Procedure 76

CLINICAL PRIVILEGE WHITE PAPER

Cesarean section

Background

Cesarean section (C-section) is the surgical delivery of a baby through incisions in a woman's abdomen and uterus. C-sections may be elective, but more often are performed because of potential health risks to the mother or child. According to the American College of Obstetricians and Gynecologists (The College), a C-section may be preferred for the following reasons:

- A multiple pregnancy (a pregnancy with two or more fetuses)
- Failure of labor to progress
- Concerns for the baby, including an abnormal heart rate
- Problems with the placenta
- A large baby
- Breech presentation (in which the baby's buttocks or feet would be born first)
- Maternal infections, such as HIV or herpes
- Maternal medical conditions, such as diabetes or high blood pressure

C-sections are also performed on women who have had a previous C-section, though increasingly, women may be eligible for a trial of labor after cesarean (TOLAC), also called vaginal birth after cesarean (VBAC), depending on a number of factors that must be weighed by the woman and her physician. These factors include the number of previous C-sections and the reasons for them, the type of incision (transverse or vertical) the mother previously had, the mother's health, and the type of hospital in which she will give birth.

A C-section is considered major abdominal surgery and is typically performed by a physician who is board-certified in obstetrics and gynecology (OB/GYN) or by a family physician who has received enhanced training in obstetrics through an extended residency, an obstetrics fellowship, and/or a preceptorship with a physician who has cesarean privileges. Despite lingering inconsistencies regarding the privileging of family medicine physicians for cesarean deliveries, the American Academy of Family Physicians (AAFP) argues that "provision of cesarean delivery by well-trained family physicians augments maternity care services available to women or, in some cases, provides a service that would not otherwise be available."

During the procedure, women are given general anesthesia, an epidural, or a spinal block to numb the lower half of their body. An IV line provides fluids and medication, including those to prevent infection, and a catheter drains the bladder. Physicians make either a transverse (horizontal) or vertical incision in the wall of

the abdomen, separate the abdominal muscles, and make a second incision, either transverse or vertical, in the wall of the uterus. After the baby is delivered and the umbilical cord cut, the placenta is removed, and the uterine and abdominal incisions are closed.

The College notes that risks associated with C-section include infection; blood loss; blood clots in the legs, pelvic organs, or lungs; injury to the bowel or bladder; and reactions to the medication or the anesthesia used. Typically, women remain in the hospital for two to four days and must not engage in strenuous activity, including driving or taking stairs, or have sexual intercourse for the first several weeks after they return home.

According to the *National Vital Statistics Report*, the Cesarean delivery rate in 2015 was 32%, the lowest rate since 2007. The rate peaked in 2009 at 32.9%, after increasing every year since 1996, when the rate was 20.7%. Between 2003 and 2009, 50% of the increase in C-section delivery was attributable to more subjective indications, including non-reassuring fetal status and arrest of dilation, compared to more objective indications, such as malpresentation and maternal-fetal and obstetric conditions.

In 2014, The College published a consensus document titled "Safe Prevention of the Primary Cesarean Delivery" (reaffirmed in 2016), which outlines ways to give women more time to labor before performing a C-section. The World Health Organization, in its 2015 "Statement on Caesarean Section Rates," concludes, "Every effort should be made to provide caesarean sections to women in need, rather than striving to achieve a specific rate."

For information on general training requirements and certification eligibility criteria for relevant specialties and subspecialties, see the following *Clinical Privilege White Papers:*

- Practice area 134—Family medicine
- Practice area 147—Obstetrics and gynecology

Involved specialties

OB/GYNs, family practitioners

Positions of specialty boards

OB/GYN

ABOG

The American Board of Obstetrics and Gynecology (ABOG) is an independent, nonprofit organization that certifies OB/GYNs in the United States. To become board-certified, physicians who have completed a four-year residency must pass a

written test and an oral exam, given after the doctor has practiced for at least two but not more than eight years. Physicians boarded after 1986 must also fulfill maintenance of certification requirements on a six-year cycle.

In addition to general certification in obstetrics and gynecology, the ABOG also offers subspecialty certification in critical care medicine, female pelvic medicine and reconstructive surgery, gynecologic oncology, hospice and palliative medicine, maternal and fetal medicine, and reproductive endocrinology/infertility. The ABOG publishes no formal position or related information on the delineation of privileges for C-section.

