contractions as determined by the obstetrician.
  - Spontaneous rupture of membranes, not in active labor, and planned cesarean who has been ruptured greater than or equal to 8 hours.

ADD-ON:

- Planned cesarean delivery that needs to deliver but is not scheduled.
- Delaying the delivery will not increase maternal and neonatal morbidity/mortality.
- Patient needs to be NPO for 8 hours
- Delivery should occur as soon as possible but not prior to the required 8-hour NPO status.
- Examples (not an exclusive list):
    - Spontaneous rupture of membranes, not in active labor, and planned cesarean delivery (i.e. malpresentation and/or prior cesarean) who has had rupture of membranes less than 8 hours. After 8 hours of rupture of membranes, the case becomes an expedited case.
    - Hypertensive disorders of pregnancy with planned cesarean delivery. Hypertensive urgency cases are categorized as expedited

SCHEDULED:

- Patient needs to be NPO for 8 hours.
- Scheduled cases take preference over ADD-ON cases.

KEY POINTS

- Physician-to-physician communication is paramount. The role of the clinical coordinator is to manage resources and facilitate physician-to-physician communication. The clinical coordinator is not an intermediary between obstetricians and anesthesiologists. Two-way communication between obstetricians and anesthesiologists is important to understand current clinical situations and resources at all times.
- In the event that there multiple c-sections needing to be done (add-ons, scheduled, expedited) or several high risk labor patients on the floor, the OB Provider will discuss with anesthesia, OB Provider, and clinical coordinator their patient's situation and plan a time to go for the patient.

H. It is the responsibility of the primary surgeon to provide credentialed assistants for all major obstetric and gynecologic operations, with the exception of emergent situations. In many cases, the complexity of the surgery or the patient's condition will require the assistance of one or more physicians to provide safe, quality care. The primary surgeon's judgment and prerogative to determine the number and qualifications of surgical assistants should not be overruled by public or private third-party payors. Surgical assistants should be appropriately compensated.

I. Senior Medical Students may be allowed to scrub but not perform surgical procedures.

J. Discharge Plan - physicians may request a discharge planning evaluation to be completed by the hospital even if patient's needs not initially identified upon screening.

K. D&E for 2nd trimester fetal demise must be performed with ultrasound guidance.

VI. MEETINGS

A. The OB/GYN Department meetings shall be held in accordance with the requirements of the Medical Staff Bylaws.

B. Written notices of the time and place of meetings shall be mailed to all members in advance of the meeting.

C. Additional meetings may be called by the Chief of the OB/GYN Department providing an announcement and written notice is given to each member at least four days in advance of said meeting.

D. Special subcommittee meetings which may be appointed by the Chief shall be held at the discretion of the subcommittee chairman.

VII. RULES AND REGULATIONS REVISION

The OB/GYN Department initiates and, with the approval of the appropriate bodies of the Hospital, adopts such rules, regulations, and policies governing the work of obstetrical and gynecological services in the Hospital, to assure safe and efficient care of the patients. All Staff members must conform to all the policies, rules, and regulations established by the OB/GYN Department. Likewise, the OB/GYN Department members must conform to all the policies, rules, and regulations established
by other departments.

These Articles shall be ratified when approved by a majority vote of the Active and Senior members present.

Amendments require a majority of the voting members to pass.

Amendments shall be forwarded to the Executive Council for review and approval and shall become effective only upon approval by the Board of Directors.

Approved: Ob/Gyn Department - 08/27/77
Revised:
Amended:
Revised: Ob/Gyn Department - 05/19/84
Revised: Ob/Gyn Department - 09/28/85
Revised: Ob/Gyn Department - 03/23/89
Revised: Ob/Gyn Department - 11/19/92
Revised: Ob/Gyn Department - 02/24/94
Revised: Ob/Gyn Department - 08/25/94
Approved: Ob/Gyn Department - 05/27/99
Approved: Ob/Gyn Department - 02/24/00
Revised: Ob/Gyn Department - 11/21/02
Revised: Ob/Gyn Department - 03/20/03
Revised: Ob/Gyn Department - 02/24/05
Revised: Ob/Gyn Department - 12/01/05
Revised: Ob/Gyn Department - 11/29/07
Revised: Ob/Gyn Department - 07/23/09
Revised: Ob/Gyn Department - 03/31/11
Revised: Ob/Gyn Department - 03/22/12
Revised: Ob/Gyn Department - 5/24/12
Revised: Ob/Gyn Department - 5/23/13
Revised: Ob/Gyn Department - 4/02/15
Revised: Ob/Gyn Department - 5/25/17
Revised: Ob/Gyn Department - 7/25/19
Revised/Approved: Ob/Gyn Department - 7/28/22
Revised/Approved: OB/Gyn Department – 2/27/25

Executive Council 09/14/77
Executive Council -05/09/78
Executive Council -08/11/82
Executive Council -06/13/84
Executive Council -12/11/85
Executive Council -06/14/89
Executive Council -01/13/93 Board - 01/25/93
Executive Council -03/09/94 Board - 03/28/94
Executive Council -10/12/94 Board - 10/28/94
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Executive Council -01/11/06 Board - 01/16/06
Executive Council -02/13/08 Board - 02/18/08
Executive Council -11/11/09 Board - 11/16/09
Executive Council -04/13/11 Board - 04/25/11
Executive Council -05/09/12 Board - 05/21/12
Executive Council -06/13/12 Board - 06/25/12
Executive Council -06/12/13 Board - 06/24/13
Executive Council -05/13/15 Board - 05/18/15
Approved Hospital BOD – 10/27/22
Executive Council -03/12/25 Board – 03/20/25