Together We Can Do Something Wonderful

The American College of Obstetricians and Gynecologists (the College) will face unique challenges during the next decade. In the future, the College and the American Congress of Obstetricians and Gynecologists will be compelled to be faster, leaner, more responsive, and more collaborative while maintaining their position at the forefront of women’s health care.

Transitioning into two separate organizations, a looming shortage of obstetric providers, and dramatic changes in the educational demands of our Fellows are unavoidable hurdles to our future success. There will be unprecedented, unpredictable, and significant changes in the health care industry. Our Fellowship is increasingly challenged by everyday practice restrictions and altered by gender and generation modifications that are unparalleled in our history. All of this will compel us to reorder the priorities of our two organizations.

I am an obstetrician–gynecologist (ob-gyn). For the last 32 years I have been in private practice in upstate New York experiencing the rewards of our specialty but also the frustrations. My hands-on, intricate knowledge of the daily challenges of private practice affords a unique perspective on the issues affecting everyday practice. Economic viability, practice efficiencies, and electronic medical records—just to name a few—are issues that those of us on the front line know all too well because we experience them daily. I know liability because I have defended myself and colleagues in liability suits. Medical liability reform has been my mantra for more than two decades.

Using the courtroom as a defender of the defenseless may have initially been a truly ethical cause, but today it is too often a money crusade. The major pretext of the plaintiffs bar is that they are just protecting the public by bringing bad doctors to justice. However, we know that this is a blatant misrepresentation. Philip Howard stated it so well when he wrote, “Trial lawyers pretend that they’re Robin Hood, with the modern twist that they keep much of the money for themselves. This modern approach to lawsuits is not about justice—it’s about greed in the clothing of justice.”1

Our legal system is seriously flawed. Direct total cost of the United States tort system equaled $252 billion in 2007.2 That is $835 per person, up from $102 dollars per person in 1950. But it is not merely about the cost. Medical liability actually harms our patients and our society. Is there anyone reading this who seriously doubts the direct relationship between the rising cesarean delivery rate and our climate of legal fear? Congress’ refusal to even consider tort reform last year made a mockery of health care reform. I am proud of the strength that our President Gerry Joseph and our Executive Board demonstrated last year when we told the Senate and the House of Representatives that health care reform without liability reform would not work for us. I pledge to carry on this same fight next year. Health care reform without liability reform is no reform at all.

We need a no-fault system that provides financial support for every neonate born with neurological damage. The ideal system would also...
encourage clinical evaluation by experts for cases in which true negligence was suspected. If no-fault could marry health courts, we would have a perfect union. If we are able to trust our legal system again, our cynicism would disappear.

Let us not allow ourselves to be fooled. We are a small voice, and tort reform at the federal level is a remote possibility. Like an ocean liner that has sunk in stormy seas, this ship will be difficult to salvage. We can steer our own ship into the proper direction so that we too do not sink. We cannot allow this issue to so consume us that we have no oxygen left for those issues that we can control.

Every President comes before you with lofty goals. I am no different. I have three main goals for the coming year:
1. to reconvene the Neonatal Encephalopathy–Cerebral Palsy Task Force,
2. to build upon our collaborative community, and
3. to take a hard look at birth issues and evaluate how we can improve maternity care into the next decade and beyond.

THE NEONATAL ENCEPHALOPATHY–CEREBRAL PALSY TASK FORCE
Eleven years ago, President Frank C. Miller stood on this podium and announced the creation of the task force to analyze the scientific evidence related to cerebral palsy. This multispecialty group ultimately created the document “Neonatal Encephalopathy and Cerebral Palsy: Defining The Pathogenesis and Pathophysiology,” which was endorsed by government and nonprofit organizations throughout the world. This report was produced because of Dr. Miller’s vision. He understood that scientific facts could become our major defense against liability. This document is one of our finest achievements. The Task Force recognized at the time of publication that we would need to update the scientific database as the knowledge on this topic expanded. I have been asked by Drs. Gary Hankins and Mary D’Alton to recall the Task Force to update and revise the report where necessary. We will reconvene an expert panel because credibility is so important. We can only win in the courtroom and in the court of public opinion if we are honest brokers respected for the accuracy of our scientific endeavors.