AOBOG

The American Osteopathic Board of Obstetrics and Gynecology (AOBOG), a nonprofit affiliate of the American Osteopathic Association (AOA), prepares and administers all examinations required for osteopathic physicians to attain primary certification in obstetrics and gynecology and subspecialty certification in female pelvic medicine and reconstructive surgery, gynecologic oncology, maternal and fetal medicine, and reproductive endocrinology. Certification in OB/GYN and its related subspecialties granted after June 1, 2002, is time-limited and requires physicians to complete osteopathic continuous certification (OCC) requirements on a six-year cycle. The AOBOG publishes no formal position or related information on the delineation of privileges for C-section.

Family medicine

ABFM

The American Board of Family Medicine (ABFM) is an independent, nonprofit organization that certifies family physicians in the United States. To become board-certified, physicians who have completed a three-year residency must pass an exam and have a currently valid, unrestricted license to practice medicine in the United States or Canada. Beginning in 2011, physicians must fulfill the ABFM's continuous certification requirements on a 10-year cycle.

In addition to general certification in family medicine, the ABFM offers subspecialty certification in adolescent medicine, geriatric medicine, hospice and palliative care medicine, pain medicine, sleep medicine, and sports medicine. The board publishes no formal position or related information on the delineation of privileges for C-section.

AOBFP

The American Osteopathic Board of Family Physicians (AOBFP), a nonprofit affiliate of the AOA, prepares and administers all examinations required for osteopathic physicians to attain primary certification in family practice/osteopathic manipulative

treatment (OMT) or in family medicine/OMT with OCC special emphasis in hospital medicine. The AOBFP also oversees these processes for the certifications of added qualifications available in the specialty, which are as follows: correctional medicine, geriatric medicine, hospice and palliative medicine, pain medicine, sleep medicine, sports medicine, and undersea and hyperbaric medicine.

Primary certification in family medicine granted after March 1997 is time-limited and requires physicians to complete OCC requirements on an eight-year cycle. The AOBFP publishes no formal position or related information on the delineation of privileges for C-section.

ABPS

The American Board of Physician Specialties (ABPS), the official certifying body for the American Association of Physician Specialists (AAPS) and the third largest national multi-specialty certification board in the United States, offers certification in family medicine obstetrics to family physicians who have completed a fellowship tract or clinical practice tract in obstetrics. In both cases, physicians must complete at least 50 C-sections and 100 vaginal deliveries. They must also pass a written exam and an oral exam and be deemed surgically competent by peer observers. The ABPS publishes no formal position or related information on the delineation of privileges for C-section.

Positions of societies, academies, colleges, and associations

OB/GYN

ACGME

The Accreditation Council for Graduate Medical Education (ACGME) accredits its OB/GYN residency programs and publishes corresponding requirements. Beginning July 2, 2012, the ACGME requires minimum thresholds for OB/GYN procedures; during their four-year residency, physicians must complete at least 200 vaginal deliveries and 145 C-sections. The ACGME also accredits family medicine residency programs, whose corresponding requirements do not mention C-section.

AOA

The AOA accredits residency programs in obstetrics and gynecology and in family medicine. The standards associated with these programs do not mention C-section. The AOA also accredits fellowship programs in maternal-fetal medicine, and the corresponding standards state that fellows should have the following cesarean-related knowledge, skills, and experiences:

- A base knowledge and experience sufficient to perform complicated cesarean delivery and cesarean hysterectomy independently
- The ability to describe the management of pregnancies following cesarean delivery

- The ability to describe the indications, techniques, and complications of cesarean delivery and cesarean hysterectomy
- Knowledge regarding anesthetic management of breech deliveries, operative vaginal deliveries, cesarean deliveries, and multi-fetal gestations
- An understanding of advantages and disadvantages of general anesthesia for cesarean delivery

EDITOR'S NOTE:
The AOA has entered into an agreement with the ACGME to transition to a single accreditation system for graduate medical education. On June 30, 2020, the AOA will cease its graduate medical education accreditation activities. Under the single accreditation system, allopathic and osteopathic medical school graduates will be able to complete their residencies and/or fellowships in ACGME-accredited programs. For more information on the unification, see www.acgme.org/What-We-Do/Accreditation/Single-GME-Accreditation-System.

