



The American College of Obstetricians and Gynecologists

Women's Health Care Physicians

COMMITTEE OPINION

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Committee on Patient Safety and Quality Improvement

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The Obstetric–Gynecologic Hospitalist

ABSTRACT: The work models for the obstetric–gynecologic hospitalist and the obstetric laborist are gaining popularity and momentum in hospitals across the nation. These models could be timely solutions to the challenging demands of the general practice of obstetrics and gynecology. The American College of Obstetricians and Gynecologists supports the continued development of the obstetric–gynecologic hospitalist model as one potential solution to achieving increased professional and patient satisfaction while maintaining safe and effective care across delivery settings.

The obstetric–gynecologic hospitalist concept emerged from the hospitalist movement of the 1990s. The term *hospitalist*, coined in 1996 by Wachter and Goldman (1), refers to physicians whose primary professional focus is the general medical care of hospitalized patients. Their activities may include patient care, teaching, research, and leadership related to hospital care. Hospitalists help manage the continuum of patient care in the hospital, often seeing patients in the emergency department, following them into the critical care unit, and organizing postacute care (2). Hospitalists are increasingly present as members of departments of medicine across the United States. According to the American Hospital Association's survey, in 2007 there were 28,000 practicing hospitalists.

Laborist Concept

The term *laborist* most commonly refers to an obstetrician–gynecologist who is employed by a hospital or physician group and whose primary role is to care for laboring patients and to manage obstetric emergencies (2). Responsibilities may be broad or narrow in focus, and can range from admitting and providing care for low-risk patients in early labor to delivering babies of all patients for a group specializing in maternal–fetal medicine. Depending on the hospital system, whether academic or nonacademic, laborists may provide direct resident and student supervision with teaching responsibilities, provide backup support to certified nurse–midwives (CNMs) and family physicians, or provide care for unassigned patients. Other responsibilities could include assisting in surgery, providing backup support

for precipitous deliveries, and providing a respite for a fatigued practitioner. An obstetric–gynecologic hospitalist may provide in-house gynecologic services as well, performing inpatient consultation and seeing patients in the emergency department as necessary. The hospital also may use multidisciplinary laborist staffing, with CNMs serving as CNM laborists within the scope of their practice in individual states. The CNM laborists may be hired either by physician practices or hospitals to attend to a variety of coverage options.

Benefits and Limitations

For the obstetric–gynecologic hospitalist, practicing solely in the hospital setting relieves the pressures of a private practice, such as overhead and collections, and may help with liability premiums. Among the possible benefits may be more predictable schedules, competitive compensation, paid benefits, and guaranteed time off.

The benefits to the hospital include enhancement of patient safety and an increased level of nursing satisfaction because a health care provider is always present and available. In addition, improved outcomes may result from laborists being well rested when coming onto their shifts in the labor and delivery unit.

Laborists are challenged by the ongoing desire of patients to continue their patient–physician relationship and share this very personal and special time of pregnancy with a clinician they know and have come to trust. Because patients may value this relationship with their primary clinicians during pregnancy, the obstetri-

cian should inform patients that laborists are part of the health care team that may provide their care.

A key element for instituting an obstetric–gynecologic hospitalist program within a facility is the establishment of clear communication methods between obstetric–gynecologic hospitalists and primary health care providers. Handoff of patients, updates on progress, and follow-up, are all important areas to address because communication gaps are a potential source of patient injury.

One area central to the laborist–private practice partnership that may not be clear focuses on cost and reimbursement. Private clinicians are concerned about whether labor management or delivery of their patients' babies by a laborist will affect their income. Delivery fees are often a major portion of compensation for pregnancy care, and as such, concern arises as to whether private attending physicians working with laborists can continue to bill for a global fee. The hospital may bill for the laborists' services, which helps partially offset the expense of having this service available. The economics of this equation—including delivery, consultation, and assistant fees—will require further evaluation in each setting considering use of a laborist.

For obstetrician–gynecologists in general practice in the community, having an obstetric–gynecologic hospitalist in practice at their admitting hospital affords several advantages. For example, obstetric–gynecologic hospitalists can assume the responsibilities of on-call obligations, which for the busy, general obstetric–gynecologic practice commonly extend beyond 24 hours. This often is followed by postcall ambulatory office hours (3). Obstetric–gynecologic hospitalists can provide coverage for patients who come to the hospital uninsured or unassigned for prenatal care. An obstetric–gynecologic hospitalist program affords office-based physicians greater autonomy over their personal and family lives. Physicians in private practice benefit by having coverage for their unscheduled laboring patients if they cannot get to the hospital, are in the middle of busy office hours, or have scheduled operative cases. Depending on the circumstances, they may choose to use the services of the laborist or come in themselves. In addition, the laborist is readily available to respond to any obstetric emergencies or urgent needs and is at the patient's bedside expeditiously, offering a timely assessment at the time of admission.

