Procedure 76

CliniCal PRIViLGE WHiTE PAPEr

Cesarean section

Background

In a cesarean section (C-section) procedure, a baby is delivered through surgical incisions made in the mother’s abdomen and uterus. Although surgical delivery is typically performed when vaginal birth is considered unsafe, some women who are not experiencing complications request to have their baby delivered surgically. According to the American Academy of Family Physicians (AAFP), cesarean delivery is a common surgical operation.

The American College of Obstetricians and Gynecologists (ACOG) states that a mother may be given medication before this procedure to reduce acid in her stomach and prevent it from entering the lungs. After a mother’s abdomen is washed and possibly shaved, a catheter is placed in the bladder to lower the chance of that organ being injured during surgery.

An IV is placed in the mother’s arm or hand to provide her with fluids and medication during the procedure. Anesthesia options during a C-section include general anesthesia, an epidural block, or a spinal block.

The ACOG states that during the procedure, a physician makes a horizontal or vertical incision through the skin and wall of the abdomen. The abdominal muscles are moved and, therefore, do not typically need to be cut. Another horizontal or vertical incision is made in the wall of the uterus. A horizontal incision is preferred because it results in less bleeding and faster healing. The baby is then delivered through these incisions, the umbilical cord is cut, and the placenta is removed. The uterus is closed with dissolving stitches; stitches or staples are used to close the skin.

According to ACOG, potential reasons for delivery by C-section rather than vaginal delivery include:

➤ A multiple-baby pregnancy
➤ Failure of labor to progress
➤ Concern for the baby, including it not being in a head-down position
➤ A patient with a history of heart disease that could be worsened by the stress of labor
➤ A patient with an infection that could be passed to the baby during a vaginal birth
➤ Problems with the placenta
Complications associated with the procedure include infection, blood loss, blood clots, injury to the bowel or bladder, and harmful reaction to medications or anesthesia.

According to the National Center for Health Statistics, the cesarean delivery rate in the United States rose to more than 30% of all births in 2006. This is a 3% increase from 2005 and a new record high. The percentage of births delivered by C-section has climbed 50% in the past decade. In 2006, a National Institutes of Health expert panel recommended against C-sections that are not medically indicated for women who desire several children and for pregnancies of less than 39 weeks.

**Involved specialties**

OB/GYNs, family medicine physicians

**Positions of societies and academies**

The AAFP is a national medical organization that represents more than 84,000 family medicine physicians, family medicine residents, and medical students nationwide.

In 1998, the AAFP and ACOG jointly published *Recommended Core Educational Guidelines for Family Practice Residents: Maternity and Gynecologic Care*. The report states that family medicine residents who need to learn the cesarean delivery procedure should be able to acquire the skill during the course of their three-year residency.

For family medicine residents who are planning to practice in communities without readily available OB/GYN consultation, and who need to provide a more complete level of OB/GYN services, the curriculum strongly recommends “additional intensified experience.” The experience should be agreed upon by the joint training committee and tailored to the needs of the residents’ intended practice. The experience, to occur within the three-year family practice residency, should include training in C-section delivery.

In its 2003 position paper *Cesarean Delivery in Family Medicine*, the AAFP states that a family medicine physician can acquire cesarean procedure skills via a preceptorship with a family medicine physician skilled in the procedure or a supportive obstetrician or general surgeon. Depending on the practice location, cesarean delivery may be performed by family medicine physicians, OB/GYNs, general surgeons, or general practitioners, according to the AAFP. It would be unusual to acquire cesarean procedure skills in brief courses, such as weekend or
weeklong courses, because a C-section is a major surgical procedure for which there are no models or simulators available.

The AAFP’s position paper also states that OB/GYN residents perform a mean (average) number of about 200 cesareans during their four years of residency, but are commonly deemed competent to perform them independently after successfully performing far fewer procedures. It also adds that the only published study documenting training volumes of family medicine physicians who perform C-sections found that the average number completed in training is 46, with a range of 25–101. Based on these numbers, the position paper states that these physicians “produced outcomes comparable to or exceeding national standards.”

Because a C-section is an abdominal operation, experience in other abdominal operations is helpful in cesarean skill development, according to the AAFP. However, since a C-section is first and foremost a birth, there may be some transferable skills inherent in assisting with vaginal deliveries.

Although discussions of training methods usually focus on the how and when of performing cesarean deliveries, these discussions should also include an understanding of what clinical settings indicate when a C-section is likely to have a high level of complications leading to patient transfer or consultation, and how to resolve those complications.

Testing and demonstration of proficiency in cesarean delivery is usually done by direct observation during training or a period of proctorship under another physician who is significantly more experienced.

The AAFP reports that published data indicate family physicians are able to maintain proficiency by performing five to 22 procedures per year. However, it adds, this subject has not been studied extensively.

The academy reports that current policies and procedures for credentialing family physicians in cesarean delivery vary from site to site.