The College/ACOG

Founded in 1951, the American College of Obstetricians and Gynecologists (The College) is a nonprofit, professional membership organization dedicated to the improvement of women's health. The College produces consensus documents, including "Safe Prevention of Primary Cesarean Delivery," and opinions, such as "Cesarean Delivery on Maternal Request." The College's companion organization, the American Congress of Obstetricians and Gynecologists (ACOG), is a nonprofit founded in 2010 that focuses on socio-economic, political, and grievance activities for its members.

ACOOG

The American College of Osteopathic Obstetricians and Gynecologists (ACOOG) is committed to excellence in women's health. The group provides educational and networking opportunities, but does not publish guidelines or position statements on the delineation of privileges for C-section.

Family medicine

AAFP

Representing more than 100,000 family physicians, family medicine residents, and medical students, the AAFP is one of the largest medical organizations in the United States. It was founded in 1947 to "promote and maintain high quality standards for family doctors who are providing continuing comprehensive health care to the public." To that end, the AAFP publishes a range of resources regarding the specialty, including several materials related to cesarean delivery by family physicians.

The academy's recommended curriculum guidelines for family medicine residents describe training in core and advanced obstetric skills, including the "indications, risks/benefits, and need for timely intervention and surgical consultation" regarding

C-sections. The AAFP notes that these guidelines are "not intended to serve as criteria for hospital privileging or credentialing."

However, according to the academy's position paper on cesarean delivery in family medicine, the curriculum does indicate that "family medicine residents who seek cesarean delivery training because of their planned practice sites should be able to acquire this advanced skill during the course of a three-year residency."

In a joint statement on cooperative practice and hospital privileges, the AAFP and ACOG affirm that surgical delivery is within the scope of family medicine and conclude that, "The assignment of hospital privileges is a local responsibility and privileges should be granted on the basis of training, experience and demonstrated current competence."

Cesarean delivery is "a major abdominal surgical procedure that typically is learned during residency, extended residency, or fellowship training," the AAFP states in its position paper, which identifies the following potential routes for family physicians to acquire C-section skills:

- Completing a traditional three-year family medicine residency. The AAFP points to a 2009 consensus statement from the Society of Teachers of Family Medicine task force, which lists cesarean delivery among the procedures in which physicians receive "focused training" during family medicine residencies.
- Completing one of the approximately 32 U.S. obstetrics fellowships for family physicians in which cesarean delivery is identified as a key skill and training is provided. A 2008 survey of 165 graduates of such programs found that 66% had obtained cesarean delivery privileges.
- Completing a four-year family medicine residency curriculum that includes an enhanced obstetrics track. A 2005 review of the first six years of one residency program's enhanced obstetrics track found that residents who completed it had cesarean and high-risk delivery numbers comparable to those of residents completing an OB/GYN residency.
- Undergoing preceptorship by a family physician, an obstetrics subspecialist, or a general surgeon who already has these privileges.

"Because cesarean delivery is a major surgical procedure, it would be unusual to acquire cesarean delivery skills in brief (e.g., weekend or weeklong) courses," the AAFP notes.

When it comes to granting cesarean privileges to family physicians, healthcare institutions' stances "vary markedly from site to site," the AAFP states in its position paper. Lack of community need is not a valid reason to "withhold cesarean delivery privileges from family physicians who practice in environments shared with obstetrics subspecialists," the academy contends, arguing that such a restriction is at odds with credentialing guidelines levied by The Joint Commission,

the American Medical Association, and the AAFP and ACOG. The academy also contends that imposing this limitation may reduce patients' care options. Additionally, it states that the ABPS' family medicine certification is "merely one of several mechanisms for verification of training and competence" in routine obstetric care and advanced maternity skills, such as cesarean delivery, arguing that family physicians should not be required to obtain this certification in order to exercise C-section privileges.

Regardless of the procedure at hand, the AAFP recommends that healthcare institutions ensure the competence of family physicians through evidence-based volume thresholds, references, and proctoring.

