OBG MANAGEMENT

The laborists are here, but can they thrive in US hospitals?

So new is this model that hard data on its value are wanting. But those who have firsthand experience report important benefits.

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IN THIS ARTICLE

At Shawnee Mission Medical Center in Kansas City, Kansas, a delivery early this year placed the 3-day-old laborist program squarely in the spotlight.

The uterus ruptured in a patient who had placenta previa. She required immediate intervention, but her private ObGyn was 25 minutes away. A laborist stepped in and performed C-section within 10 minutes, while the private physician was still en route.

"And our neonatologist said, had we had to wait the extra 5 or 10 minutes it took for that doc to arrive and get started, there would have been a much worse outcome for that baby because it had lost 40% of its blood volume," says Deb Ohnoutka, administrative director of women's and children's services.

Not all interventions involving a laborist are as dramatic, but the laborist, or OB hospitalist, model—in which a hospital employs board-certified ObGyns for 24/7 coverage of labor and delivery—is gradually taking hold.

Because the model is new, there are no concrete data on exactly how many hospitals employ laborists or whether safety has improved as a result. To get an idea of how this model is faring, OBG MANAGEMENT interviewed a number of program administrators and laborists, whose comments are woven into this article. They describe diminishing pressures on community ObGyns, improved job satisfaction among laborists, greater patient safety, and other benefits.

Whence the inspiration?

It all started in 2003, when Louis Weinstein, MD, now chairman of obstetrics and gynecology at Jefferson Medi-

Are you a laborist?

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"Why is there a laborist, Mommy?" Because the hospitalist model works so well...

Louis Weinstein, MD, chairman of obstetrics and gynecology at Jefferson Medical College in Philadelphia, proposed the laborist model in 2003.[1] Among the justifications he gave for the new model were the following observations about the hospitalist model:

- "The reasons for development of the hospitalist model included an increase in the serious nature of disease in hospitalized patients, the need for physicians to spend more time in their offices with increasing outpatient volume, the decrease in inpatient admissions, the difficulty for most practitioners to stay at the cutting edge of medical care, and the documented fact that those who do something repetitively do it better and with less expense."[1]
- "Studies have demonstrated that patient satisfaction has been preserved by using a hospitalist and that significant reductions in resource utilization have occurred while good clinical outcomes were maintained."[1–4]
- "An interesting analysis of hospitalists themselves demonstrated a high level of job satisfaction, low levels of burnout, and a long-term commitment to remaining in this field."[1,5]
- "A concern frequently expressed about the hospitalist is the disruption of care when the hospitalist becomes responsible for the hospitalized patient. Evidence exists among medical patients that they are very satisfied with the care of the hospitalist because of immediate physician availability, increase in time to talk with the patient and family, and expertise in patient management."[1,6]

cal College in Philadelphia, penned an opinion piece for the *American Journal of Obstetrics and Gynecology* on the need for a new way of practicing obstetrics.[1] Weinstein cited some of the pressures assailing the profession.

"The desire to control one's personal life, coupled with an apparent decrease in aggregate productivity and the increasing cost of professional liability insurance," he wrote, "have the potential to lead to a decrease in the available obstetric work force within the next decade."[1]

Weinstein now says that, in fact, roughly "30% of physicians will stop working in the next 7 years. People say there's a shortage of physicians, but it's really a shortage of *working* physicians. It's because of physician dissatisfaction."

The solution?

Weinstein points to the success of the hospitalist model, which originated in 1996. He proposed a similar paradigm for obstetrics.

"I just sat down and worked out this thing called the laborist movement. When you look at the hospitalist model, their safety is way up" and job satisfaction is improved, he says, noting that he expects the laborist model to have a similar impact.

It took a while for Weinstein's proposal to percolate through the specialty.

"I wrote about it in 2003 and for 2 years nobody even talked to me about it," he says. It wasn't until 2005 that the discussion began.

People began to acknowledge that a significant change in practice was needed to improve quality of care, increase safety for the patient and her fetus, and reduce medical negligence actions for hospitals.

"The way we practice obstetrics is insane," says Weinstein. "People can't work like they're working."

Life in the "old days"

Krista Wills, MD, lead physician of OB hospitalists at Presbyterian Hospital in Albuquerque, clearly recalls the days before the program started. Everyone was stretched a little too thin back then.

"The patient would be in triage until the doc could come by and evaluate her and send her out," says Wills.

Depending on the physician's location and office schedule, that wait could be several hours.

"If the mom came in in active labor and had not had any prenatal care, the doc whose name was on the ED [emergency department] call roster would be called and would have to come in and do the delivery," Wills says. One of the problems with this system was that unassigned patients "who haven't had any prenatal care in general tend to be high-risk patients, and for the community physicians it was just becoming an increasing burden. People did absorb it before, but

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it was something that creates not exactly friction but physician dissatisfaction."