BUILDING UPON OUR COLLABORATIVE COMMUNITY
Our ob-gyn workforce is aging, and physicians are leaving the delivery room on average 10 years earlier than previous generations. Residents, in record numbers, are choosing careers that do not include obstetrics. The “80-hour work week” has resulted in a 20% decrease in resident work hours. However, there is recent evidence that nonresident physicians are working fewer hours as well. At this moment “approximately half (49%) of the 3,107 U.S. counties lack an ob-gyn physician. Nearly 9.5 million Americans live in these predominantly rural counties” (William F. Rayburn, MD, MBA; work in progress).

So, we have fewer Fellows doing obstetrics, and the ones that are doing deliveries are working fewer hours. We are already geographically challenged and poorly deployed for optimal maternity care.

In 2007 there were 302 million U.S. residents. This number is increasing by 1.1% per year, and the U.S. Census Bureau predicts that we will reach 440 million by 2050. The generational and gender changes in our organization are having a dramatic effect. When we add in this population explosion, calculate the lost manpower related to decreasing physician work hours, and consider the potential expansion of health insurance coverage, the need for more maternity care providers seems quite obvious. Unfortunately, the number of residents that we are producing has not increased significantly since 1993. Our static pipeline and increased need forecast a severe shortage of obstetric care providers in the near future.

Our hospital work has taught us that communication and teamwork are critically important. Mother Teresa stated it so well when she said: “What I do you cannot do; but what you do, I cannot do. The needs are great, and none of us, including me, ever do great things. But we can all do small things, with great love, and together we can do something wonderful.”

The ability to improve and extend medical care to all women and their newborns, a clear goal of health care reform, will depend, in part, on the quality of our collaborative efforts. We have an opportunity to be inclusive and work with all of the organizations that provide women’s health care by building, promoting, and nurturing our relationships. I firmly believe that our collaborative organizational intelligence is critical to improving our team work in the front lines of care.

With this in mind, my focus for the year will be a joint project with the American College of Nurse–Midwives (ACNM). Both the College and ACNM will ask their members to submit papers describing successful models of midwifery and obstetric collaboration. The papers will need to be submitted jointly by obstetric and midwifery collaborative teams. To-
BIRTH ISSUES AND IMPROVEMENT OF MATERNITY CARE INTO THE NEXT DECADE AND BEYOND

The American College of Obstetricians and Gynecologists has the ability and the responsibility to play a strong role in guiding maternity care. There is so much we can and should do. I will be appointing a work group to examine maternity care in the United States. This is a superb time to step back, evaluate, and make a real plan of action for the remainder of this century.

We have so many genuine issues in maternity care. Let me mention several of the areas that require action.

- Lack of consistent and comprehensive data about births in the United States is one area needing attention. Can you believe that this country with so much know-how and advanced technology has not implemented a uniform method of recording birth statistics? We do not have a system to evaluate birth in a detailed manner by using outcome data or performance measures. Such systems would provide information needed to assess practices and evidence needed to make clinically sound decisions in maternity care.

- The increasing rate of maternal deaths in this country is a significant and troubling problem. The U.S. maternity mortality ratio has doubled in the last 20 years, reversing years of progress. Increasing obesity, increasing maternal age, increasing cesarean deliveries and changing population demographics all certainly play a role. Black women are more than four times more likely to die from pregnancy complications than white women. We cannot reverse racial disparity in maternal mortality unless we invest the dollars in meaningful research. Other countries have developed robust approaches to maternal mortality and we should follow their lead.

- In the future we will be facing a shortage of obstetric providers. In addition, our practitioners are becoming less experienced because of the early retirement of seasoned obstetricians. We are losing our “Captain Sully’s” in our delivery rooms. In my opinion, it is not acceptable to watch skilled operative vaginal delivery become extinct after 400 years of usage. We can prevent that from happening but it will take a concerted effort. In an emergency does anyone in our delivery rooms know how to apply Piper Forceps to an after coming head? How can we increase the vaginal birth after cesarean rate in our chilling liability environment? How do we handle breech deliveries and twins?

- In the last few years our formal focus on safety has expanded. We can move this forward by becoming the leaders of the safety agenda. Basking in a culture of safety will save lives, prevent harm, increase good will and help inure us to legal assaults. We can create safer processes, improve our communication techniques, and document the care we provide more accurately. We can encourage and facilitate fetal heart monitor credentialing. Checklists can be developed that are precise and efficient enough to be of real help clinically and to be bulletproof legally. Checklists will improve our consistency. Oxytocin monitoring checklists have already been shown to improve outcomes and reduce litigation. Airplane pilots routinely use checklists to reduce risks and improve safety; why shouldn’t we?