"Studies have shown that the maternal and infant outcomes of cesarean deliveries performed by family physicians in active practice or in training can meet or exceed national standards," the AAFP states, though it acknowledges that the available data are limited and often dated. Specifically, the academy points to the narrow research and high variability surrounding the number of cesarean deliveries performed during family medicine training programs and required to secure or maintain hospital privileges, citing several studies:

- A 2006 study of the cesarean delivery training curriculum in one three-year family medicine residency program found an average of 60 cesarean deliveries performed per resident
- In a survey of family medicine maternity care fellowships, the estimated mean number of cesarean deliveries performed annually by fellows was 108.6 (SD = 48.2), with a range of 60 to 190 performed
- A study of cesarean deliveries performed by three family physicians in a rural hospital found that the physicians had performed 37–50 primary cesarean deliveries and assisted on 75–110 cesarean deliveries before they were evaluated for privileges at the hospital
- A 2008 study of family physicians who completed obstetrics fellowships found an overall average of 28.9 cesarean deliveries per year

"The variability of training numbers for cesarean delivery emphasizes the need for careful supervision and review of trainees, and the need for progressive proctoring in training and assessment of competence that is not heavily based on training numbers," the academy states.

Given the disparate approaches and somewhat limited guidance surrounding cesarean privileges for family physicians, the AAFP advises those in the specialty to maintain "extensive documentation" of their C-section experience, including the number of procedures performed during training and in practice; the patient's relevant medical history; the physician's role in surgery; the supervising surgeon; and salient outcomes/complications. The AAFP also recommends that family physicians secure letters from instructors, preceptors, and proctors that attest to training, experience, demonstrated abilities, and current competence.

AAPS

Founded in 1950, the AAPS is a national, nonprofit professional organization for licensed MDs and DOs. Its affiliated academies of medicine set professional standards; provide educational resources, networking opportunities, and advocacy; and recognize excellence across nine specialties, while its certifying board, the ABPS, offers certification and recertification in 18 medical specialties.

"Cesarean Hysterectomy for Family Medicine Physicians Practicing Obstetrics," which appears in a Spring 2009 issue of the AAPS' *American Journal of Clinical Medicine*, states that "one of the criticisms of family medicine physicians practicing obstetrics is that they are not trained in cesarean hysterectomy," which the article's authors call "an uncommonly performed, but lifesaving operation, usually for massive hemorrhage." Arguing that OB/GYNs often have similarly limited experience with the procedure, the authors outline "a straightforward approach to cesarean hysterectomy that family medicine physicians practicing obstetrics or newly graduated OB/GYN physicians can perform." They also provide a case report of a successful cesarean section hysterectomy performed by a general surgeon and a family physician who had completed an obstetrics fellowship.

In its cesarean delivery position paper, the AAFP shares a similar stance, advising healthcare institutions against withholding C-section privileges from family physicians on the sole basis of inexperience with rare procedures like cesarean hysterectomy:

> *At some institutions, ability to manage complications of cesarean delivery may be a requirement for obtaining privileges. For example, the ability to perform a cesarean hysterectomy for persistent hemorrhage may be required, in spite of the fact that cesarean hysterectomy is a rare procedure that a family physician would not typically need to perform. All physicians, regardless of specialty, would be expected to seek consultation for a rare condition … Preoperative risk factors for complications of cesarean delivery that are outside of the family physician's scope of practice can be identified to prompt consultation, referral, or transfer of patients before surgery, as necessary.*

Positions of subject matter experts

Arnold W. Cohen, MD
Einstein Healthcare Network
Philadelphia

"I think the right percentage of C-sections is 100% for those women who need it, and zero for those who don't," says **Arnold W. Cohen, MD,** chairman emeritus of the department of OB/GYN at Philadelphia's Einstein Healthcare Network and professor of OB/GYN at Kimmel Medical College. Cohen has performed thousands of C-sections in 40 years of practice; currently, he works three days a week and does 50–75 surgeries a year.

There are pressures on both the patient, who may not want to labor, and the physician, who may have competing priorities; both of these may result in higher than ideal C-section rates, Cohen says. At Einstein Healthcare Network, 60% of women who have had previous C-sections are eligible for a TOLAC, and 80% of them have successful vaginal deliveries, Cohen says. He notes that this rate is significantly higher than the national norm, in which only about 10%–20% of women who have had a C-section choose to have a vaginal delivery. Because Einstein has residents and attending physicians on the labor floor 24 hours a day, there is no pressure to get a mother delivered, Cohen points out.

