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HISTORY OF MEDICINE
A Transition in Obstetrics
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In 2003, Louis Weinstein proposed a new practice model for intrapartum obstetrical care, suggesting obstetricians emulate the "hospitalist model" of patient care. Weinstein defined the "laborist" as a board-certified obstetrician-gynecologist whose focus of practice is managing patients in labor and communicating with their obstetrician regarding outpatient follow-up. In this model, office-based obstetricians provide outpatient antepartum and postpartum care.

The laborist concept takes several forms depending on the type of hospital (teaching versus nonteaching), size of the hospital delivery service, number of obstetricians, and number of uninsured patients. Examples of laborist models are [1]:

- *Teaching Hospital Model*. The earliest laborist models began in the traditional academic teaching hospital which requires 24-hour, in-house faculty supervision of all obstetrical care provided by interns and residents. This represents a team-based approach, providing a clear line of communication and collaboration between the antepartum and postpartum care givers and the delivering physician (laborist). If private patients are admitted, the private physician has the option of supplying inpatient obstetrical care or allowing the laborist to assume responsibility for care.
- *Community Hospital Model*. The laborist assumes inpatient labor and delivery coverage for walk-in and uninsured obstetrical patients and obstetric emergencies and is available to care for private obstetrical patients upon their private physician's request.
- *Weinstein Model*. In the model proposed by Dr. Weinstein, [2] the hospital would employ laborists to oversee obstetrical care for all patients in labor and delivery. The laborist would manage private patients in labor and give their obstetricians the option to be present for delivery [2].

Since the concept's introduction in 2003, initial acceptance has been slow; within 2 years, 10 hospitals in the United States reported using laborists [3]. After advertising for laborists, though, hospitals and health care systems reported an overwhelming response from physicians nationwide. Some project that within 10 years most hospitals that deliver 2,000 or more babies a year will employ laborists [4, 5].

Benefits of the Laborist Model
Although patients and physicians may not recognize it immediately, the greatest advantage of the laborist model is the availability of an in-house obstetrician at all

times [2]. A laborist can respond to emergencies instantly, evaluate a patient's progress frequently, be available to answer questions around the clock, and offer services that might not be available without in-house coverage. For example, many clinicians are unable to offer vaginal birth after cesarean delivery (VBAC) since they would have to be present throughout labor; under the laborist model, opportunities for VBACs increase.

A growing body of literature documents that medical students and residents are increasingly taking lifestyle and workplace conditions into account when making medical-specialty career decisions. Many feel that obstetrics and gynecology is not "lifestyle friendly" compared to other medical specialties [6, 7]. Laborists, though, have the opportunity to choose to work days, evenings, or weekends and benefit from job sharing or part-time employment to balance family and professional needs. This flexibility might make obstetrics more attractive to medical students who would like to pursue that specialty but currently do not because of the demands it has traditionally made on lifestyle.

Some physicians might become laborists to avoid the burdens of running a medical practice—completion of insurance forms, billing and coding requirements, and day-to-day management of running an office or clinic. These functions would most likely be assumed by the laborist's employer, depending on the employment model utilized.

Obstetricians who remain office-based would probably see a reduction in malpractice premiums, since labor and delivery entail greater risk than pre- and post-natal care. Career satisfaction is likely to increase since more time could be devoted to office visits and surgical procedures without distractions from labor and delivery or on-call requirements [8].

Patients might benefit from a shared model that uses a nurse-midwife and laborist. A recent Cochrane review suggests that midwife-led obstetrical care results in reduced need for regional anesthesia, with fewer episiotomies and instrument-assisted vaginal deliveries. And more women felt they were in control during labor when midwives directed the delivery [9]. A shared model of nurse-midwife and laborist care might result in similar benefits. Other benefits of having a full-time, in-house obstetrician include:

- Standardized skills to interpret fetal heart-rate monitoring.
- Standardized criteria for the use of oxytocin and instrument deliveries.
- Development and refinement of a team approach in the management of obstetrical emergencies, e.g., fetal distress, shoulder dystocia, and obstetrical hemorrhage.
- More opportunities for VBACs in accordance with ACOG guidelines that require physicians to be immediately available throughout active labor, capable of monitoring labor and performing an emergency cesarean delivery [10].

- Lower rate of cesarean deliveries [11, 12].

