



## Steadfastly forward

**Timothy R. B. Johnson, MD**

*Department of Obstetrics and Gynecology, University of Michigan Medical School, Ann Arbor, MI*

Received for publication February 24, 2005; revised May 5, 2005; accepted August 1, 2005

“Every time I look back, I meet the eyes of my foreparents looking steadfastly forward.”

Professor Roger Shinn

Concerns abound with regard to the future of our specialty of obstetrics and gynecology. In his presidential address to the American College of Obstetricians and Gynecologists,<sup>1</sup> Dr John Gibbons summarized the issues that dominate discussion: (1) recruitment of medical students; (2) change in residency programs; and (3) the new face of private or academic practice. The first is highlighted by the decrease in the percentage of graduating US seniors choosing a career in obstetrics and gynecology and the associated decrease in residency slots filled by US graduates. The marked decrease in the number of men entering the specialty is noted with concern, and the shift of student interest to emergency medicine, radiology, ophthalmology, anesthesiology, and dermatology noted with envy. It must be said that a decade ago both anesthesiology and radiology sounded their own alarms, so the astute observer must suppose that there are powerful cyclic forces operating.

The concern about residency training focuses on the ever broadening scope of requirements, something that as a member of the Residency Review Committee I am

well aware of, but the breadth of medical knowledge presents a challenge to all undergraduate and graduate medical education programs. The 80-hour work week has surely placed new challenges on our residency programs. As to practice, increased debt burden, administrative burdens, liability concerns,<sup>2</sup> and family and personal interests all contribute. Dr Gibbons speaks enthusiastically and hopefully about the potential to “refocus our specialty.”

One only need cast a brief glance at history to realize that similar concerns are not new for our specialty. Two of our most insightful and visionary specialty leaders, both my predecessors as chair at the University of Michigan, were important observers of this phenomenon.

In a 1920 address to the American Medical Association,<sup>3</sup> Dr Reuben Peterson, chair from 1901 to 1931, outlined “The Future of Obstetrics and Gynecology as a Specialty.” This was a time when obstetrics and gynecology were considered widely by many as separate specialties, and “gynecologists threw themselves into the development of pelvic surgery to such an extent that things outside the operative field failed to interest them. ... The result is that the ground work absolutely essential to one aspiring to devote himself to one division of obstetrics and gynecology is lost sight of and there is a wild scramble for a short cut to fame and fortune, usually through the dexterous handling of the scalpel.” He then argued for the unification of obstetrics and gynecology and for an emphasis on broad education as the basis for both specialists and subspecialists.

Dr Peterson saw merit in a suggestion that only medical school gynecologists and psychiatrists should select those most suited for gynecologic surgical careers, for “if by any chance (they) were to run across an

Presented as the Wayne Johnson Memorial Lecture at the Annual Meeting of the Association of Professors of Gynecology and Obstetrics and the Council on Resident Education in Obstetrics and Gynecology, March 2, 2005, Salt Lake City, UT.

Reprints not available from the author. Address correspondence to Timothy R. B. Johnson, MD, Department of Obstetrics and Gynecology, University of Michigan Medical School, 1500 East Medical Center Drive, L4000 WH, Ann Arbor, MI 48109-0276.

E-mail: trbj@umich.edu

applicant who had ambition to become an expert in everything, physical and functional, pertaining to the genital tract of women, it would be comparatively easy to have such a person become either a temporary or a permanent occupant of the psychiatric clinic.”

He envisioned strong hospital-based training programs for both medical students and postgraduates, not yet widely called “residents.” His description of the ideal department of obstetric and gynecology to offer training for “young graduates” fits very well with the academic obstetrics and gynecology residency program that we would all recognize today. Peterson wrote that “each man would work out the hardships of being up all night with a confinement case and then be obliged to do difficult hysterectomies the next day” and hoped the trainee would “keep faith and find enough in his specialty to interest him so he will do his regular work well and add a little something to the sum of human knowledge.”

In another major address, published in the *American Journal of Obstetrics and Gynecology* as “Obstetrics-Gynecology: A Time for Change,”<sup>4</sup> Dr J. Robert Willson, my chairman who held his position from 1962 to 1979, raised not dissimilar issues: “changes in attitude and education of medical students; a proliferation of scientific and technical information to be incorporated into clinical practice; increasingly burdensome controls by burgeoning institutional, professional, and governmental bureaucracies; changing patient attitudes; changing physician attitudes.” Dr Willson was an early acceptor and proponent of primary and preventive care<sup>5</sup> and felt that “too little emphasis is placed on preparing house officers for contemporary practice.” He was one of the first to understand that we must be responsive to society and our patients as we develop the curricular content of our educational programs. Dr Willson’s detailed critique of residency training remains insightful and provocative and resonates in the current discussions at the Accreditation Council for Graduate Medical Education (ACGME) and the Residency Review Committee (RRC).