Though research suggests that attending physicians who perform fewer than 20 C-sections per year have higher rates of maternal complications, Cohen believes there is an important distinction between statistical and clinical significance. In addition, requiring a specific number of C-sections to obtain or maintain relevant privileges may result in lack of access for patients and create a perverse incentive to perform more surgeries, Cohen argues.

Some OB/GYNs don't perform C-sections because they choose to specialize, for example, in oncology or infertility, or because they transition their practice to gynecology so they don't have to care for patients who are laboring. However, those doctors are still qualified by virtue of their training to perform C-sections, Cohen notes. All physicians are subject to focused reviews to determine whether their practice—including the number of C-sections they perform—is consistent with good care, he adds.

Though the surgery itself hasn't changed, C-sections are easier to perform today than they were when Cohen first began practicing because certain steps—such as sewing the bladder to the uterus—are no longer necessary. Advances in wound care and infection control create fewer risks for mothers and babies, he notes.

Andrea Arguello, MD
MacArthur Medical Center
Irving, Texas

"C-sections and vaginal deliveries are the OB/GYN's bread and butter," says **Andrea Arguello, MD,** whose practice serves three hospitals in the Dallas-Fort Worth area: Las Colinas Medical Center, Texas Health Harris Methodist HEB, and Baylor Scott & White Irving. "As long as you have graduated from a four-year residency in good standing, and you complete the number of cases you need to graduate, you can perform surgery."

Unlike physicians in some specialties who only need to pass a written exam to become board-certified, OB/GYNs take a written exam when they complete their residency and an oral exam after about two years of practice. During her residency, Arguello performed about 300 C-sections, far surpassing the required number of

145. In her first several years of practice, she has completed between 80 and 100 C-sections per year.

Arguello notes that though "the safest thing for the mother and the baby, in an ideal situation, is to have a vaginal delivery," there are any number of reasons why a woman might be scheduled for a primary C-section. They include a high-risk multiple birth or a baby that is large or not presenting head down in the birth canal. Women who have previously had a C-section are at greater risk of uterine rupture, but if they have had only one previous C-section and are otherwise a good candidate for labor, they may be eligible for a TOLAC.

Typically, TOLAC is only allowed for a woman who has a low transverse scar, across the lower part of the uterus, where the tissue is less likely to rupture, Arguello points out. Still, mothers who want a vaginal birth after C-section must be counseled about the risks, including the need for emergency surgery. All else being equal, planned C-sections are likely to result in fewer problems—including hemorrhage, infection, and damage to the bowel and bladder—than those that are done once complications arise.

In an effort to reduce the number of C-sections, some hospitals have begun to mandate that women who are having their first baby not be allowed to schedule an elective induction before 40 or 41 weeks, Arguello says. Inducing labor for a vaginal delivery can be done at 39 weeks and is sometimes scheduled based on patient request because it may be more convenient for the woman or her family. However, giving a woman more time to be ready for birth may lower the chances she will end up with a C-section, Arguello notes. In addition, the use of hospitalists or in-house OB/GYNs who can monitor labor and are available in an emergency might make a physician who is not on-site more comfortable with waiting longer to let a mother's labor progress before committing to surgery.

Deborah Herchelroath, DO
Pinnacle Health System
Harrisburg, Pennsylvania

"There's a sweet spot" between letting a woman labor and choosing to do a C-section, "and we all have to do our best to find it," says **Deborah Herchelroath, DO,** an attending physician in OB/GYN. Herchelroath has been practicing for 19 years and does 30–50 C-sections per year.

There are probably 50 indications for why a woman would need a primary (as opposed to a repeat) C-section, but the top two are for arrest of labor and fetal heart rate abnormality, Herchelroath says. Current guidelines suggesting that women be allowed to labor longer before considering surgery are helping to reduce the numbers of C-sections, she says, "But at what cost? There is more morbidity that goes hand-in-hand with vaginal deliveries when a woman has labored longer,

including the possibilities for more infections and more lacerations." Individualized, patient-centered care is key to choosing the right intervention for each patient, she believes.

Herchelroath acknowledges that there is a learning curve to performing any surgery, including C-sections, but she fears that requiring doctors perform a certain number of procedures to maintain privileges might limit a woman's access to care. In similar fashion, the availability of family physicians who received additional training to perform C-sections may reduce the need for women to travel long distances to have their babies delivered safely, Herchelroath adds.