In hospitals where it is not usual for family medicine physicians to perform C-sections, there may be no mechanism for credentialing them. Completion of a residency in OB/GYN may be stated as a prerequisite for obtaining cesarean privileges.
The American Osteopathic Association (AOA) and the American College of Osteopathic Family Physicians (ACOFP) developed the document *Basic Standards for Fellowship Training in Maternal/Fetal Care and Operative Obstetrics in Osteopathic Family Practice and Manipulative Treatment*. This document outlines the minimum requirements and standards to establish and maintain osteopathic training programs in maternal/fetal care and operative obstetrics in conjunction with osteopathic family practice and manipulative treatment.

The organizations developed these standards to train physicians in advanced maternal care and skills, including operative birth. Upon successful completion of training, a physician will be competent to provide obstetrical care, including operative procedures.

Candidates for acceptance into the one-year subspecialty program may be:
- An American Osteopathic Board of Family Physicians–certified practicing osteopathic family physician
- A graduate of a three-year AOA/ACOFP–approved family practice residency program or a resident in good standing at an AOA-approved family practice residency program

A physician who has completed the program will be able to:
- Describe the indications for C-section
- Describe alternatives to C-section
- Describe conditions that increase the risks of operative complications, including but not limited to preterm C-section, grand multiparous, placenta previa and accreta, repeat C-section with extensive adhesions, morbidly obese patients, fetal abnormalities, maternal coagulopathy, and multiple gestation
- List the complications of C-sections, such as injury to the bowel or bladder; extension of uterine incision into uterine arteries, cervix, or vagina; uterine atony; uterine infection; wound hematoma or infection; coagulopathy or thromboembolic disease
- Diagnose and manage common perinatal conditions, such as premature labor, infections in pregnancy, gestational diabetes, fetal distress, malpresentation, abnormal progression of labor, preeclampsia, and other conditions

Among the numerous mandatory procedures that physicians must complete in the program are 15 assisted C-sections and
Cesarean section

25 C-sections as the primary surgeon (in addition to 100 vaginal deliveries).

ACOG

The ACOG is a nonprofit member organization of professionals who provide healthcare for women. For information about the joint AAFP and ACOG Recommended Core Educational Guidelines for Family Practice Residents: Maternity and Gynecologic Care, please see the preceding section on AAFP.

Positions of other interested parties

The American Osteopathic Board of Obstetrics and Gynecology (AOBOG) is one of the eighteen specialty boards approved by the AOA, the primary certification board for osteopathic physicians.

AOBOG

To obtain specialty certification in OB/GYN, candidates must pass a written and clinical examination. Candidates for the written examination must be graduates of an AOA-accredited college of osteopathic medicine and be residents in or graduates of an AOA or Accreditation Council for Graduate Medical Education (ACGME)–approved fellowship training program in OB/GYN.

Candidates for the clinical examination must meet the following criteria:

- Have passed the AOBOG written examination
- Have completed an AOA-approved internship
- Have received approval of all years of residency training from the American College of Osteopathic Obstetricians and Gynecologists Residency Evaluating Committee
- Have received AOA approval of all ACGME residency training
- Hold a current unrestricted medical license in the state(s) or territory(ies) where practice is conducted
- Be a member in good standing of the AOA or the Canadian Osteopathic Association for a continuous period of two years, immediately prior to the date of certification

Following completion of both examinations, the AOBOG will submit a recommendation to the AOA’s Bureau of Osteopathic Specialists that the candidate should receive OB/GYN certification. Continued membership in the AOA is required for certification to remain active.

Certification granted after June 1, 2002, is time-limited and requires recertification every six years. Certification granted prior to June 1, 2002, is lifetime and does not require recertification.
To maintain certification status, a diplomat must remain an active member in good standing of the AOA.

**ABOG** The American Board of Obstetrics and Gynecology (ABOG) is one of the 24 specialty boards recognized by the American Board of Medical Specialties. According to the ABOG, an OB/GYN completes four years of specialized residency training in areas dealing with preconception health, pregnancy, labor and childbirth, postpartum care, genetics, genetic counseling, and prenatal diagnosis. The training also covers general women’s health, including reproductive organs, breasts, and sexual function. OB/GYNs also learn about preventive healthcare during the four years of training.

To become ABOG-certified, a physician must pass a written test and an oral examination. To maintain certification, physicians certified after 1986 must be recertified at periodic intervals.

Although all board-certified OB/GYNs can treat patients with the following disorders, some physicians have three years of extra training after a basic residency. The training qualifies them to take a written and oral test to receive certification in the following areas:

- Maternal-fetal medicine
- Gynecologic oncology
- Reproductive endocrinology and infertility
- Female pelvic medicine and reconstructive surgery

**Frank R. Witter, MD,** is a professor in the department of obstetrics and gynecology at The Johns Hopkins University School of Medicine and head of the hospital’s OB/GYN credentialing committee.

According to Witter, obstetricians perform the majority of C-sections. He says the C-section is the second most common procedure performed in the United States (behind dermatological procedures).

Witter says in addition to obstetricians, some family medicine practitioners complete an extra year of training in obstetrics to perform C-sections. However, he states Johns Hopkins has never had anyone apply with those credentials because the hospital does not have a family medicine department.

