The OB hospitalist and the risk manager: Ready for prime time

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In 1996, Wachter and Goldman described a new model of care in which hospital-based physicians provided patients’ inpatient care in lieu of the patient’s primary physician.(1) They termed these physicians hospitalists. The hospitalist movement had taken hold, and by 1999, 65% of internists had hospitalists in their community and 28% reported using them for inpatient care.(2) In 2003, Louis Weinstein, in an article entitled “The Laborist: A New Focus of Practice for the Obstetrician”(3) advocated for the adoption of the hospitalist model to obstetrical care. In a 2010 study, of 28,545 members of the American College of Obstetricians and Gynecologists (ACOG) contacted in a national survey, 7,044 clinicians responded, which yielded a response rate of 25%. Of the respondents, 1,020 clinicians (15% of respondents, 3.6% of the entire sample) described themselves as obstetrics/gynecology hospitalists or laborists.(4) According to the web site www.obgynhospitalist.com, there are at least 115 hospitals in the country that utilize a laborist or OB hospitalist model of care.(5)

INTRODUCTION

“Getting to Havarti” is a metaphor that this author has advanced for improving safety in the perinatal unit.(6) The Swiss cheese model of James Reason is an important concept describing how accidents occur in complex organizations such as labor and delivery units.(7) Reason’s model suggests that when failures in existing defenses and safeguards line up, the trajectory of a potential accident can penetrate all of these accident protections to cause an injury. The idea of making the holes in the Swiss cheese smaller (i.e., “Getting to Havarti,” a Danish cheese with very small holes) is a metaphor for targeting certain areas of a perinatal unit to tighten defenses and safeguards so the chance of penetration by an accident’s trajectory is reduced and deflected. The idea of placing an obstetrician in-house, 24/7, is one recommendation that theoretically tightens a perinatal unit’s defenses (reduces the size of the holes) and reduces the chance for patient injury.

Why does an OB hospitalist program function as a safety net for a perinatal unit? Can’t the patient’s physician always be available and in-house during his
These include some or all of the following:

- Participating in nursing education.
- Leadership roles in simulation design and debriefings.
- Providing emergency call coverage for patients without physicians who present to the ED or to the labor unit.

An example of such an intervention is a case of a primiparous patient laboring at 41 weeks' gestation with reassuring fetal heart tracing demonstrating normal baseline and variability, frequent accelerations, and normal uterine activity pattern. As the labor became more active at approximately 6–7 cm slightly after midnight, the fetal heart tracing demonstrated a prolonged deceleration, which proceeded to a sustained bradycardia with loss of variability. This pattern persisted over the next 10 minutes during transfer of the patient to the obstetric operating suite while the attending obstetrician was being called in from home. The OB hospitalist then initiated the cesarean section and delivered a fetus with Apgar scores of 7 at 1 minute and 9 at 5 minutes as the attending was arriving. The arterial cord pH was 7.13, affirming the appropriateness and importance or early intervention and management. (11)

THE OB HOSPITALIST MOVEMENT AND MODELS OF CARE

An important consideration, which is directly related to patient safety, involves the benefits of the OB hospitalist model to the lifestyle stresses of the practice of obstetrics. The practice of obstetrics frequently involves extensive multitasking, working when fatigued, time pressures, sacrificing valued family time, and concern that any error may precipitate litigation. This may lead to what has been termed burnout. It has been shown that in cases of physician burnout there is an association with an increased chance for errors. Desirable aspects of the OB hospitalist model, as opposed to a more traditional obstetrics/gynecology practice model, include regularly scheduled shifts, more control in the work hours (and, therefore, less fatigue), and guaranteed time off. (10)

There are multiple models that have been successful in creating in-house coverage. Every model will have some of the same challenges and issues, however, in establishing this type of coverage. These issues include the number of full-time employees (FTEs), professional fees or salaries, billing practices, credentialing, professional liability coverage, and the scope of practice of the OB hospitalist. At one end of the spectrum of coverage is to contract with an organization that will provide an entire team of OB hospitalists. Every model has some level of control over these issues.