Herchelroath says little has changed over the years in the way she performs C-sections, and the risks remain, including infection and damage to the woman's bowels, bladder, and blood vessels. In addition, when C-section rates increase, so does the risk for various placental implantation problems. Surgery is never to be taken lightly, and it's rarely anyone's first choice, says Herchelroath, but used judiciously—for the right women at the right time—it can be lifesaving for mother and child.

Positions of accreditation bodies

CMS

CMS has no formal position concerning the delineation of privileges for C-section. However, the CMS *Conditions of Participation (CoP)* define a requirement for a criteria-based privileging process in §482.22(c)(6) stating, "The bylaws must include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges."

§482.12(a)(6) states, "The governing body must assure that the medical staff bylaws describe the privileging process. The process articulated in the bylaws, rules or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers:

- Individual character
- Individual competence
- Individual training
- Individual experience
- Individual judgment

The governing body must ensure that the hospital's bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners."

Specific privileges must reflect activities that the majority of practitioners in that category can perform competently and that the hospital can support. Privileges are not granted for tasks, procedures, or activities that are not conducted within the hospital, regardless of the practitioner's ability to perform them.

Each practitioner must be individually evaluated for requested privileges. It cannot be assumed that every practitioner can perform every task, activity, or privilege specific to a specialty, nor can it be assumed that the practitioner should be automatically granted the full range of privileges. The individual practitioner's ability to perform each task, activity, or privilege must be individually assessed.

CMS also requires that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

CMS' *CoP*s include the need for a periodic appraisal of practitioners appointed to the medical staff/granted medical staff privileges (§482.22[a][1]). In the absence of a state law that establishes a time frame for the periodic appraisal, CMS recommends that an appraisal be conducted at least every 24 months. The purpose of the periodic appraisal is to determine whether clinical privileges or membership should be continued, discontinued, revised, or otherwise changed.

The Joint Commission

The Joint Commission has no formal position concerning the delineation of privileges for C-section. However, in its Comprehensive Accreditation Manual for Hospitals, The Joint Commission stipulates that accredited hospitals collect information regarding practitioners' current license status, training, experience, competence, and ability to perform the requested privilege (MS.06.01.03).

In the introduction for MS.06.01.03, The Joint Commission states that there must be a reliable and consistent system in place to process applications and verify credentials. The organized medical staff must then review and evaluate the data collected. The resultant privilege recommendations to the governing body are based on the data assessment.

Accredited facilities' medical staffs are responsible for planning and implementing a privileging process, according to MS.06.01.05, which also states that this process typically includes:

- Developing and approving a procedures list
- Processing applications
- Evaluating applicant-specific information
- Submitting recommendations to the governing body for applicant-specific delineated privileges
- Notifying applicants, relevant personnel, and, when required by law, external entities of the privileging decision
- Monitoring privilege use and quality-of-care issues

The decision to grant, deny, or renew privileges is an objective process based on evidence, according to MS.06.01.05.

The EPs for standard MS.06.01.05 require:

- All licensed independent practitioners who provide care, treatment, and services to have a current license, certification, or registration, as required by law
- Established criteria as recommended by the organization's medical staff and approved by the governing body, with specific evaluation of current licensure/certification, specific relevant training, evidence of physical ability, professional practice review data from the applicant's current organization, peer and/or faculty recommendation, and a review of the practitioner's performance within the hospital (for renewal of privileges)
- Consistent application of criteria
- A clearly defined and documented procedure for processing clinical privilege requests that is approved by the organized medical staff
- A documented, confirmed statement from the applicant that no health problems exist that would affect his or her ability to perform the requested privileges
- A query of the NPDB for initial privileges, renewal of privileges, and when a new privilege is requested
- Written peer recommendations that address the practitioner's current medical and clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism
- A list of specific challenges or concerns that the organized medical staff must evaluate prior to recommending privileges (MS.06.01.05, EP 9)
- A process to determine whether there is sufficient clinical performance information to make a decision related to privileges
- A decision (action) on the completed application for privileges that occurs within the time period specified in the organization's medical staff bylaws
- Information regarding any changes to practitioners' clinical privileges, updated as they occur

The Joint Commission calls for the organized medical staff to review and analyze information regarding practitioners' current licensure status, training, experience, current competence, and ability to perform requested privileges (MS.06.01.07).