As to medical students, he comments “that we now have as many or more applicants than first-year positions is considered by some to be an indication of success ... but are we being responsible? ... How many obstetrician-gynecologists trained in the present model will be content to spend almost all their time counseling adolescents, the elderly, and others and providing contraceptive and other routine ambulatory services and how well will they do these things?”

Dr Willson then advocated changes and proposed eliminating ineffective programs, approving only programs that provide comprehensive training, competency-based evaluations of trainees, regular program reviews, appropriate specialty examinations, and recertification. He saw the American Board of Obstetrics and Gynecology, American College of Obstetricians and Gynecolo-

gists, Association of Professors of Gynecology and Obstetrics, the Council on Resident Education in Obstetrics and Gynecology, and the Residency Review Committee all as important participants in this change, and it is remarkable that virtually all of his recommendations have been successfully implemented, if not as quickly as he would have liked or in time for him to see.

So if similar concerns have existed for more than a century and previous leaders have predicted, advocated, and directed change, I believe we must follow their lead, face the challenges, and find the solutions that will chart the course for the optimal wellness and health of our patients and our specialty.

I believe, as did Dr Willson, that change must come from our leaders and leadership organizations. I have demonstrated that as a specialty we have faced similar—remarkably similar—challenges before and have responded constructively.

Reuben Peterson and J. Robert Willson were right that our specialty will flourish if defined broadly: obstetrics and gynecology, surgery and primary care, specialty and subspecialty. We must address the concerns of those of who advocate for attention to surgical training,<sup>6-8</sup> but breadth and balance must be maintained. The role of primary and preventive care was emphasized by Dr Willson, and its importance was recently reaffirmed by specialty leaders<sup>9</sup> in an “academic blueprint.”

Dr Peterson also raised the issue of time, specifically night call.<sup>10</sup> We need to heed the lesson of the 80-hour work week. After the ACGME mandate, the University of Michigan Medical School implemented an 80-hour work week for medical students. It did not take long, nor should it have, for the faculty to ask, “How about us?” Dr Gibbons is correct that we must address the challenges not by focusing on residents and residency education or on medical students and medical education, but we must focus on practitioners and their practice: the very specialty of obstetrics and gynecology. Student interest groups will not change the reality of practice. Resident professionalized in an 80-hour work week will bring new expectations to their professional lives. We must refocus, redefine, if not reinvent our specialty. Already, as Dr Gibbons notes, there is movement toward larger practice groups, groups that can absorb part-time doctors and offer reasonable call schedules.

Other specialties have developed hospitalists, full-time hospital-based clinicians.<sup>11</sup> Weinstein<sup>12</sup> has proposed the role of “laborist,” someone whose focus is management of laboring patients. One of the risks of some of these innovations is loss of continuity, but ultimately we must assure quality care and patient safety while maximizing satisfaction for all participants in the health care system. Recently our Maternal Fetal Medicine faculty have experimented with a night float system, taking the lead from residents and medical students for whom night float has become a national standard. In our

	Values	Work	Org. culture
Traditional generation, 1925-1940	Traditional obligation to conform	Duty	Command and control
Baby boomers, 1945-1963	Radicals	Self-fulfillment	Consensus
	Individuals	Opportunity for advancement	Participation
	Dual careers	Work is leisure	Idealists
	Self-gratification		Self-directed
Generation Xers, 1965-1982	Latchkey kids	Balance	Competence
	Extended adolescence	Learning opportunities	Realists
			Free agents
			Self-reliant

*Org.*, Organizational.

department, despite occasional logistic challenges, third- and fourth-year residents and medical students have well developed and enhanced night float systems. More junior residents are experimenting with options on how best to adapt it to their educational needs and work hour constraints.

We need to develop programs for reentry and retraining because well-prepared colleagues who have taken time out for family or life issues can be invaluable when they are ready to return to full or limited specialty practice. Family medicine has recently reported a comprehensive prescription for the successful future of that specialty.<sup>13</sup> I believe strongly in a model in which the academic training programs, both university and non-university based, serve as change agents. These departments can be laboratories to test laborist, generalist, night float, part-time, reentry, and other options. And those models that are most successful will and must serve as exemplars for others to adapt in their own local, historical, and cultural context.<sup>14,15</sup> These departments and their leaders must take the risk and create the innovation to be laboratories and exemplars of what obstetrics and gynecology as a specialty can be, should be, and will be.

