Transactions of the Second Combined Annual Meeting of the American Gynecological Society and American Association of Obstetricians and Gynecologists

Obstetrics-gynecology: A time for change

Presidential address

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To see what is right and not to do it is want of courage.

Confucius

IN HIS PRESIDENTIAL ADDRESS before the first combined meeting of the American Gynecological Society and the American Association of Obstetricians and Gynecologists, Dr. George Mitchell discussed the process of decision-making in obstetrics-gynecology. He mentioned some of the difficulties we have had in arriving at logical decisions and, of greater importance, suggested areas in which decisions must be made promptly if we are to remain in control of the development of our speciality. I agree so completely with his ideas that I have used some of them as a basis for my remarks today.

The demise of a professional society whose Fellows have been responsible for many of the advances in scientific and clinical obstetrics-gynecology for more than 100 years engenders feelings of remorse. In this instance, any regrets we may have are mitigated by our expectations for the future. We look forward not to an end, but to a beginning as we amalgamate with another prestigious society to form a new organization, the American Gynecological and Obstetrical Society. We all expect that the new Society will be an even more important force in shaping the future of our discipline than were its predecessors.

It would be neither appropriate nor productive to try to review the accomplishments of the Fellows of the American Gynecological Society. It is fitting, however, to examine the goals that were set for the organization and to consider how successful we have been in accomplishing them. I will also, as did our first president, challenge the officers and Fellows of the new Society by suggesting a role which will be more controversial than that given to the Founding Fellows.

The stated reason for organizing the American Gynecological Society was ". . . the promotion of knowledge in all that relates to the Diseases of Women and to Obstetrics." Fordyce Barker,[1] in the first Presidential Address, elaborated upon this by suggesting four specific goals.

1. ". . . may we hope that . . . this work may be done so well that . . . the Centennial Anniversary of this So-

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ciety may be well worthy of commemoration by those who succeed us?" Indeed it was. In 1976, the founding of the American Gynecological Society was celebrated during a memorable meeting at which almost every important obstetrics and gynecology organization in the world was represented.

2. "May we not confidently anticipate that this Society will exert a marked influence . . . in contributing to the progress of science and our national reputation in this branch of our profession?" There is no question but that this aim was achieved. The American Gynecological Society has been one of the two premier organizations in our specialty. Its Fellows have been in the forefront in providing the scientific information and in introducing the innovations in teaching and practice which have permitted obstetrics-gynecology to achieve its present status. They continue in this role in the forum of our society, as well as in those of new organizations which were formed to enhance communication in several highly specialized areas which would have been incomprehensible to our predecessors.

3. "May we not secure for it such a character, by zealous, honest, able work, as that all who aim for representation in the department of Obstetrics and Gynecology, will seek to obtain membership, as giving the seal and stamp of eminence?" Again, this aim was achieved. In most instances fellowship in the Society has been awarded to those holding important posts in universities or to eminent practitioners who were influential in directing the development of our specialty.

4. "Can we . . . give it such a direction . . . that each annual volume of our *Transactions* shall contain papers of value so great that all . . . who strive to keep abreast with the progress of the science will desire to secure a copy . . .?" Not everyone agreed that this objective was accomplished. J. Whitridge Williams rated the first 1,010 papers presented before the Society. He concluded that only 27 of them were excellent and 42 "creditable."

We can conclude, quite logically, that the American Gynecological Society did play an important role in advancing the science and art of obstetrics and of gynecology and that it has lived up to the expectations of its Founding Fellows.

The Fellows of a new society will face problems that our predecessors could never have anticipated: changes in the attitudes and education of medical students; a change from personal preceptorships to institutional training programs; a proliferation of scientific and technical information to be incorporated into clinical practice; increasingly burdensome controls by burgeoning institutional, professional, and governmental bureaucracies; changing patient attitudes; changing physician attitudes; and a host of others with which you are all too familiar. Some of these have been to the advantage of our discipline, while others have been detrimental.

