Ob.Gyn. Specialty Shifts Practice, Training Methods

Everything from new attitudes to technology will alter the way young physicians do their work.

BY SHERRY BOSCHERT
San Francisco Bureau

RANCHO MIRAGE, CALIF. — The face of ob.gyns. is changing, and so are practices and training methods in the specialty, several speakers said at the annual meeting of the Society of Gynecologic Surgeons.

"Our specialty is currently in crisis," said Joseph Schaffer, M.D., who moderated a session on the future of the specialty. Problems with changing attitudes toward work among younger physicians, increasing subspecialization, reimbursement, and malpractice insurance premiums, and shorter hours for residents pose challenges that will alter the lives of many ob.gyns., said Dr. Schaffer of the University of Texas Southwestern Medical Center, Dallas.

Many younger physicians value their free time highly and prefer to limit practice hours, even if it means staying out of the operating room or delivery room, Stanley Zinberg, M.D., said, adding that he sees this as a generational issue. "To many of our young graduates, medicine is not a calling or a commitment, it's a job," said Dr. Zinberg, vice president for practice activities for the American College of Obstetricians and Gynecologists (ACOG).

At the same time, the gender balance in ACOG is changing rapidly. ACOG leaders are pleased that the college is expected to have an equal number of male and female members by 2010, earlier than the previous estimate of 2014, Dr. Zinberg noted. Of ACOG's 47,322 members, 42% are women, but among its 9,600 "junior fellows" (in residency or early practice) 71% are women.

For many years, only about 2% of ob.gyns. were subspecialists, but this too will change, he predicted. In the near future, perhaps half of ob.gyns. will follow the conventional generalist model of practice and the rest will practice maternal-fetal medicine, gynecologic oncology, pelvic reconstructive surgery, or reproductive endocrinology. Fellowship slots in these subspecialties today tend to be full, which wasn't the case a few years ago.

Governmental actions portend other changes. Medicare reimbursements will be reduced by 31% over the next 5 years, while physicians' costs will increase by 15%, not counting changes in the cost of liability insurance, Dr. Zinberg said. "Ob.gyns. may decide to accept fewer Medicare patients."

Congressional leaders have said they will not consider adjustments to Medicare payment rates unless these changes include reforms to base pay on measures of physician performance, called "pay for performance." Despite a lack of validated, evidence-based measures of physician performance, "pay for performance is on a fast track, whether we're ready or not," he said.

Separately, a key turf battle looms over physicians' right to perform ultrasound imaging. "Radiologists' top legislative priority is to make sure that nonradiologists do not perform imaging procedures," Dr. Zinberg said. No legislation has been introduced, but there is talk of requiring accreditation for ultrasound imaging, which ACOG opposes.

Another shift is seen in gynecologic surgery training in response to 80-hour limits on residents' workweeks, technological innovations, and other factors, Dee Fenner, M.D., said in a separate presentation during the session.

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DR. FENNER

No longer will surgical training rely predominantly on the apprenticeship model, which teaches through the example of skilled mentors and repetition of a high number of procedures, said Dr. Fenner, director of gynecology of the University of Michigan, Ann Arbor.

"The apprentice system will never go away. It will always be a major part of our surgical education, but we need to modify it," she said. The adoption of formal curricula is a key move toward creating reliable, valid criteria for assessing surgical competency and away from the subjective assessments used in the apprenticeship model.

With shorter hours, residents today experience a smaller volume of surgeries. Many residents now train at four hospitals rather than at a single institution, an obstacle to developing mentor relationships. Pressures on faculty to produce revenue or meet other goals interfere with teaching, altering the one-to-one ratio of residents to faculty that once was the norm.

Ethical and cost considerations also hinder the apprenticeship model. Time in the operating room (OR) is expensive. Patients may demand a faculty surgeon rather than a resident for their operation.

Increasingly, surgery will be learned and practiced outside of the OR using simulators, models, and patient substitutes. "There are no data to say that you can't use a watermelon for a C-section" as effectively as a more expensive manufactured model, but an increasing number of models will be available, Dr. Fenner said.