Presbyterian Hospital began its OB hospitalist program in January 2006. In general, its laborists have four main responsibilities:

- "We labor and deliver all the babies that come from high-risk mothers" that are cared for by a private group of perinatologists based at the hospital, says Wills. "We accept all the maternal transports from all over the state. The majority of these moms have had care in a small town in New Mexico—one of our regional facilities or just a small town—and the mom is either very sick and requires tertiary care or the baby is going to be born prematurely and needs a level III NICU."
- "We take care of the unassigned patients who drop into the ED or OB triage area."
- "We first-assist for a majority of the C-sections performed in the hospital."
- "We are also a backup for our community doctors." ("We're not trying to take away their billings or anything like that," Wills adds. "We just want to decrease our unattended delivery rate. And we just want to be able to get patients through triage more quickly.")

Safety and continuity of care are among the benefits

At Middle Tennessee Medical Center in Murfreesboro, where the laborist program has been in effect for almost 20 months, the principal benefit has been increased safety—although that isn't the only advantage.

"We've had three instances already since November of 2006 where we feel that there would have been a significant negative outcome either with a mother or a baby if we had not had a physician in house ready to go when that particular obstetrical emergency presented," says Andy Brown, MD, vice president of medical affairs. "So we do feel that [the laborist program] provides a very good standard of care for the hospital."

Overall, ObGyns in the community have been pleased with the program.

"It has actually allowed them to increase the size of their practices because they're in much better control of what happens during the routine office hours," says Brown. "They have better control over their office schedules."

And the patients of those physicians?

"The vast majority of patients would be relieved to realize that there is someone there for an emergent situation," Brown says.

Concurring with that observation is C. Brent Boles, MD. "We are very happy with the program," he says. "I'm speaking with two hats on because I'm the medical director of the laborist program [at Middle Tennessee Medical Center], but I'm also a private physician."

Boles confirms that a drive for ever-increasing safety was one of the concerns that prompted creation of the program.

"I wouldn't say that it was the principal driving force, but it was certainly one of the top two or three reasons. Probably the consistency or continuity of care that is now easy to provide for the service call patients and the immediate coverage of in-house emergencies are the two major benefits to the community."

Another benefit of the laborist model: It makes a trial of labor after C-section [vaginal birth after C-section (VBAC)] possible in hospitals that have 24/7 coverage. At Shawnee Mission Medical Center, the laborist program has greatly increased the number of VBACs.

"We had actually stopped laboring VBACs," says Ohnoutka. "We mostly sectioned them." Since the laborist program began, "we've seen a huge increase. There are some docs who really and truly believe in laboring VBACs and have hated not to be able to do it. So [the laborist program] has driven some volume here because other hospitals in our community aren't doing it."

At Monmouth Medical Center in Long Branch, New Jersey, a laborist program has been in place for a little over 2 years.

"It's going very well in the sense that the solo practitioners that we have in the area really do appreciate it," says Raksha Joshi, MD, chief medical officer and medical director of Monmouth Family Health Center. "It prevents disruption to their office practice as well as to their lifestyle."

That does not mean the program is accepted wholeheartedly by every physician and patient, however.

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>
> ›› ANDY BROWN, MD

Launching a laborist program: Why three hospitals did it (and how)

MIDDLE TENNESSEE MEDICAL CENTER

- Murfreesboro, Tennessee
- 286-bed private hospital (nonprofit); 2,500 deliveries a year
- Launch: November 2006

Motivators: "Before, it was the standard in most communities that an ObGyn had to be available within a reasonable length of time," says Andy Brown, vice president of medical affairs. "And for a lot of communities, that length of time is 30 minutes. But 30 minutes is a long time when you're in an emergent situation."

How things work: Laborists work seven 12-hour shifts over a 2-week period. Responsibilities include managing unassigned patients who present with ObGyn complaints, 24/7 coverage for emergencies, and backing up private physicians who cannot get to the hospital in a reasonable time.

PRESBYTERIAN HOSPITAL

- Albuquerque, New Mexico
- 453-bed tertiary community hospital; 5,937 deliveries in 2007
- Launch: January 2006

Motivators: The need to treat high-risk gravidas from small towns and rural areas of New Mexico, who are transported to Presbyterian Hospital for specialist care and the level III NICU.

How things work: Laborists work three 12-hour shifts a week. Responsibilities include delivering babies of high-risk mothers cared for by in-house perinatologists; managing unassigned pregnant patients who drop into the ED or OB triage area; backing up community ObGyns who cannot get to the hospital in a reasonable time or who have more than one delivery at a time; and first-assisting for a majority of the hospital's C-sections.