The OB hospitalist movement exists along this continuum as alternatives. For example, an organization that will provide an entire team of OB hospitalists can be created in-house or contracted with external organizations. Alternatively, a hospital may create a hybrid model that involves contractual agreements with outside providers who are on the OB hospitalist team's lifestyle. There are multiple models that exist along this continuum of care as alternatives. For example, a hospital may recruit individual OB hospitalists from the community (either locally or nationally) or a hospital

or her patient’s labor? Because there are many aspects of obstetrical practice that may require the physician to be away from labor and delivery during some portion of a given patient’s labor, the answer is often “no.” As aptly stated by Clark, et al:

**Obstetrics today is a team process, requiring the coordinated, integrated involvement of physicians, midwives, nurses, technicians, laboratory support personnel, and the mother.** … Obstetrics in the United States is, however, … unique in that the traditional captain of the team is often not present during important parts of the labor process. (8)

Additionally, there is the human factor of fatigue that, at times, interfaces with the obstetrical workload. This workload, including night call, may require a particular obstetrician to be available for multiple successive nights to manage the labors of their patients. With regard to fatigue and its association with a possible deleterious effect on patient safety, a recent ACOG Committee Opinion recommends that “all practitioners … address fatigue, and efforts should be made to adjust workloads, work hours, and time commitments to avoid fatigue when caring for patients.” (9)

Can the establishment of in-house coverage with an OB hospitalist model actually improve patient safety and reduce claims of malpractice? In 2008, Clark et al. addressed this issue with the following:

*A review of almost 200 closed malpractice claims demonstrated that 40% of adverse outcomes related to intrapartum fetal hypoxia, and their associated malpractice claims, may have been avoided had such (in-house) coverage been available.* (10)

Physicians, nurses, and risk managers have all recognized that an in-house OB hospitalist model can serve as an important safety net for patient care in a variety of ways. These include some or all of the following:

- Decreasing the chance for precipitous deliveries while the patient’s physician is in transit.
- Acting as a liaison between nurses and physicians when there is concern about a potential unsafe practice.
- Rescue of baby from an abruption or ruptured uterus by performing an emergency cesarean delivery.
- Offering to give second opinions to both nurses and physicians.
- Stepping in for the physician as an assistant for surgery and/or other obstetrical emergencies such as shoulder dystocia and postpartum hemorrhage.
- Providing the “immediate availability” for trials of labor after cesarean deliveries (VBAC).
- Providing backup for midlevel providers.
could contract with an individual group of obstetricians in the community who agree to provide hospitalist coverage for the unit. There are a number of web sites and resources that can be accessed to determine which model is best for a given perinatal unit’s volume and makeup (see references).

**Overcoming challenges/The role of the risk manager**

There are multiple challenges associated with establishing a successful OB hospitalist program regardless of the model that is chosen. The risk manager can help overcome these challenges by using patient safety as a central theme. Whether the challenge is the “business case” for safety, patient and provider satisfaction, or the establishment of appropriate policies and procedures, the risk manager should take the opportunity to bring the safety aspects of such a program into sharp focus for the entire perinatal and administrative team.

**Cost**

It is clear that any organization considering the addition of OB hospitalists will have to address the costs of such a program. Specifically, when it comes to looking at cost and examining the “business case for safety,” the risk manager should work with senior management to gain buy-in regarding the economic impact of adding an OB hospitalist model. With respect to recouping the costs of such a program, a 2008 study conducted by the Advisory Board estimated that with a volume of approximately 1,000 deliveries per year, a perinatal unit, with active billing procedures, could come close to breaking even for the necessary costs of the additional FTEs.(12) It is sometimes difficult to prove prospectively that actual savings will occur with respect to obstetrical rescues, decreased liability, and fewer missed deliveries that the OB hospitalist model promises. However, the risk manager, with anecdotes and available data, should play an important role in framing the “business case” in terms of added safety.