In some ways, a laborist can function in a manner similar to a partner in absentia. While a health care provider finishes office hours, completes an operating room case, or gets a few more hours of sleep, the laborist can attend to the health care provider's hospital patients, thus saving the primary health care provider multiple trips to the hospital. A successful laborist program may be one of the first steps toward assisting communities faced with a shortage of obstetricians. This model also may provide an alternative for obstetricians who are considering giv-

ing up obstetric practice that requires both prenatal and delivery services.

Many university-based teaching institutions have an implicit version of the obstetric–gynecologic hospitalist model that relates to their faculty who are required by the Accreditation Council for Graduate Medical Education/Residency Review Committee mandate to supervise residents in-house. The difference between this and a true laborist program is that the laborist position can be expanded to include nonacademic private practice health care providers. Depending on the type of laborist program an institution uses, one might staff the labor and delivery unit full time with these acute-care physicians, while prenatal care is provided as a separate entity in the office. Further, the model can be altered to allow private practitioners to receive updates on their patients from the laborist while in the office, the operating room, or at home, and be given a choice of if or when they would like to come in. Finally, the laborist may assist in such early labor care events as monitoring fetal heart tracings, performing cervical examinations and amniotomy, starting labor induction, initiating oxytocin augmentation, or ordering epidurals, and documenting these events in the medical record.

One primary limitation of the laborist model focuses on the nonlaborist maintaining obstetric privileges in the hospital setting. Hospitals may require physicians to perform a minimum number of procedures to retain their privileges. It may be more difficult for office-based physicians to demonstrate current clinical competence if most of their in-hospital patient care is handled by laborists. This is a critical consideration in establishing an obstetric–gynecologic hospitalist program.

Obstetrician–gynecologists in different phases of their careers will have different responses to the obstetric–gynecologic hospitalist role. The obstetric–gynecologic hospitalist model may be met with some resistance from some physicians and patients. It will require a paradigm shift for certain obstetrician–gynecologists to accept the use of obstetric–gynecologic hospitalists in their respective facilities. However, this model may be appealing, particularly for younger obstetrician–gynecologists who are concerned about liability coverage, establishing an independent practice, and maintaining a comfortable life style.

Other Considerations

Successful implementation of an obstetric–gynecologic hospitalist program will require consideration of a number of factors. The most important of these factors is establishing mechanisms for communication between the obstetric–gynecologic hospitalist and the patient's primary physician, including ready access to the patient's complete ambulatory records. Another important consideration is the establishment of protocols and policies that all health care providers agree to accept. Consensus has to be reached on various clinical approaches, including indications for induction, management of preeclampsia, and parturition and postpartum order sets (4).

An ideal obstetric–gynecologic hospitalist program might have a group of health care providers led by a medical director who assists in coordinating schedules, protocols, policies, and committee meetings at which both the obstetric–gynecologic hospitalists and private practitioners are represented. Obstetric–gynecologic hospitalists should not be expected to provide patient care according to private practitioners’ instructions with which they disagree or which are not supported by clinical evidence or hospital policy. Standardized order sets and antepartum records among all affiliated private practitioners would decrease the frequency and number of adjudication conversations.

Various Models

The probability and success of a laborist program will vary by hospital type (teaching versus nonteaching), size of service (number of deliveries), number of obstetricians who support such a program, community circumstances, financial circumstances, and reimbursement methods. No one approach will fit all situations. The costs of employing obstetric–gynecologic hospitalists may be offset by an increase in patient safety, improved documentation, lower liability payouts, and the ability to bill for the obstetric–gynecologic hospitalists’ services.

Summary

The obstetric–gynecologic hospitalist model has the potential to achieve benefits for the obstetrician–gynecologist given the varied demands of the specialty. These demands may include heavy call schedules; high volume; the potential for emergent situations, particularly in obstetrics; and the increasing number of in-office and outpatient procedures. These factors also must be balanced within the medical–legal climate of medicine because the option of prenatal care may be limited by the liability carrier. There may be added potential benefits to patients and their families.

The separation of the prenatal care process from labor and delivery is one solution for physicians who, for a variety of reasons, may be considering giving up the practice of obstetrics. A balance between a combined obstetric–gynecologic practice versus a gynecology-only practice may be achieved through an obstetric–gynecologic hospitalist program.

For the various reasons outlined in this Committee Opinion, the American College of Obstetricians and Gynecologists supports the continued development of the obstetric–gynecologic hospitalist model as one potential approach to achieving increased professional and patient satisfaction while maintaining safe and effective care across delivery settings.

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