

A Difficult Labor: The Practice of Obstetrics and Gynecology

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Broadly speaking, the two main challenges currently confronting Obstetrics and Gynecology are:

1. optimizing obstetric outcomes and maintaining quality, life-long gynecologic care; and
2. sustaining the OB/GYN workforce.

Optimizing obstetric and gynecologic care requires implementation of relevant new technologies, regular assessment of clinical competency, meaningful health care quality assurance, and improved patient safety. Maintaining and increasing our professional workforce means attracting more residents, improving the lifestyle of the practicing obstetrician, and developing fair and just alternatives to our current tort system.

To improve health care quality, physicians must enhance skills in clinical assessment and the use of new treatment and diagnostic technologies. The day-to-day practice of obstetrics is impacted by the increasing numbers of pregnant women who are judged to be at high risk. The national obesity problem, increasing maternal age, and the number of patients now having multiple gestations as a result of fertility treatments have contributed to the growing group of high-risk patients. The continuing evolution of obstetric ultrasound will facilitate their care.

Preconception screening, as well as prenatal screening, now gives prospective parents more information and more reproductive choices before and after conception. However, the number of genetic diagnoses for which we can now screen requires more time from the obstetric provider to make sure patients are accurately counseled and screened, and the available screening options will only increase in the future.

Another challenge facing OB/GYNs is an increased emphasis on assessments of competency and professionalism. In cooperation with the American Board of Medical Specialties, the American Board of Obstetrics and Gynecology will introduce a new Maintenance of Certification program in January 2008, focused on four major areas:

- professional standing;
- lifetime learning/self-assessment;
- cognitive expertise; and
- continuous quality improvement.

Cognitive expertise will be evaluated by written examination every six years; the other components will be evaluated annually. Also, the Joint Commission will soon implement six competencies for hospital credentialing of physicians. These mimic those developed by the Accreditation Council of Graduate Medical Education (ACGME) for residency training.

Reducing Errors

Medical error is often based on the failure of systems, rather than the failure of individuals. Use of computer-assisted medication prescribing (to ensure correct drug/dosage and the absence of contraindications and drug interactions), surgical simulation training, and emergency response drills can improve patient safety. So, too, can the improved screening of medical students and residents for interpersonal and communication skills (as well as relational attributes such as empathy and caring). ACOG's Patient Safety and Quality Improvement department continues to collaborate with other groups on relevant OB/GYN initiatives. These include sharing ACOG records and formats with EMR/EHR software manufacturers at no cost and liaison relationships with the Certification Commission on Health Information Technology (CCHIT) and Integrating the Healthcare Enterprise (IHE).

The challenge of maintaining and increasing the workforce of OB/GYNs has received increased emphasis since 2004, when the percentage of United States senior medical school graduates matching in available ACGME-approved residency programs fell to 65 percent. The factors most commonly cited by medical students for not choosing OB/GYN are:

- insufficient time for family and leisure,
- irregular work hours,
- low pay,
- litigation/fear of litigation, and
- cost and availability of liability insurance.¹

On the positive side, no other specialty combines a diversity of practice which, in addition to obstetric and gynecologic care, offers elements of reproductive endocrinology, internal medicine, mental health, urogynecology, and oncology. Moreover, practice in institutional and large group settings has ameliorated many quality-of-life and liability-related issues for new residency graduates. The 2007 increase in U.S. medical school graduates entering OB/GYN programs (to 72.5 percent of available positions) is a cause for cautious optimism.

Improving the lifestyle for those who practice obstetrics and gynecology is, of course, part of our task in recruiting to the specialty. It is also an important element in preventing burnout and keeping established OB/GYNs in obstetrics longer. According to ACOG's 2006 liability survey, the average age of physicians leaving obstetrics for a gynecology-only practice was 43 years for women and 52 years for men. In addition, OB/GYNs sense a loss of control and a loss of mastery in clinical practice, which results in an overall loss of satisfaction in having done a job

well. Because of time constraints, OB/GYNs frequently feel unable to give their best to each patient, unable to be confident that they have done all that needs to be done, and unable to be certain that a diagnosis is correct. This challenge will be addressed in part by new technologies. For example, computer and PDA-based treatment algorithms will improve the quality of differential diagnosis, and electronic records and prescribing software will expose drug contraindications and minimize drug interactions before the prescription is written.

The Cost of Doing Obstetrics

In terms of keeping the office open, no other specialty labors with the levels of diminished reimbursement and extraordinarily high liability insurance costs presently experienced by OB/GYNs. For instance, in 10 of 50 states, 2006 malpractice insurance premiums average between \$107,000 and \$192,000 and may be as high as \$299,000.² Depending upon geographic locale and prevailing rates of reimbursement for a single delivery, an OB/GYN might perform between 75 and 150 deliveries a year just to pay his or her premium.

Yet another level of impact is the stress and fear engendered by lawsuits. Current research indicates that, in cases of neonatal encephalopathy, only 10 of 100 cases are related to intrapartum events.³⁻⁴ Of those 10 cases, an undetermined number are of a type which does not permit any effective intervention by the clinician and cannot therefore be judged of negligent cause. Yet, babies with neonatal encephalopathy often represent potential multi-million dollar lawsuits.

While all areas of medicine are facing difficulties, OB/GYNs struggle in the face of economic stresses from diminished reimbursement and increased professional liability costs. We all hope that new technologies for both clinical care and practice management will be successful in improving the efficiencies and cost-effectiveness of the physician's office. As patients' diagnoses become more complicated and the number of services they need continue to expand, much is expected from these potential developments. ■

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Patient B represents a less common and more complex situation. This patient wishes to change her mind. Regardless of the reasons for her initial choice not to receive an epidural, that decision was made at a time when the patient was not in labor and not in pain. Is this truly an informed decision? Perhaps not. It has been suggested that true informed consent for pain relief cannot be completely "informed" until the patient actually experiences the severity of the pain.⁵⁻⁶ Hence, perhaps the process of consent for pain relief in labor should actually be a two-part procedure, with a discussion prior to labor focusing on risks, and during labor focusing on benefits. A very realistic scenario is that a woman who initially refuses an epidural based on risks may eventually ask for and receive one based on benefits. True adherence to the principles of autonomy includes recognition of one's right to withdraw consent; everyone has the right to change his or her mind at any time.

Ideal circumstances would have all pregnant patients exposed to a comprehensive array of information regarding labor pain relief options, prior to the stresses of actual labor itself. Many obstacles preclude full implementation of this goal. Enhanced advocacy of extensive and unbiased sources of information in the prenatal education process would be of benefit.

Women in labor enjoy multiple pain-control choices, and the safety record of currently used techniques is remarkable. According to a recent statement by the American College of Obstetricians and Gynecologists, "many techniques are available for analgesia in laboring patients. None of the techniques appears to be associated with an increased risk of cesarean delivery. The choice of technique, agent, and dosage is based on many factors, including patient preference, medical status, and contraindications. Decisions regarding analgesia should be closely coordinated among the obstetrician, the anesthesiologist, the patient, and skilled support personnel."⁷ ■

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