During the first 50 years of the existence of the American Gynecological Society there were relatively few obstetrician-gynecologists and they confined themselves mainly to specialty and consultation practice. Maternal and perinatal mortality rates were high. General practitioners, who were providing most of the obstetric care, had had little training in obstetrics and were incapable of anticipating, preventing, and managing serious obstetric complications. There were few organized hospital obstetric services; individual practice privileges based upon demonstrated clinical ability were not usually delineated, and there were no regulations concerning consultations when problems arose. Little effective treatment was available for most gynecologic disorders and surgical procedures were considered only as a last resort. Most gynecologic operations were performed by general surgeons; conversely, few gynecologists confined themselves to operating upon the reproductive organs.

This situation prevailed until after the organization of the American Board of Obstetrics and Gynecology, the introduction of structured hospital residencies, and the development of stringent requirements for hospital accreditation. These changes provided the impetus to each department to establish regulations designed to improve the hospital practice of obstetrics-gynecology.

The graduates of the new residencies made prenatal care available to both private and clinic patients; they encouraged presumably well women to have regular periodic examinations; they offered contraceptive counseling, and they were able to deal more effectively with a wide variety of gynecologic disorders and obstetric complications than were their predecessors. As a consequence, the demands for care by trained obstetrician-gynecologists increased dramatically.

Then we made our first major mistake. We insisted that only specialists were capable of providing obstetric and gynecologic care, no matter how trivial the problem. When it became obvious that there were too few of us to meet the demands for the services we had introduced, we responded by increasing the number of residency programs, many of them in hospitals with limited experience in education.

Obstetrician-gynecologists have remained busy, but our practices have changed. We have retained most of our specialist-consultant responsibilities, but there are now so many of us that the provision of true specialist care constitutes a minority of our total effort. Many have expanded periodic examinations to include com-

plete physical assessment, rather than examination of only the breasts and reproductive organs. An increasing number treat selected general medical conditions in their own patients.

We resist the new image we have created for ourselves. Obstetrician-gynecologists, even those whose major responsibility is in providing primary care, consider themselves to be specialist-consultants in the pattern of their professional ancestors. In part, this attitude is acquired during residency training. Few programs have made the changes which reflect the actual responsibilities of today's practitioners. The traditional concentration on surgical techniques and complicated obstetrics has been maintained, but too little emphasis is placed on preparing house officers for contemporary practice.

Even the specialized experiences in many training programs are inadequate. As we attempted to respond to the insatiable demands for obstetric-gynecologic services, we increased the number of trainees well beyond our capacity to educate them as specialist-consultants. Our efforts have been complicated further by a change in distribution of patients, a trend which is likely to continue. As more women seek care from private practitioners, there are fewer for whom residents can provide a complete spectrum of obstetric-gynecologic services. No matter how generous the staff is in "turning over" technical procedures, the training suffers if house officers cannot assume total, but adequately supervised, responsibility for the care of a large number of patients, both in outpatient care and in the hospital. In many programs there are so few patients to be distributed among so many residents that none of them can develop true diagnostic and therapeutic competence.

We are now graduating too many residents who can conduct normal and cesarean deliveries but whose experience in the total management of patients with serious obstetric complications and in operative vaginal delivery is limited. Part of the increase in the cesarean delivery rate has occurred because young obstetricians doubt their abilities to conduct the forceps extractions and breech deliveries which they could perform safely had they been properly prepared. In the past, house officers learned the techniques of forceps delivery by using low forceps so often that they became quite competent in applying them. The step from this experience to more difficult, but appropriate, forceps deliveries was a short one. Unfortunately, too few residents today have the opportunity to become experts, even in low-forceps delivery.

The change can be attributed only in part to patients who insist on "natural" delivery. Program directors and practitioners must share the responsibility. We have applied the demands of our most vocal critics indiscriminately, even to women who are not convinced of the presumed advantage of retrogressive obstetrics. Directors of residencies once were proud of low cesarean delivery rates balanced by a high percentage of forceps extractions and a low percentage of spontaneous deliveries. One now hears some service chiefs apologize for cesarean section rates of less than 20% or for more than 10% forceps deliveries.