There are several recognizable explanations for some of the current challenges, some already clearly described Dr Gibbons. To these, I want to highlight a few:

## Generational issues

I do not believe we have paid adequate attention to generational issues, which are becoming more relevant and important than they have ever been before. Our business school colleagues have come to accept these fundamental differences among my generation, the baby boomers, and generation X.<sup>16-20</sup> And it looks like generation Y will be even more problematic for generation X than generation X has been for the boomers. We need to understand each other's values and work together better as we all move forward.

**Table II** Assets and liabilities

Baby boomer assets	Generation Xer assets
<ul style="list-style-type: none"> <li>• Team player</li> <li>• Driven</li> <li>• Service oriented</li> <li>• Willing to go the extra mile</li> </ul>	<ul style="list-style-type: none"> <li>• Independent/individualistic</li> <li>• Adaptable</li> <li>• Techno-literate</li> <li>• Creative</li> <li>• Unintimidated by authority</li> </ul>
Baby boomer liabilities	Generation Xer liabilities
<ul style="list-style-type: none"> <li>• Not budget minded</li> <li>• Self-centered</li> <li>• Judgmental</li> </ul>	<ul style="list-style-type: none"> <li>• Impatient</li> <li>• Poor people skills</li> <li>• Inexperienced</li> <li>• Cynical</li> </ul>

A series of authors have identified and classified generations as the traditionalist or silent generation (1925-1940), the baby boomers (1945-1963), the generation Xers (1963-1982), and generation Y (1985-). With respect to health care and medicine, "the silent generation" saw medicine as mysterious and doctors as god; "baby boomers" craved convenience and control and saw health problems as major life events; and generation X, Y, and onward are highly educated, highly uninsured, and Internet savvy and think they can diagnose their own disease. For boomers, seminal events are Vietnam, civil rights, birth control pills, and Woodstock and for generation Xers, personal computers, AIDS, the energy crisis, and now 9/11.

These life experiences lead to different values (Table I) and different assets and liabilities (Table II). To simplify, boomers are workaholics and generation Xers strive to "get a life." These differences lead to different approaches to work-life conflicts and low morale. Generation Xers will be more direct and outspoken, giving the impression that they are self-centered. In fact, expectations about work hours, time spent at work, and productivity as well as financial remuneration can be very different. Mentors need to understand these generational differences and use this knowledge to best advise and assist students, residents, and young colleagues.

## Gender issues

We must also understand that in addition to generational issues, gender inevitably will play a role in all medical practice, not just obstetric and gynecologic practice in the future.<sup>21</sup> With more than 50% of medical students now women, with more than 75% of all obstetrics and gynecology residents now women, “attention must be paid” to gender: women’s roles in society, families, and professions are inevitably going to influence change—practice style and tenure, to mention just a few—and this change will affect and benefit women and men in the years to come.

Differences that have been described, and I am grossly oversimplifying, show that women and the groups they form tend to use expressive skills; show compassion; and value relationships, interpersonal connections, and interactions as compared with traditional male individualism, separation, and independence. So if you add family and personal concerns, the biomedical information explosion, administrative burdens, debt and liability, and the 80-hour work week to generational issues and gender, we have a perfect storm that for our specialty seems sometimes to rival the most destructive natural disaster.

So how do we move forward? I believe we need to be bold and aggressive. Peterson and Willson both were, but I am concerned that recently we have seen too much hand wringing, too much backward looking and longing for the past, too few innovative ideas and innovations, too little understanding of issues, too few experiments, and too little execution. In one of my favorite recent books, *Execution: The Discipline of Getting Things Done*,<sup>22</sup> 2 business leaders speak of the importance of execution:

“Everybody talks about change. In recent years, a small industry of changemeisters has preached revolution, reinvention, quantum change, breakthrough thinking, audacious goals, learning organizations, and the like. ... But unless you translate big thoughts into concrete steps for action, they’re pointless. Without execution, the breakthrough thinking breaks down, learning adds no value, people don’t meet their stretch goals, and the revolution stops dead in its tracks. What you get is change for the worse because failure drains the energy from your organization. Repeated failure destroys it.”

So I advocate for action and execution in the clinical training and academic laboratories that I described above. This active transformation of our specialty, which will quickly and inevitably spread, will serve as an important signal to our medical students and residents that what we are doing has much to offer for them, for Bossidy and Charan also write:

“The beliefs that influence specific behaviors ... need changing. These beliefs are conditioned by training, experience, what people hear ... about prospects and perceptions about what leaders are doing and saying.

