The Evolution of the Laborist

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KEYWORDS

• Laborist • Obstetric hospitalist • Labor outcomes • Economic impact

KEY POINTS

- The laborist movement, although relatively new, is rapidly expanding as a means to improve patient care and physician burnout and decrease malpractice claims.
- Although there are many different models of laborists, full-time laborists may have a greater impact on improvement in obstetric outcomes.
- Full-time laborists are found to decrease rates of cesarean delivery; however, their impact on other maternal or neonatal morbidity markers is unknown.
- The use of laborists can decrease rates of malpractice claims and litigation, not only through the immediate availability of physicians for emergent scenarios but through improved care in uncertain clinical scenarios.

INTRODUCTION

Historically, a patient's physician in the outpatient setting would follow up with the patient and provide care in the inpatient setting as well. However, throughout the latter quarter of the 20th century, hospitalizations became increasingly complicated with multiple tests and treatments needing to be ordered, interpreted, and responded to in rapid succession. Similarly, patients in the outpatient environment have also increased in complexity, and the demands on physicians balancing both the outpatient and inpatient medicine became more challenging. The hospitalist movement was formally introduced in 1996 by Robert Watcher.[1] The hospitalist was introduced as a way to improve the quality of care patients receive, to decrease hospital costs by shortening length of stay, and to improve physician quality of life.

In obstetrics, the concept of the laborist was first described by Weinstein[2] in 2003 as an offshoot to the hospitalist movement, although this kind of coverage had been used in large Health Maintenance Organization practices such as Kaiser Permanente since

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the 1990s. This concept represented a dramatic shift in the way in which obstetric care was provided. Previously, obstetricians had to simultaneously balance a full office practice with the demands of patients admitted to the labor suite. Additionally, many obstetricians took frequent night call, with solo practice clinicians being on call every night except on the rare vacation. The laborist provided a model to hand off the demands of the labor suite to physicians whose sole responsibility was the care of women in labor, while improving care and decreasing rates of physician burnout.[2]

Since the introduction of the laborist more than 10 years ago, this specialty role has gained momentum and traction, particularly in large hospitals with high-volume labor and delivery suites. In a 2010 statement, the American College of Obstetricians and Gynecologists (ACOG) released a statement supporting "the continued development of the obstetric-gynecologic hospitalist model as one potential approach to achieving increased professional and patient satisfaction while maintaining safe and effective care across delivery settings".[3] Later that same year, 25% of ACOG member responders identified themselves as either a laborist or hospitalist.[4] In another 2010 study surveying National Perinatal Information Center/Quality Analytic Services member hospitals, approximately 40% were employing laborists.[5] By 2011, the Society of OB/Gyn Hospitalists formed and by 2016 had 600 dues-paying members. In part, the evolution of the laborist movement was founded on improving provider job satisfaction and decreasing rates of physician burnout. In the same 2010 survey of ACOG members, those who self-identified as laborists or hospitalists were asked to rate their job satisfaction. More than 92% rated themselves between satisfied and extremely satisfied.[4]

Although the laborist movement has expanded, there does not exist a standardized definition of what laborist coverage looks like. Similarly, there are minimal data on maternal and neonatal outcomes or differences in rates of litigation. This article reviews models of laborist care, discusses the potential benefits in quality of maternal care, and discusses the potential financial impact of this care model.

MODELS OF CARE

In the original model presented by Weinstein,[2] the labor suite would be covered by 4 physicians working no more than 14 hours in a shift. This was, he argued, to minimize fatigue and optimize the care provided to patients. Since this original recommendation, the role of the laborist and the physician who fulfills that role has varied greatly between hospitals.

In the traditional model, a group of laborists are hired by the hospital to cover the labor and delivery unit within the hospital. Commonly, the laborist groups care for patients belonging to certain private groups along with patients without a designated provider such as those admitted to a hospital that is different from where they received prenatal care. These physicians are also readily available to manage obstetric emergencies or precipitous deliveries of patients belonging to other practices. Additionally, this role can be expanded to cover the hospital's gynecologic emergencies and consultations. In a variation of this model, some laborist groups primarily cover the labor suite and gynecologic consults in the emergency department with a small proportion of their time being spent in an outpatient clinic.

Another model shares shift work within large practice groups or between multiple small practice groups, also called *community laborists*. In this model, private practice physicians occasionally cover labor and delivery for 12- or 24-hour shifts. During their laborist shift, they don't have clinical responsibilities and thus can provide complete

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