SHAWNEE MISSION MEDICAL CENTER

- Kansas City, Kansas
- 385-bed community hospital (nonprofit); 3,200 deliveries a year
- Launch: February 2008

Motivators: The need for an ObGyn to be "immediately available" for VBAC deliveries, according to ACOG guidelines, says Deb Ohnoutka, administrative director of women's and children's services. "We also wanted to take that next notch up and provide the safest, highest quality care."

How things work: Laborists work two 24-hour shifts a week managing unassigned patients who present to the hospital, precipitous births, and VBAC patients; they also back up private ObGyns who may not be able to get to the hospital in a reasonable amount of time.

"I think there may be some resistance from both sides in the sense that, traditionally, ObGyn has been a model where a patient has had a full ride," says Joshi, "of demanding and expecting that her own physician will be the one to deliver her. That may be a bit of a barrier to overcome."

Life as a laborist

From the point of view of the laborists themselves, the advantages of the job are many.

"I would say a lot less stress, a lot more free time," says Kathryn Mills, MD, one of the laborists at Middle Tennessee Medical Center. "I have free time during the week if I'm not on a shift, so it's great."

Laura McMurray, MD, a laborist at Shawnee Mission Medical Center, is also enthusiastic.

"I love doing OB and this is the best of both worlds," she says, "where you can do what you like to do—take care of patients—but you don't have the call issues and the daily pressures of private practice. It allows you to have more time with your family and to be able to participate in a lot more of their activities."

Krista Wills, MD, the head of the laborist program at Presbyterian Hospital in Albuquerque, is also a laborist herself. She is very happy with the job.

"I started practice in 1990," she says. "At the time, a female ObGyn quit OB after roughly 10 years and went to GYN only. Her patient volume was built, her patients had aged with her, and now she could switch over to GYN."

"If OB is truly your love but you need a more scheduled lifestyle, then being an OB hospitalist gives you that opportunity," says Wills. "I love the OB part of ObGyn. I still get very excited for deliveries—it doesn't matter if it's two or three in the morning, I still get psyched with it."

"We have no office; we have no overhead; our liability insurance is paid by the hospital. And it allows me to continue doing OB in a manner that doesn't give me 60-hour workweeks and being up all day, then up all night, then up all day, which is really exhausting," she adds.

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If there is a downside, it is narrowing of the spectrum, says McMurray.

"You may not be doing the entire scope of what you might be doing in private practice in terms of GYN. You don't really develop a relationship with the patient—a long-term relationship with the patient. I think that's true of any type of emergency room, any situation in which you are doing more of a shift as opposed to being on call as a private practice sort of thing. But I don't view those as negatives. Somebody might, but that's part of how it's set up."

According to Boles, word of the advantages of working as a laborist is spreading among ObGyns as a whole.

"I get phone calls from physicians who are interested in finding out if we have any openings because they would love to close their private practice and walk away from the hassle."

> "Hospitals are offering $100 an hour for call and nobody will take them up on it."
>
> ›› LOUIS WEINSTEIN, MD

Does the laborist model pay for itself?

The answer depends on how you calculate its benefits.

"We don't expect it to make a profit," says Ohnoutka, "but we do hopefully expect it to get close to breaking even."

"I think when you look at all the drivers, there are different ways to make that happen," she says. "If a private doc consults, we can bill consultant fees. If we do a delivery for them, we can bill a delivery fee. But I think when you look at improved physician satisfaction and improved nursing satisfaction, when you look at decreasing liability because you have somebody here at all times, it will pay for itself in many other ways than just the bottom line."

At Presbyterian Hospital, the case is more clear-cut.

"Our biggest thing is that we are able to increase the number of maternal transports that we are able to take from all over the state," says Wills.

Because the NICU "traditionally is a profit-maker for hospitals because the babies are all insured or qualified for Medicaid, there is a downstream benefit: It helps out the women's program overall, it helps out the children's program overall, if you look at the bottom line," she says.

At Middle Tennessee Medical Center, hospital administrators aren't as concerned about the strict bottom line.

"With the goodwill in the local ObGyn community and with the standard of care that we are now able to provide for the community, I think that's where the payoff comes in," says Brown.

Will the model spread?

Louis Weinstein, MD, thinks it will. He predicts that, in 10 years, most hospitals with more than 2,000 deliveries a year will have a laborist program.

"Hospitals are offering $100 an hour for call and nobody will take them up on it," he says. That makes a new model inevitable.

Like Weinstein, Boles sees lifestyle issues as a dominant force.

"Our three full-time laborists are very happy with their work schedule. When they're working, they're at the hospital. When it's not their shift, they go away, they turn their beeper off, they don't have to answer their cell phone, and they can go do whatever they want to do. So it's a model that will become increasingly attractive for many, many people as the pressures on private practices increase."

If the laborist model has significant warts, they have yet to reveal themselves, at least among the programs described here. It may be that the burden of business as usual has become so great that the model's primary impact is relief. As it matures, areas in need of fine-tuning or overhaul should become apparent.

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