Risks and Shortcomings of the Laborist Model

The most obvious shortcoming of the laborist model is interruption of traditional patient-physician relationships in which the obstetrician provides care from the beginning of pregnancy through the postpartum period. Initially, patients and physicians may resist the laborist model because patients dislike having an unknown physician providing their intrapartum care. In reality, however, many patients whose physicians are partners in large obstetric groups have become accustomed to the idea that an unfamiliar partner may deliver their baby, so the model may not be as foreign as initially believed.

To work effectively, the laborist model requires clear, timely, and complete communication among the office-based obstetrician, patient, and laborist. Patients should be informed well in advance about the existence of the laborist system, in time to research the practice at their delivering hospital and, if desired, change their obstetric care giver. In emergency situations laborists must make treatment decisions rapidly without the benefit of a prior patient-physician relationship and may encounter difficulty in establishing patient trust. For this reason, laborists should develop a plan to introduce themselves to future obstetrical patients by, for example, providing a brochure that introduces them and explains their expectant role, offering a presentation during childbirth classes, or presenting an orientation class for upcoming patients. Patient acceptance of the laborist model remains uncertain, and hospitals that employ laborists may have difficulty attracting obstetrical patients and may lose existing patients who decide to deliver elsewhere. One survey suggests that patients might deliver elsewhere if they knew a hospitalist was going to deliver their baby, but other hospitals report positive experience with the laborist model [13-16].

Ethical Concerns of the Laborist Model

Respect for the patient's autonomy recognizes the patient's right to be completely informed about her condition and fully involved in therapeutic decisions. Concerns about patient autonomy demand that the laborist, office-based obstetrician, and patient herself maintain clear communication concerning all treatment options, understanding that differences in management recommendations may occur between the physicians. The expected difference of opinions in management between the laborist and the office-based obstetrician can and should be anticipated so that, when they arise, a mechanism is in place to resolve them. Several topics in labor and delivery over which obstetricians might disagree are [17]:

- Management of the periviable infant at 23-24 weeks gestation.
- Tocolytic therapy in preterm labor.
- Management of preterm, premature rupture of membranes (PPROM).
- Management of VBAC.
- Elective induction of labor at term.
- Management of the short cervix by means of mid-trimester cervical cerclage, versus bed rest, versus no treatment.

- Use of operative vaginal delivery.
- Elective, non-indicated cesarean delivery.

At times, respect for patient autonomy conflicts with the principles of nomaleficence and beneficence, such as when a patient desires an elective, non-indicated cesarean delivery. Nomaleficence and beneficence demand that the physician discuss the risks and benefits of cesarean delivery versus vaginal delivery with the patient and then respect her right to make an autonomous decision. The office-based obstetrician with whom the patient has a long-term relationship, after informing the patient adequately, might consent to her request to pursue an elective, non-indicated cesarean delivery, only to realize that the laborist scheduled for the delivery is unwilling to implement that request. Such differences can be resolved if they are anticipated and discussed before the delivery is scheduled. If one patient is allowed to elect cesarean delivery, does the ethical principle of justice obligate the laborist to treat all those in similar circumstances the same way? While most would agree that all patients have the right to refuse unwanted treatment, do all patients then have a commensurate right to demand an elective, non-indicated cesarean delivery? Certainly medical judgment comes into play here (e.g., are the two patients' circumstances truly "similar"?), and the office-based obstetrician and laborist must discuss differences in judgment when they exist.

Future of the Laborist Model

The laborist concept is a new and possibly improved practice model that benefits not only obstetricians but also hospitals and obstetrical patients. In the past, obstetricians attempted to deliver all of their patients' babies, thinking that only they could provide the best care. One can question, however, whether it was truly in the patient's best interest to have an exhausted obstetrician attend every delivery [18]. Presently, there is little research on the theoretical benefits or shortcomings of the laborist model, yet the movement presents an opportunity to improve the quality and efficiency of care. Realizing that one model will not work for all hospitals and individual situations, the laborist concept in general might allow obstetricians to "keep medicine in perspective and keep more balance in [their] lives," [19] and in the process, improve career satisfaction, foster career longevity, and reduce burnout. As Kenneth Noller noted during the ACOG Inaugural Address in 2007, "We don't have the best hours; we don't have the highest incomes and we certainly don't have the lowest malpractice insurance rates," but we do have "a unique and fulfilling specialty that cannot be equaled in any other field" [20].

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