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CLINICAL CASE

Laborist Staffing Requires Careful Attention

Commentary by Louise P. King, MD, JD, and George D. Wendel Jr., MD

Mrs. Lawrence arrived at a large, urban hospital in active labor at 23 4/7 weeks. She was a patient of Dr. Greene but registered under the care of Dr. James, a laborist employed by the hospital. Mrs. Lawrence was carrying an extremely low-birth-weight fetus with a poor prognosis. When the fetal heart tracing became non-reassuring, Dr. James counseled her to undergo an emergent cesarean delivery. Just as Mrs. Lawrence was being prepped for the surgery, Dr. Greene arrived and took issue with the laborist's decision. She believed her patient had been poorly counseled about the prognosis for the fetus and maternal morbidity associated with a classic cesarean section at such an early stage of gestation.

Dr. Greene questioned whether the laborist had been completely unbiased in her decision making. After all, Dr. James worked for the hospital that stood to benefit from a lengthy, yet reimbursable NICU stay. Drs. Greene and James found themselves at an impasse. Dr. Greene sought to re-establish care for her patient; but the patient, by now, was adamant that she wanted a cesarean delivery to "save her baby."

Commentary

The practice of obstetrics and gynecology has changed dramatically in recent years. Traditionally, obstetricians were available at all hours for every patient's labor and delivery. Today, patients often choose their obstetricians based on whether they are routinely available at delivery. Perhaps in response to the unique demands of obstetrics, physicians are leaving practices at younger ages, discontinuing obstetric services, and choosing other specialty training. Surveys of those in practice show an increase in professional dissatisfaction, poor personal relationships, and burnout [1]. Given the extensive demands of a traditional obstetrics practice and the higher costs of medical liability insurance for obstetrics, it is no surprise that there are fewer obstetricians and gynecologists in solo practice.

Introduction of Laborists

The laborist was introduced largely to address time demands. Laborists are hospitalists employed by larger hospitals to manage the care of walk-in patients, those in labor, or those with emergent gynecological issues. They are there to deliver babies of patients whose physicians are affiliated with the hospital when those physicians are unavailable. Laborists typically work in shifts but may make rounds on patients admitted to their service. Introduced primarily to reduce the workload for obstetricians, laborists may also improve hospital safety, inasmuch as they are

immediately available on the labor unit to address dysfunctional labor or a non-reassuring fetal-heart tracing. Finally, by reducing the time and stress burden on practicing obstetricians, laborists lower the risk of errors that occur when physicians are overworked [1, 2].

Despite the obvious benefits of employing laborists in hospitals, their presence can prompt ethical and legal complications, as this case illustrates. In the scenario, three separate relationships arise among the laborist, treating obstetrician, and patient. Similar complex relationships have existed before in obstetrics, namely among the certified nurse midwife, consulting obstetrician, and patient. But in the past the roles have been more easily defined, with the obstetrician providing care in an emergency or directing care as needed in an uncomplicated delivery. In many instances, the midwife works as a member of the obstetrician's team in his or her office unless it is necessary to transfer the patient out of the birthing center and into the care of a physician [2].

But here, the laborist and treating obstetrician are both independent physicians, who, at the outset of treatment, created separate and coexistent contractual relationships with the patient. Apart from each of their ties to the hospital, they have no formal ties to each other. During an uncomplicated delivery it is likely that the hospitalist would proceed without much need to consult the treating obstetrician. In a complicated, emergent situation such as that proposed in this scenario, consulting the treating physician may be impractical. Does Dr. James have an ethical or legal duty to consult with the treating physician? How is this duty affected by Mrs. Lawrence and Dr. Greene's patient-physician relationship? Stated another way, what duty does Dr. James have to honor the treating relationship between Dr. Greene and Mrs. Lawrence?

Laborist, Treating Physician Relationship

To answer these questions, assume that a laborist functions like an emergency physician. According to the Code of Ethics for Emergency Physicians proposed by the American College of Emergency Physicians, when interacting with a patient's primary care physician, the emergency physician should "cooperate with the primary care physician to provide continuity of care that satisfies the needs of the patient and minimizes burdens to other providers" [3]. Applied to the current case, this statement suggests that the laborist has an ethical and professional duty to contact the primary care physician and ascertain his or her plan regarding emergent intervention for each patient in every instance possible.

But this analogy does not completely capture the complexities of obstetrical practice. Drs. James and Greene can reasonably disagree about the best course for Mrs. Lawrence. Although the prognosis for this infant is poor, predictions of a long-term outcome for any neonate, especially one with very low birth weight early in gestation, are far from perfect [4]. In an 18-to-22-month follow-up of neonates delivered at 22 to 25 weeks gestation, Neonatal Research Network investigators found that 49 percent had died, 61 percent had died or had profound impairment, and

73 percent had died or had some impairment [5]. They concluded that consideration of multiple factors is likely to promote treatment decisions that are less arbitrary, more individualized, more transparent, and better justified than decisions based solely on gestational-age thresholds.

