

COMMENTARY

OB Hospitalist Program Is a Go!

When the CEO of my hospital first announced that we would be developing an obstetrical hospitalist program in 2005, she didn't get a warm reception. As the person tapped to lead this new initiative, I was on the receiving end of my fair share of angry rants from colleagues. But I'm happy to report that just 4 years later, our program is wildly popular with our staff and our patients, and is financially self-sustaining.

I credit part of the success to the staffing model we chose, part to the seasoned and professional physicians who came to work here as hospitalists, and the rest to our cadre of private physicians who have embraced the concept with the same vigor with which they had originally opposed it.

Foremost among our goals when we sat down to create an OB hospitalist program was the need to improve patient safety by ensuring that a board-certified ob.gyn. was at the hospital 24 hours a day. We also wanted to create a program that would allow us to address medical-legal concerns and improve provider satisfaction.

Rather than go with a standard laborist model, we chose to set up an OB hospitalist program that could provide coverage for labor and delivery, as well as handle unattended ob.gyn. patients and provide coverage for the emergency department.

We are a small community hospital,

but with about 3,500 deliveries each year, our team of private physicians was getting fatigued. Our hope was that by having a small staff of OB hospitalists, we could significantly cut down on the call time our private physicians would need to spend in the hospital.



BY WILLIAM D. PELLETIER, M.D.

Our staffing model was simple. We hired four hospitalists to work 12-hour shifts, providing coverage 24 hours a day, 7 days a week. We designed the program with 12-hour shifts because most of the literature shows that fatigue tends to occur when physicians work beyond that point.

Hiring the four hospitalists was a critical piece, and one that did not go smoothly at first. We initially made offers to four graduating residents in the area, who all backed out. While they were all qualified and enthusiastic, I realize now that our private physicians would have steamrolled right over these fresh, young doctors. After an extensive search, we were able to hire a group of experienced ob.gyns. who were well respected by the physicians in our community. As experienced ob.gyns., our hospitalists have handled the rare confrontation from the private sector.

When we finally launched the program in the spring of 2007, I was shocked by the change in acceptance from the private physicians in our community. Those who had complained the loudest about loss of autonomy as doctors began to volunteer to take

shifts if a hospitalist got sick or had an emergency. Their biggest fear was that the program might not succeed and they would have to go back to managing preterm labor at 2 a.m.

Our hospitalists are busy. They handle all the ob.gyn. cases that come through the emergency department, they assist in labor and delivery and gynecologic surgeries, and handle anything a private doctor asks them to. It's uncanny how few private ob.gyns. you will find at the hospital after 9 p.m. these days.

The program worked because our patients are satisfied. In obstetrics or gynecology, they no longer wait to be monitored until their doctor arrives. They have direct contact with a physician almost immediately upon arrival. They are educated about the role of the hospitalist and are still welcoming of their primary ob.gyn. upon transfer of care. Preterm labor, fetal distress, and ectopic pregnancies are all identified earlier.

Unquestionably, a huge factor is the confidence our OB hospitalists have inspired among our private doctors and our patients. We also had encouragement from our nursing staff, and our hospital leaders gave us the flexibility to make this a program that the entire medical staff could support. It wasn't easy getting it off the ground, but I can't imagine doing it any other way now. ■

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LETTERS

An Incomplete Article

Although I am a retired ob.gyn., I continue to read your fine OB.GYN. NEWS. An article on the front page of the August issue entitled, "Fetal Rotation Reduced Cesarean Section Rate" was well written but incomplete.

The basic premise was that cesarean section can be successfully avoided by manual rotation. But this option should be considered along with another obstetrical maneuver: the Scanzoni maneuver or use of forceps to rotate a fetus.

When the Luikart-Simpson or Tucker-McLane forceps come into play with double application, the impacted, molded vertex presentation with left occiput posterior (LOP) or right occiput posterior variety make a cesarean of secondary importance.

The maneuver has to be performed with adequate anesthesia. Continuous caudal or lumbar epidural anesthesia are options, but caudal is preferred. The cervix has to be retracted, and the tips of the forceps have to be observed very closely with the deep rotation (first application).

The Scanzoni maneuver was developed to stem the tide of cesarean section with its associated morbidity. My cesarean section rate was around 10%—any higher rate was not acceptable and was subject to committee review.

I believe a manual rotation could be performed with skill and care, but an impacted LOP at 0400 hours usually does not cooperate. The Scanzoni maneuver with forceps could save the day when you need assistance the most.

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Redlands, Calif.

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COMMENTARY

Putting the Web to Use in Practice

I am a strong believer in using the resources we have so readily at hand to inform ourselves of the latest medical information and guidelines and to inform our patients.

The sites I find useful fall into these categories:

► **Social bookmarking.** With the explosion of social networking sites in the past year, there has been a corresponding increase in sites, such as delicious.com, that let you explore and evaluate online resources in a collective way.

► **Patient education.** If a patient needs information, I turn to sites vetted by medical organizations or government agencies such as the National Library of Medicine at <http://medlineplus.gov>, which provides patient-oriented, one-page overviews with links to more detailed information at other reviewed sites, and the Mayo

Clinic's site (www.mayoclinic.com).

► **Physician education.** When I'm looking for a high-level overview or when I can't remember a specific fact, I'll go to www.fpnotebook.com, which

offers a lot of information for free. Another site that offers free information is www.emedicine.com. The 600-pound gorilla for drug information, of course, is www.epocrates.com.

The Agency for Healthcare Research and Quality's Electronic Preventive Services Selector (www.epss.ahrq.gov) offers downloadable applications that are useful for remembering evidence-based services that

an individual may need. For guidelines on any topic, go to www.guidelines.gov.

To some degree I worry about physicians who aren't checking Web resources. Our memory of what we

learned in medical school is imperfect. And what was true back then, has probably changed. ■

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BY PETER J. ZIEMKOWSKI, M.D.

LETTERS

Letters in response to articles in OB.GYN. NEWS and its supplements should include your name and address, affiliation, and conflicts of interest in regard to the topic discussed. Letters may be edited for space and clarity.

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