

# COMMENT & CONTROVERSY

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"Laborists, nocturnalists, weekendists.  
Will the 'ists' preserve the rewards of OB practice?"  
by Robert L. Barbieri, MD (Editorial, September)

## Laborist model is "abhorrent"

I've been in practice for about 30 years, and I have never been so glad that I am approaching retirement. What has happened to our specialty? I really hope your tongue was in your cheek when you wrote that editorial. I find it disturbing that a laborist might be managing the whole labor and then, just before delivery is to occur, the so-called personal obstetrician steps in. Babies are born at all hours of the day and also on weekends and holidays; it's the nature of the profession.

Laborists are an abhorrent idea. Just when the patient needs the calming influence of "her" doctor, someone else comes in and introduces him/herself as "your doctor for the night." What will a patient think when she has gone to a "boutique" practice for 9 months and then shows up in labor to be managed by a laborist? Who is going to manage preterm labors in nervous patients, and who is going to manage postpartum complications if they take place after convenient hours?

Malpractice lawyers must have created this "ists" idea because it will make them all very wealthy. If current and future ObGyns find the work too difficult, they should consider training to be another kind of "ist": dermatologist, pathologist, psychiatrist....

**Roger Cayer, MD**  
Choctaw National Healthcare Center  
Talihina, Okla

## Stable group practice can eliminate need for "ists"

All of the models suggested are poor substitutes for a stable group practice of like-minded physicians who share a patient base and call schedule. A group that can provide a 1:5 or greater call schedule preserves continuity and protects ObGyns from being replaced with nurse practitioners in the office and nurse midwives in the hospital. It allows one physician or her partners to continue to share the patient's goals for the pregnancy through prenatal care, delivery, and postpartum. It can address safety issues as well. What it cannot do is lower the cost of obstetric malpractice premiums. That—rather than lifestyle—may be the root of the problem for many ObGyns in private practice.

**Nathana Lurvey, MD**  
Culver City, Calif



## Younger ObGyns see lifestyle issues as priority

Your readers might want to explore [www.oblaborist.org](http://www.oblaborist.org), where they will find articles discussing the laborist model and other paradigms and an overview of laborists. All of the models are voluntary, so docs can use or bypass the program as they desire. This option allows physicians to weigh personal inconvenience and schedule conflicts against the desire to participate in the labor process.

As a resident director who trains and counsels residents, and as a department chair who hires young faculty and community physicians, I am seeing young doctors emphasize lifestyle to a greater

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**"Malpractice lawyers must have created this 'ists' idea because it will make them all very wealthy"**

extent, and nights on call and labor-and-delivery coverage are major determinants of quality of life—so laborist programs are also becoming central to recruiting.

**William J. Mann Jr, MD**  
Chairman and Gynecologic Oncologist  
Jersey Shore University Medical Center  
Neptune, NJ

**Dr. Barbieri responds:**  
**OB practice is changing**

I appreciate the thoughtful responses from Drs. Cayer, Lurvey, and Mann. I resonate deeply with the commitment to the traditional model of obstetrics in which a small group of “like-minded” obstetricians personally provides direct care to their patients and cross-cover during nights and weekends. However, all indications are that we are at the threshold of a major change in obstetric practice and will need to lead and adapt to it over the next decade. Many dynamic factors, including the patient-safety movement, the growing desire to better balance family and work-life, and the significant problem of physician burnout are pushing us toward a “laborist” model. The Web site mentioned by Dr. Mann provides a good overview of some of the advantages and disadvantages of the laborist model.

“Do SSRIs cause major birth defects?” Commentary by Andrew M. Kaunitz, MD (Examining the Evidence, September)

**Are SSRIs linked to birth defects—or not?**

As a loyal OBG MANAGEMENT reader, I love your features and your emphasis on the evidence. So I was really surprised when I read the article on selective serotonin reuptake inhibitors (SSRIs) and birth defects.

I don’t think it is correct to look at the two studies that Dr. Kaunitz reviewed (both of which showed statistically significant associations between SSRIs and major birth defects) and conclude that the answer to the question “Do SSRIs cause major birth defects” is “No.” I think that is a mistake that requires correction or explanation so that we can present the

evidence properly to both patients and providers.

**Adam C. Urato, MD**  
Assistant Professor, Maternal-Fetal Medicine  
Tufts University—New England Medical Center  
Boston

**Dr. Kaunitz responds:**  
**SSRIs are not major teratogens**

I appreciate Dr. Urato’s thoughtful comments. His surprise over the conclusion that SSRIs do not cause major birth defects is not unfounded. The issue has received considerable media attention of late, with different interpretations of the data.

I think the editorial by Michael F. Greene, MD, that accompanied the two studies in the *New England Journal of Medicine* offers a coherent summary of the data to date—and its title hints at his conclusions: “Teratogenicity of SSRIs—serious concern or much ado about little?”<sup>1-3</sup> Dr. Greene writes: “A survey of the aggregate data now available—positive, negative, and equivocal—makes it clear that neither SSRIs as a group nor individual SSRIs are major teratogens on the order of thalidomide or isotretinoin.”

Dr. Greene also acknowledges the desire, among both patients and physicians, for a clear line of demarcation between “risk” and “no risk” and consistency between studies—as well as the rarity of such clarity. As he concludes, and as I pointed out in my commentary, “The two reports in this issue of the *Journal*, together with other available information, do suggest that any increased risks of these malformations in association with the use of SSRIs are likely to be small in terms of absolute risks.”

**References**

1. Alwan S, Reefhuis J, Rasmussen SA, Olney RS, Friedman JM, for the National Birth Defects Prevention Study. Use of selective serotonin-reuptake inhibitors in pregnancy and the risk of birth defects. *N Engl J Med.* 2007;356:2684-2692.
2. Louik C, Lin AE, Werler MM, Hernández-Díaz S, Mitchell AA. First-trimester use of selective serotonin-reuptake inhibitors and the risk of birth defects. *N Engl J Med.* 2007;356:2675-2683.
3. Greene MF. Teratogenicity of SSRIs—serious concern or much ado about little? *N Engl J Med.* 2007;356:2732-2733.

**“All indications are that we are at the threshold of a major change in obstetric practice”**

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...unless we  
**HEAR FROM YOU.**

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