Duty to Counsel the Patient?

Presenting this type of probability data to expectant mothers is challenging. Parents want to know exactly what will happen to their child—a question that can almost never be answered. Each patient has a different cultural understanding and brings different moral values to thinking about the long-term consequences for a child born severely prematurely. Hence, counseling a patient regarding interventions at the cusp of viability is extremely difficult [5]. Ideally, the patient would have discussed her child's prognosis and personal beliefs in detail with her treating physician. One could argue that, even in the context of an emergency, a well-informed patient has enough information at her disposal to decide between a cesarean delivery and expectant management followed by a vaginal delivery.

The most conscientious physician cannot prepare a family for every possible occurrence at each gestational age, however. Even if a family is educated about the risks of a preterm delivery, those risks and possible outcomes can change during gestation over weeks and even days. Labor and delivery situations are unlike the typical cases an emergency-medicine resident confronts in a patient at the end of life. Many patients with terminal illness have had months to prepare and educate themselves about their disease and prognosis. Although their condition changes over months and years, the disease itself is fairly static, and they have time to digest its implications. Some have living wills that make the process easier. At the very least, an emergency physician can resuscitate a patient at the end of life per a family's request and consider withdrawal of care at a later time.

By contrast, the decision to perform an emergency-cesarean delivery for fetal distress must be made and acted upon in a matter of minutes. As described by Ann Drapkin Lyerly, the morbidity associated with a classic cesarean delivery (vertical incision involving the contractile portion of the uterus) performed at very early gestational age, as well as that associated with emergent anesthesia, are significant [6]. Dr. James presumably believed that Mrs. Lawrence's child had "enough of a chance" to justify emergent intervention and presented the options to Mrs. Lawrence with this bias. Once given the chance to save her baby, it is unlikely that Mrs. Lawrence would be able to consider any other option as reasonable or acceptable. Dr. James would have served his patient better by allowing her to speak with her treating physician who is more familiar with her case and better equipped to counsel her.

In such an emotionally charged situation, Dr. Greene's assertion that Dr. James may have been motivated by financial concerns is surely counterproductive and possibly inaccurate. It brings to light, however, the perception of bias that is bound to occur when a physician is employed by a hospital to deliver babies. Medicaid reimburses

care for infants sent to the neonatal intensive care unit (NICU) regardless of the mother's funding status during her pregnancy. Thus, NICU infants might be considered by some to be a reliable source of revenue for hospitals. The addition of laborists to a hospital team could be justified financially by an increase in walk-in deliveries and the consequent reimbursement, with the knowledge that some of the babies will need prolonged, expensive NICU stays. Theoretically, there is some financial incentive, therefore, for a laborist employed by the hospital to encourage deliveries of extremely preterm infants rather than advising maternal transport to another NICU or expectant management. Even assuming that a laborist would *not* be unduly influenced by this possible incentive, which is likely, it is better for the treating physician to counsel the patient regarding her option to avoid even the appearance of bias.

In sum, although it adds a level of complexity to interactions between the laborist and patients in labor and delivery, the laborist has a duty to preserve the established relationship between the treating obstetrician and patient. This is especially true in emergent situations that arise early in gestation when decision making is difficult and requires an established rapport with the patient to facilitate the best possible outcome. Following this principle will allow obstetricians to retain continuity of care for their pregnant patients (long praised as a strength of our specialty field) while addressing the needs of the obstetrical workforce and alleviating some of pressures that have driven physicians from our specialty.

References

1. Weinstein L. The laborist: a new focus of practice for the obstetrician. *Am J Obstet Gynecol.* 2003;188(2):310-312.
2. Wells CE. Personal communication. October 1, 2008.
3. American College of Emergency Physicians. Code of ethics for emergency physicians. 2008. <http://www.acep.org/practres.aspx?id=29144>. Accessed on October 27, 2008.
4. Voss W, Neubauer AP, Wachtendorf M, Verhey JF, Kattner E. Neurodevelopmental outcome in extremely low birth weight infants: what is the minimum age for reliable developmental prognosis? *Acta Paediatr.* 2007;96(3):342-347.
5. Tyson JE, Parikh NA, Langer J, et al. Intensive care for extreme prematurity—moving beyond gestational-age thresholds. *N Engl J Med.* 2008;358(16):1672-1681.
6. Lysterly AD. Reframing neutral counseling. *Virtual Mentor.* 2008;10(10):635-639. <http://virtualmentor.ama-assn.org/2008/10/ccas3-0810.html>.

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