- In 2008 the cesarean delivery rate reached another record high—32.8% of all births. There is a community not far from my home in which 45% of the newborns are delivered via an abdominal incision. Let me be very honest, this increase in cesarean delivery rate grieves me because it seems as if we are changing the culture of birth without Nature’s permission. While it is certainly true that a physician has a contract with an individual patient, our specialty has a covenant with our society. We need to take responsibility and be cognizant of the impact we have on the world.

- Deciding to perform a cesarean can often be a difficult. Each one of us enters the labor and delivery room shouldering our concern for our two patients and weighed down by the overwhelming yoke of liability. Our decisions are still made as much by art as they are by science. We have always accepted the burden of making the difficult decisions for mother and baby but they were hard enough before the culture of legal fear invaded our maternity units. Those buck stops here decisions are tough enough without the fears of losing our liability insurance, our livelihood, our financial reserves, or being publicly humiliated. Liability dampens our spirits but unfortunately, it is also starting to define our specialty.

- Let us recommit to do everything in our power to perform surgery only when necessary. Let us recommit to induce only when indicated and let us vow to never electively induce or perform an elective cesarean prior to 39 weeks. Any time we are tempted to
take the safe path but not the righteous path, we should all say, “not on my shift.”

Maternal deaths, too many cesarean deliveries, late premature births, racial disparity in access and outcomes, inadequate data collection, and loss of experience in the workplace are only a few of the issues. We also have critics who are increasingly frustrated by the increase use of technology and what they perceive as the dehumanization of the birth process. They are quite vocal about “overuse of many interventions and practices associated with harm and waste” and “indicators that have moved in the wrong direction.”* Quality and safety can always be enhanced but we also need to listen and respond to even our harshest critics. The College can and really must address these concerns.

ADVICE FOR NEW FELLOWS

And now some advice to our newest Fellows. My father had simple advice for me in the beginning of my career. He told me to always do the right thing. That guidance has served me well, so I am happy to share it with you today. Embrace transparency and integrity matters always. Ethics, professionalism, and your reputation are your most valuable commodities, so guard them assiduously.

You now represent the College and our entire membership. Be proud every day and in every way. Practice with honor and joy. Uphold our tradition of excellence. Remain active in the College. I am proof that any one of you can rise to the highest level of this organization.

As you move away from the “one on one” care that our generation provided early in our careers, it becomes critically important to rethink your goals. Of course, the number one goal is to have healthy patients and intact families, but there is so much more. Always remember the tremendous impact you have on the lives you touch.

If you are planning to deliver newborns, remember that we have an obligation to empower women and families through the birth process. Women in labor are so very vulnerable, and our goal must not only to protect their health, but to protect their dignity and make them feel appreciated and respected. Women and families have a lifelong memory of beloved children being born. They may remember every word, every moment, every nuance of the birth. Delivering a newborn is simply the single greatest natural high that you can experience in a medical career.

You will fall in love with this field. There is no greater calling than to bring precious life into this world with your own hands or reduce women’s suffering by clinical excellence through your caring hearts and minds. You will all experience unforgettable moments—treasure them. Obstetrics and gynecology is so rich. Be passionate about our specialty. Women deserve nothing less.

This specialty is so frequently spectacular. But you will encounter problems. The highs are incredible but the lows also come with the territory. Be sure to recognize this fact and to take care of yourself physically and emotionally.

There is so much more we can do for women and families, and we are counting on you to get it done. You have an unlimited opportunity to shape women’s health care and have a profound impact on humanity. We celebrate your future.

The American College of Obstetricians and Gynecologists has a reputation for excellence that could be harnessed to improve women’s health care here in the United States and indeed into the far reaches of the world. As we strengthen the bonds of respect and caring for others, we will enhance our global reputation and further benefit society. We often hear that the College is the preeminent women’s health organization, and indeed, I think that is true. However, we must not be satisfied with that because, as good as we have been, I think that we can be so much more. We have an incredible untapped potential, and we must not be afraid to dream of an even brighter future!

REFERENCES