

Obstetrics' Re-Evolution – Brian Gilpin, MD

Obstetrics (OB) hospitalist medicine grew out of lifestyle issues for the obstetrician and safety issues for the hospital. Since its inception, programs have evolved and changed to meet the needs of their communities. The very first programs bear little resemblance to current OB hospitalist practices. This is a positive evolution, as reflected by new training programs, which aim to teach and prepare potential OB hospitalists accordingly.

OB hospitalist programs were originally developed for the in-house care of pregnant women who did not have designated obstetricians, so as to provide them intrapartum and obstetric emergency care. The focus was on coverage rather than management. Over time, however, hospitalist programs led to culture changes within obstetric departments and hospital systems. OB hospitalists became specialists in hospital-based obstetrics, the primary sources for OB management protocols, educators of hospital maternity and postpartum staff, and leaders in the anticipatory care and onsite management of adverse obstetric events.

As an obstetrician-gynecologist (OB/GYN) for over 20 years and an OB hospitalist for over 10, I've seen our specialty change its focus from primary care to sub-specialization. Most present-day residents gravitate towards this sub-specialization, which offers increased job satisfaction via control of lifestyle, and the opportunity to develop expertise in a particular, focused field. Likewise in OB/GYN, a growing number are focusing on particular aspects of the specialty, such as robotic surgery and OB hospitalist medicine.

I work for a large group that includes maternal-fetal medicine (MFM) physicians and neonatologists. Early in our development, we strategized as to how OB hospitalists would fit into our system. Would we be best suited to cover unassigned deliveries, OB emergencies and the Emergency Department (ED), or should we function like "in-house" MFMs? We concluded that by having the best, properly motivated person(s), and by training and supporting them assiduously, we could evolve into a new sub-specialty capable of improving the quality of in-house care for our mothers.

We recruited only those who were highly interested in high-risk obstetrics. We trained them in ultrasound, supervised and collaborated with them on intensive-care patients and encouraged them to participate in leadership positions within our hospital systems. We avoided the "shift work" mentality by preferring physicians committed to reside within our community, incorporating them into teaching programs for OB residents and medical students. In those hospitals without teaching programs, we conducted twice-a-day "board rounds", whereby nurses actually presented each of their patients, much as a resident would. All of this was led by the OB hospitalist so as to function as overseer of the Labor and Delivery unit rather than one

who was simply covering for emergencies. Our hospitalists function like “MFM fellows,” with a lead MFM as a partner.

It is important to distinguish “back-up” services versus “collaborative care” because the former is inferior to the latter. Our hospitalists feel that they are part of a team taking care of the patient, wanting to not only work together with OB nurses and MFMs, but also to actually collaborate on and forward management excellence, to better serve the patient.

How does a partnership work when teammates are not financial partners? Surprisingly well, if the MFM is invested in the team. The concerns most frequently voiced by MFMs who have not previously participated in OB hospitalist programs is uncertainty about OB hospitalists’ skill set and knowledge base: they feel uncomfortable turning over care of their patient to, or relying on recommendations from, the OB hospitalist. Involvement of the MFM is essential in order to create a cohesive, supportive relationship. They need to be part of the recruitment process, training, and management of the team members.

In recent times, hospitals have often been the initiators of this system. At the hospital’s behest, the MFM is charged with organization of the unit, implementation of protocols/order sets and for setting the standard of care at the hospital. Initially, there can be difficulties with the hospital relationship. There is tremendous range and inconsistency between the medical staff members regarding knowledge base, but also with respect to flexibility and willingness to adapt. Hospitalists may not only ensure consistency, but may help bridge the educational and attitudinal gaps amongst team members.

Recent data from *Brandt, et al.* suggests that the full time presence of an MFM on Labor and Delivery may not change outcome, but may increase satisfaction of those on the unit. It is interesting that when MFMs are present, OBs are much more likely to seek their assistance. However, this scenario is neither reasonable nor cost-effective. Yet, with career OB hospitalists “ever-present”, especially in the model I have presented, we have experienced exceptional satisfaction from attending physicians, nursing and administration. In surveys done over the last several years, the recurring themes are of happiness and satisfaction with the constant presence and vigil of OB hospitalists, thereby increasing retention of quality staff. It is a re-evolution of the OB hospitalist sub-specialization model that is successfully works in our specific community yet is flexible enough to adjust to suit external and internal hospital factors.