People change them only when new evidence shows them persuasively that they’re false. ... We don’t think ourselves into a new way of acting; we act ourselves into a new way of thinking.”

We must share in the criticism Bossidy and Charan level at those who have spent too much time on strategic planning and managing operations—clinical operations for many us—and not enough on execution. Gibbons, Gabbe, and others have shown us the challenges and suggested solutions, American College of Obstetricians and Gynecologists task forces are giving us plans and opportunities: We need to move forward. We need to try new ways of doing things: laborists, generalists, computerized continuing medical education, simulated surgical training, night floats, shared practices, liability reform, preferably in departments that can share their examples of best practice with others. This is what our predecessors did. They are looking for us to do the same.

In closing, I would like to adapt and invoke the challenge and spiritual commitment of my favorite hymn: “Let there be thoughtful, progressive transformation of the specialty of obstetrics-gynecology, and let it begin with us.”

## References

- Gibbons JM. Presidential address: springtime for obstetrics and gynecology: will the specialty continue to blossom? *American College of Obstetricians and Gynecologists. Obstet Gynecol* 2003; 102:443-5.
- Robinson P, Xu X, Keeton K, Fenner D, Johnson TRB, Ransom S. The impact of medical legal risk on obstetrician-gynecologist supply. *Obstet Gynecol* 2005;105:1296-302.
- Peterson R. The future of obstetrics and gynecology as a specialty. *JAMA* 1920;74:1361-4.
- Willson JR. Obstetrics-gynecology: a time for change. *Am J Obstet Gynecol* 1981;141:857-63.
- Willson JR, Burkon DM. Obstetrician-gynecologists are primary physicians to women. Education for a new role. *Am J Obstet Gynecol* 1976;126:744-54.
- Fenner DE. Training of a gynecologic surgeon. *Obstet Gynecol* 2005;105:193-6.
- Rogers RM, Julian TM. Training the gynecologic surgeon. *Obstet Gynecol* 2005;105:197-200.
- Gurtcheff SE. Training the gynecologic surgeon: a (recently graduated) resident’s perspective. *Obstet Gynecol* 2005;105: 2-3.
- Gabbe SG, Mueller-Heubach E, Blechner JN, Pearse WH, Depp R, Creasy RK. A blueprint for academic obstetrics and gynecology. *Obstet Gynecol* 1998;92:1033-7.
- Bettes BA, Chalas E, Coleman VH, Schulkin J. Heavier workload, less personal control: impact of delivery on obstetrician/xgynecologists’ career satisfaction. *Am J Obstet Gynecol* 2004; 190:851-7.
- Wachter RM, Goldman L. The emerging role of “hospitalists” in the American health care system. *N Engl J Med* 1996;335: 514-7.
- Weinstein L. The laborist: a new focus of practice for the obstetrician. *Am J Obstet Gynecol* 2003;188:310-2.

13. Martin JC, Avant RF, Bowman MA, Bucholtz JR, Dickinson JR, Evans KL, et al. The future of family medicine: a collaborative project of the family medicine community. *Ann Fam Med* 2004; 2(Suppl 1):S3-32.
14. Berman DR, Johnson TRB, Apgar BS, Schwenk TL. A model of family medicine and obstetrics/gynecology collaboration in obstetrical care at the University of Michigan. *Obstet Gynecol* 2000;96:308-13.
15. Anderson GD, Nelson-Becker C, Hannigan EV, Berenson AB, Hankins GDV. A patient-centered health care delivery system by a university obstetrics and gynecology department. *Obstet Gynecol* 2005;105:205-10.
16. Zenke R, Raines C, Filipczak B. *Generations at work*. New York (NY): Amacom; 2000.
17. Karp H, Fuller C, Sirias D. *Bridging the boomer Xer gap*. Palo Alto (CA): Davies-Black; 2002.
18. Lancaster LC, Stillman. *When generations collide*. New York (NY): Harper; 2002.
19. Bickel J, Brown AJ. Generation X: implications for faculty recruitment and development in academic health centers. *Acad Med* 2005;80:205-10.
20. Smith LG. Medical professionalism and the generation gap. *Am J Med* 2005;118:439-42.
21. Moschos E, Beyer MJ. Resident attrition: is gender a factor? *Am J Obstet Gynecol* 2004;191:387-91.
22. Bossidy L, Charan R. *Execution: the discipline of getting things done*. New York (NY): Crown Business; 2002.