**Patient satisfaction**

Depending on the OB hospitalist model, patient satisfaction may or may not become an issue. It is common and understandable that outpatients usually want their physician or midwife to be involved with their delivery. Because care by group practices divide care, it is common, even without hospitalists, to have physicians or midwives other than the patient’s primary caregiver involved with care in labor and delivery. Framing the introduction of the OB hospitalists in terms of patient safety is the best strategy when introducing the OB hospitalist team to the community and individual patients. Many models of OB hospitalist coverage do not include the hospitalist’s doing deliveries for private patients except in emergencies, but do allow for hospitalist’s compassionate support and interventions during labor if the patient’s primary caregiver is out of the hospital.

**Provider satisfaction**

Challenges to the implementation of an OB hospitalist program may occur from providers, nursing staff, and administration. Education regarding rescues, reminding how an in-house physician can prevent accidents, continued participation in analysis of adverse events and near misses, and ongoing awareness and distribution of literature with regard to OB hospitalists will serve to advance the cause of this safety net.

Perceived threats that physicians or midwives will be excluded from their own patient’s care are common with the initiation of OB hospitalist programs, but soon dissipate as the safety elements of the program become real and the true role of the hospitalist becomes common knowledge. Those who have practiced obstetrics for many years have all missed deliveries, felt the anxiety of having to be in two or more places at once, and wished for an immediate assistant in the face of an unexpected emergency. As these situations are addressed and “rescues” occur from having a skilled physician who is always in the hospital, the perceived threats to autonomy are likely to evaporate.

**Establishment of policies and procedures surrounding the OB hospitalist model**

The risk manager should work with the perinatal department as part of a multidisciplinary team to remain focused on policies, procedures, and operational models to improve patient safety. In order to ensure that the OB hospitalist model is integrated into the operational structure of the unit, clarity about the scope of practice, the limitations of interventions, and communications throughout all levels of the unit will need to be established with new policies and procedures.

*A key element for instituting an obstetric … hospitalist program within a facility is the establishment of clear communication methods between … 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.(13)*

There are many policies that will need clear definition. Some of these include issues of billing practices (what if the hospitalist stands by for a potential delivery for a physician in transit but the physician arrives just in time to deliver his or her own patient—is that a billable event?); issues of safety (what if a patient is admitted to the hospital for induction and the OB hospitalist is asked to intervene by rupturing membranes and the OB hospitalist does not think the induction is timely or indicated—what communications between providers need to take place to resolve this conflict?); and issues that define the scope of practice of the OB hospitalist (what if a physician wants the OB hospitalist to care for a patient in the hospital while the OB hospitalist feels that the patient should be transferred
to a higher level of care?). Clearly, not every contingency can be addressed in a given policy but a departmental committee that includes all stakeholders should be established to resolve such conflicts if and when they arise.

As we look at the role of the OB hospitalist as an important step along the sometimes circuitous road to improving patient safety in obstetrics, one should keep in mind the following endorsement from the 2010 Committee Opinion of the American College of Obstetricians and Gynecologists:

… the American College of Obstetricians and Gynecologists supports the continued development of the obstetric–gynecologic hospitalist model as one potential approach to achieving improved professional and patient satisfaction while maintaining safe and effective care across delivery settings.(13)

REFERENCES


11. Neilson D, MD, Medical Director, Women’s Health Services, Legacy Health System, Portland, Oregon, personal communication.


Additional web sites:


ABOUT THE AUTHOR

Larry Veltman, M.D., practiced obstetrics and gynecology in Portland, Oregon for 30 years. He retired from clinical practice in 2007. He was the Chairman of the Department of Obstetrics and Gynecology at Providence St. Vincent Medical Center in Portland for 9 years. He served as Chair of the Professional Liability Committee of the American College of Obstetricians and Gynecologists and is a member of ACOG’s Committee on Patient Safety and Quality Improvement. He has been involved with risk management since 1985 and a member of ASHRM since 1988. In 2000, he was the Chairperson of the ASHRM Task Force that published, “Risk Management Pearls for Obstetrics.” He has published articles on teaching risk management to physicians, achieving patient safety in obstetrics, vaginal birth after cesarean section, and the patient safety aspects of disruptive physician behavior. He has given multiple presentations on a variety of subjects dealing with medical malpractice, risk management, disclosure and apology, improving communication amongst obstetrical team members, system failures leading to adverse obstetrical outcomes, and physician disruptive behavior as it affects adverse outcomes in healthcare.