In the EPs for standard MS.06.01.07, The Joint Commission states that the information review and analysis process must be clearly defined and that the decision process must be timely. Based on recommendations by the organized medical staff and approval by the governing body, the organization develops criteria to be considered in the decision to grant, limit, or deny a request for privileges. The criteria must be consistently applied and directly relate to the quality of care, treatment, and services. Ultimately, the governing body or delegate has final authority for granting, renewing, or denying clinical privileges, and privileges may not be granted for a period of more than two years.

Criteria that determine a practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested are consistently evaluated.

The Joint Commission standards also require ongoing professional practice evaluation information to be a factored in decisions to maintain, revise, or revoke existing privileges prior to or at the time of renewal (MS.08.01.03).

In the EPs for MS.08.01.03, The Joint Commission calls for a clearly defined process for evaluating each practitioner's professional practice, and that individual departments determine, and the organized medical staff approves, the type of information to be collected for this process. The information revealed during this ongoing evaluation is used to determine whether to continue, limit, or revoke any existing privilege.

HFAP

The Healthcare Facilities Accreditation Program (HFAP) has no formal position concerning the delineation of privileges for C-section. HFAP addresses the credentialing and privileging requirements for practitioners in the 2015 HFAP *Accreditation Requirements for Acute Care Hospitals*, which mirrors the expectations established by CMS.

All practitioners who require privileges in order to furnish care to hospital patients must be evaluated under the hospital's medical staff privileging system before the hospital's governing body may grant them privileges (03.00.01). The appraisal must consider evidence of qualifications and competencies specific to the nature of the request.

The medical staff must examine the credentials of all eligible candidates for medical staff membership and make recommendations to the governing body on the appointment of these candidates in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations (03.00.06).

There must be a mechanism established to examine credentials of individual prospective members (new appointments or reappointments) by the medical staff. The individual's credentials to be examined must include at least:

- A request for clinical privileges
- Evidence of current licensure
- Evidence of training and professional education
- Documented experience
- Supporting references of competence

Only the hospital's governing body has the authority to grant a practitioner privileges to provide care in the hospital. The governing body must rely on the medical staff to apply the criteria for privileging and appointment to those eligible candidates and to

make their recommendations before the governing body makes a final decision to appoint or not appoint a practitioner to the medical staff (03.00.10).

The governing body must also consider whether the procedure is one that the hospital can support. Privileges cannot be granted for procedures that are not conducted within the hospital, regardless of the individual practitioner's ability to perform them (03.00.06). For example, it would not be appropriate for practitioners to be granted psychiatric privileges if psychiatric services were not available at the hospital.

With multiple-hospital healthcare systems, when granting practitioners privileges to provide patient care, a hospital's governing body must specify those hospitals in the system where the privileges apply, since, in addition to the qualifications of individual practitioners, the services provided at each hospital must be considered when granting privileges (03.00.11).

The medical staff must have a process to monitor the competency of its members. Ongoing professional practice evaluation information is factored into the decision to maintain an existing privilege, to revise an existing privilege, and/or to revoke an existing privilege prior to or at the time of renewal (03.15.01). Focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff (03.15.02).

DNV GL

DNV GL Healthcare USA has no formal position concerning the delineation of privileges for C-section. MS.12 Standard Requirement (SR) #1 states, "The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges."

The governing body shall ensure that under no circumstances is medical staff membership or professional privileges in the organization dependent solely upon certification, fellowship, or membership in a specialty body or society.

Regarding the Medical Staff Standards related to Clinical Privileges (MS.12), DNV requires specific provisions within the medical staff bylaws for:

- The consideration of automatic suspension of clinical privileges in the following circumstances: revocation/restriction of licensure; revocation, suspension, or probation of a DEA license; failure to maintain professional liability insurance as specified; and noncompliance with written medical record delinquency/deficiency requirements
- Immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner's Medicare/Medicaid status
- Fair hearing and appeal

The Interpretive Guidelines also state that core privileges for general surgery and surgical subspecialties are acceptable as long as the core is properly defined.

DNV also requires a mechanism (outlined in the bylaws) to ensure that all individuals provide services only within the scope of privileges granted (MS.12, SR.4).