The rapidly growing field of haptics (the science of touch) infuses simulators with a lifelike feel when you poke with an instrument or grab with a grasper. Newer mannequins can be programmed for codes—give one epinephrine and it will exhibit tachycardia, for example. Virtual-reality technology is being used to develop training models for such procedures as obstetrical deliveries and ultrasound, as well as for handling forceps and all types of scopes. A virtual OR provides practice in surgical skills and also can help train teams or team leaders.

"This is where we'll be training our residents and our faculty in the very, very near future," she said.

Telementoring will begin to play a role, with surgical mentors outside the OR sometimes guiding trainees in real surgery through audiovisual connections.

All this new technology isn't inexpensive, but hospitals probably will cover much of the cost if certifying physicians' surgical skills can help reduce malpractice risks, Dr. Fenner said.

Ob.gyn. residents should have a bit more time for surgical rotations after July 2005, when primary care requirements will be trimmed. No mandatory rotations in primary care clinics and fewer continuity clinics will mean more time for subjects that are more integral to ob.gyns.—a prediction applauded by physicians at the meeting. ■

Baby Boomers May Overwhelm Entire U.S. Medical System

BY TIMOTHY F. KIRN
Sacramento Bureau

SAN FRANCISCO — The baby boomers might do more than bankrupt Medicare—they could break the entire medical system, members of a panel said at the annual meeting of the American College of Physicians.

With 76 million baby boomers starting to approach age 65, the elderly population will double by 2040, potentially bankrupting the Medicare trust fund by 2020 and Social Security by 2042.

But they may also overwhelm the health care system with chronic conditions. The medical system is set up to assume that patients with a chronic condition have only one, but most of the elderly have more than one chronic condition, said Robert A. Berenson, M.D., a senior fellow in health policy at the Urban Institute in Washington.

Of persons older than 65 years, 84% have at least one chronic condition, 62% have two or more, and 20% have four or more. People with chronic conditions see more physicians more often, which greatly increases the potential for inefficiency and confusion in their care, Dr. Berenson said.

The average person with no chronic conditions sees 1.3 physicians a year and has two medical visits. In contrast, the average person with five chronic conditions sees almost 14 physicians (including radiologists and anesthesiologists) per year and has a total of 37 visits, Dr. Berenson said.

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A Harris survey asking persons with a chronic condition about their care in the preceding 12 months found 54% had been told they were at risk for a harmful drug interaction because of what they were taking, 54% had duplicate tests or procedures, 52% had received different diagnoses from different physicians, and 45% had received contradictory medical information.

Fundamental problems in the medical system must be addressed to manage the influx of baby boomers with multiple needs. These problems include the shortage of geriatricians; training oriented toward hospital care, rather than prevention and management of chronic conditions; and even the reliance on guidelines for care. Guidelines are generally written for one condition and tend to ignore comorbidities, Dr. Berenson said.

The growth of the elderly population is a problem compounded by the obesity epidemic and the sedentary lifestyle of many Americans, said David K. McCulloch, M.D., of GroupHealth Cooperative, Seattle.

To respond to this "triple whammy" crisis in health care, the medical system will have to reinvent itself to embrace more prevention and coordinated care, including adopting pay-for-performance strategies that offer providers incentives for keeping patients well, Dr. McCulloch said.

There is evidence that a chronic-illness model of care delivery that coordinates care and provides wellness services can reduce costs and hospitalizations and benefit patients. Many of the patients who can benefit from this approach are diabetic patients, he said.

At Dr. McCulloch's HMO, a 3-year pilot program for 18,000 diabetic patients decreased hospitalizations by 25% and overall costs by 11%, although pharmacy costs increased 16%. The program was credited with improving the patient group's average hemoglobin A_{1c} levels significantly.

An unpublished Rand study found evidence that this type of program can be implemented in private physicians' practices, and that when one practice in an area adopts such an approach, other practices in the area begin to copy it, he said.

Dr. Berenson commented that the relative value, resource-based system of payment might have to be overhauled so that there is more incentive for good chronic-disease management. ■