Witter cites three acceptable paths to apply for privileges to
perform C-sections: a physician with an MD or DO, a foreign-trained physician with appropriate documentation and qualifications, and a physician who stopped practicing in obstetrics and wants to return to the field.

Physicians with an MD or DO must be board-eligible or board-certified with ABOG or AOBOG, according to Witter. The Johns Hopkins Hospital accepts both.

The Johns Hopkins Hospital grants provisional basic obstetrical privileges to physicians in their first year. Subsequently, the physicians must renew every two years. Basic obstetrical privileges include C-sections. During privilege reappointment, the credentialing committee reviews performance improvement, morbidity and mortality conference data, and records of physician performance. The committee also requires three peer review recommendations to determine whether a physician can retain the privileges.

“We also request, if they were practicing at any other hospital, that we have some information from that hospital that they are in good standing and they haven’t had their privileges revoked,” Witter says.

For physicians returning to practicing obstetrics, the hospital requires them to perform three C-sections, supervised by a medical staff physician who currently holds the privileges. “That person needs to sign off that the physician performed them adequately,” says Witter.

Witter says the C-section is the most common procedure performed in a physician’s fellowship program. During their program, physicians are initially involved in C-sections as assistants and later as the primary surgeon.

“Depending on the volume of surgery at their program, they may start doing cesarean sections as the primary operator in the latter half of the first year of their four-year program,” he says. “Or they may start doing it in the second year of their program.” By the time a physician graduates from the fellowship program, Witter says he or she will have had at least three years of experience in performing C-sections. He says this is a good indicator that the physician is competent in performing the procedure. “Some [physicians] have more mechanical skills and are able to
be independent after a short number of cases, say 10,” he says. “Others may need 25 or so because their skills develop slower.”

To maintain competence, Witter says a physician should perform five to 10 procedures per year. However, he states that his hospital doesn’t require a minimum number, as they do for other procedures that require continual practice.

Witter cites several reasons why the number of cesarean deliveries is on the rise: physicians would rather deliver a single-birth breech baby via C-section, since vaginal delivery requires skill and experience that many physicians do not have; the rise in multiple births; and the increase in average birth weight.

The Joint Commission (formerly JCAHO) has no formal position concerning the delineation of privileges for C-section procedures. However, in its Comprehensive Accreditation Manual for Hospitals, the Joint Commission states, “The hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege” (MS.06.01.03).

In the rationale 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 assessment of the data.

The Joint Commission further states, “The organized medical staff reviews and analyzes information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege” (MS.06.01.07).

In the EPs for standard MS.06.01.07, The Joint Commission says the information review and analysis process is clearly defined. The organization, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a request for privileges.

The Joint Commission further states, “Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privileges, or to
revoke an existing privilege prior to or at the time of renewal” (MS.08.01.03).

In the EPs for MS.08.01.03, The Joint Commission says there is a clearly defined process facilitating the evaluation of each practitioner’s professional practice, in which the type of information collected is determined by individual departments and approved by the organized medical staff.

Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege.

**CRC draft criteria**

The following draft criteria are intended to serve solely as a starting point for the development of an institution’s policy regarding this procedure area.

**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 one-to-two year family medicine obstetric fellowship.

**Required previous experience:** If the applicant has not completed the aforementioned minimal formal training in the prior 12 months, he or she must demonstrate current competence and evidence of the performance of at least 50 deliveries, including five by C-section, in the prior 12 months.

A letter of reference must come from the department chair at the hospital where the physician currently holds obstetrics privileges or from the director of the physician’s obstetrics residency program.

**References**

Reappointment should be based on unbiased, objective results of care, according to a hospital’s quality assurance mechanism.

Applicants must be able to demonstrate the performance of at least 50 deliveries, including five by C-section, annually during the reappointment cycle.

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

For more information regarding this procedure area, contact:
For more information

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The Joint Commission
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Fax: 630/792-5005
Web site: www.jointcommission.org
Privilege request form
To be eligible to request clinical privileges to perform cesarean section deliveries, an applicant must meet the following minimum threshold criteria:

➤ 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 one-to-two year family medicine obstetric fellowship.

➤ Required previous experience: If the applicant has not completed the aforementioned minimal formal training in the prior 12 months, he or she must demonstrate current competence and evidence of the performance of at least 50 deliveries, including five by C-section, in the prior 12 months.

➤ References: A letter of reference must come from the department chair at the hospital where the physician currently holds obstetrics privileges or from the director of the physician’s obstetrics residency program.

➤ Reappointment: Reappointment should be based on unbiased, objective results of care, according to a hospital’s quality assurance mechanism.

Applicants must be able to demonstrate the performance of at least 50 deliveries, including five by C-section, annually during the reappointment cycle.

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

I understand that by making this request, I am bound by the applicable bylaws or policies of the hospital, and hereby stipulate that I meet the minimum threshold criteria for this request.

Physician’s signature: ____________________________________________________________

Typed or printed name: __________________________________________________________

Date: ________________________________________________________________________
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