Clinical privileges (and appointments or reappointments) are for a period as defined by state law or, if permitted by state law, not to exceed three years (MS.12, SR.2).

Individual practitioner performance data must be measured, utilized, and evaluated as a part of the decision-making for appointment and reappointment. Although not specifically stated, this would apply to the individual practitioner's respective delineation of privilege requests.

CRC draft criteria

The following draft language is intended to serve solely as a starting point for the development of an institution's privileging criteria for C-section.

Minimum threshold criteria for requesting privileges in C-section

Basic education: MD or DO.

Minimal formal training: Successful completion of an ACGME- or AOA-accredited residency in OB/GYN. Alternatively, if the applicant has completed a residency program in family medicine, he or she must be able to demonstrate the successful completion of a 12-month, full-time obstetrics or maternal and child care fellowship.

Required current experience: Demonstrated current competence in at least [n] procedures during the past 12 months or demonstrated completion of training within the past 12 months.

References

If the applicant is recently trained, a letter of reference should come from the director of the applicant's training program. Alternatively, a letter of reference may come from the applicable department chair and/or clinical service chief at the facility where the applicant most recently practiced.

Reappointment

Reappointment should be based on unbiased, objective results of care according to a hospital's quality assurance mechanism. To be eligible to renew privileges in C-section, the applicant must demonstrate current competence and an adequate

volume of experience ([n] procedures) with acceptable results for the past [n] months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.

[Maintenance of certification is required.]

In addition, continuing education related to C-section should be required.

For more information

Accreditation Council for Graduate Medical Education
401 North Michigan Avenue, Suite 2000
Chicago, IL 60611
Telephone: 312-755-5000
Fax: 312-755-7498
Website: *www.acgme.org*

American Academy of Family Physicians
11400 Tomahawk Creek Parkway
Leawood, KS 66211-2672
Telephone: 800-274-2237
Fax: 913-906-6075
Website: *www.aafp.org*

American Association of Physician Specialists
5550 West Executive Drive, Suite 400
Tampa, FL 33609
Telephone: 813-433-2277
Fax: 813-830-6599
Website: *www.aapsus.org*

American Board of Family Medicine
1648 McGrathiana Parkway, Suite 550
Lexington, KY 40511
Telephone: 859-269-5626 or 888-995-5700
Fax: 859-335-7501 or 859-335-7509
Website: *www.theabfm.org*

American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Telephone: 214-871-1619
Fax: 214-871-1943
Website: *www.abog.org*

American Board of Physician Specialties
5550 West Executive Drive, Suite 400
Tampa, FL 33609
Telephone: 813-433-2277
Website: *www.abpsus.org*

American College of Osteopathic Obstetricians and Gynecologists
201 Main Street, 6th Floor
Fort Worth, TX 76102
Telephone: 817-377-0421
Fax: 817-377-0439
Website: *www.acoog.org*

American Congress of Obstetricians and Gynecologists
409 12th Street, SW
P.O. Box 70620
Washington, DC 20024-9998
Telephone: 800-673-8444 or 202-638-5577
Website: *www.acog.org*

American Osteopathic Association
142 E. Ontario Street
Chicago, IL 60611-2864
Telephone: 312-202-8000
Fax: 312-202-8200
Website: *www.osteopathic.org*

American Osteopathic Board of Family Physicians
330 E. Algonquin Road, Suite 6
Arlington Heights, IL 60005
Telephone: 847-640-8477
Website: *www.aobfp.org*

American Osteopathic Board of Obstetrics and Gynecology
142 E. Ontario Street, 4th Floor
Chicago, IL 60611
Telephone: 312-202-8271
Fax: 312-202-8482
Website: *www.aobog.org*

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Telephone: 877-267-2323
Website: *www.cms.gov*

DNV GL Healthcare USA, Inc.
400 Techne Center Drive, Suite 100
Milford, OH 45150
Telephone: 513-947-8343
Website: *www.dnvglhealthcare.com*

Healthcare Facilities Accreditation Program
142 E. Ontario Street
Chicago, IL 60611
Telephone: 312-202-8258
Website: *www.hfap.org*

The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Telephone: 630-792-5000
Fax: 630-792-5005
Website: *www.jointcommission.org*