Among the things a specialist-consultant obstetrician-gynecologist does is operate, but there is a limit to the number of gynecologic operations which are truly indicated. When we overemphasize surgery in our training programs, we are encouraging surgical treatment, even when an alternative nonoperative approach might be equally as appropriate. This dilemma is insoluble within the present system. Obstetrician-gynecologists must learn to perform the operations they will be doing in practice, but in too many programs the concentration is on operative technique, with little concern for the pathophysiology of disease processes and for the criteria for selecting alternative nonsurgical forms of treatment. The basic problem is that there are too many obstetrician-gynecologists who have been trained to operate and too few women who need to be operated upon.

Expansion of information and new technology permitted us to develop complicated and intricate diagnostic and treatment methods which are beyond the abilities of obstetrician-gynecologists who have had standard training, even that provided in the best institutions. The introduction of advanced subspecialty programs, designed to prepare a limited number of obstetrician-gynecologists to use the new information, was a logical result. Although subspecialty training was an important and necessary advance, it led inevitably to changes, some overt and others more subtle, in house officer education. House officers used to participate actively in the management of all the patients on the service, no matter how difficult the problem. They were expected to acquire a basic understanding of how unusual conditions were managed. Now many patients with complications are being transferred to specialized centers for care. While this system improves the outcome for the patient, it is disadvantageous for house officer education in the referring hospital. Residents who complete the program have often had limited experience in complicated obstetrics and gynecology. Even rotations through specialized services in other hospitals do not completely make up for the deficiency.

At the opposite end of the professional scale we have reintroduced nonphysician-practitioners whom we

eliminated years ago. The most effective roles for nurse-practitioners and nurse-midwives are in normal obstetrics; periodic examinations of presumably well women; counseling, particularly of adolescents, infertile couples, elderly women, those with psychosexual problems, and those with cancer; the provision of contraceptive services; and the management of minor gynecologic problems. This encompasses much of the practice of many obstetrician-gynecologists.

Residents finishing a standard program are left in the middle. They are too highly trained for many of the tasks that will occupy much of their time in practice. As a result they may do them reluctantly and less well than do nonphysician-associates who are prepared specifically for that purpose. Conversely, they are not skillful enough to solve many of the medical and surgical problems they would have been expected to deal with in the past.

A substantial portion of the problem originated with our own well-meaning but poorly considered decisions. We recognized the increasing demands for the obstetric, gynecologic, and general medical services we offer, but we made the mistake of considering only one solution, that of training more obstetrician-gynecologists. In addition, we continued to prepare house officers to serve as specialist-consultants despite the obvious fact that there is too little need for highly specialized care to keep them all busy.

In other words, many of our present stereotyped programs prepare house officers to practice in a manner which was appropriate 40 years ago. This has become outmoded by our overproduction of obstetrician-gynecologists.

As we struggle with the problems of resident education, additional pressures are brought to bear on practitioners. Patients' attitudes toward medical care in general, and toward obstetric-gynecologic care in particular, have changed considerably in the past several years. Spontaneous delivery with minimal interference, family-centered obstetric care, birthing centers, and home delivery are now in vogue. We have voluntarily relinquished much prenatal education to "childbirth educators," over whose philosophies we have no control. Too many of them are antiobstetrician and antihospital. We are accused of being unresponsive to the health care needs of women and much too eager to operate.

The role of the obstetrician *has* changed, and we now face a situation similar to that described by T. Gaillard Thomas,[2] in his Presidential Address before the American Gynecological Society in 1879. He stated: "So too, is the time at hand for the complete obliteration of a prevalent idea in the public mind, that the functions of the Obstetrician ordinarily consist in watching by the parturient couch, receiving the coming child, and creating harmony and good feelings by well turned compliments and blandness of manner." He went on to say that inadequate and inappropriate obstetric care leads to ". . . a long list of pathological states, which will cling to them (the patients) for life, sapping their usefulness, and destroying the happiness of their households." By acceding meekly to the demands of our most vocal critics we have abrogated one of our major responsibilities, that of informing patients of the advantages of some of the protective and preventive procedures we have introduced. One notable example is our reluctance to perform prophylactic episiotomy, even in those who do not insist on "natural delivery." This will result inevitably in an increase in extensive vaginal relaxations which have been virtually eliminated by good obstetric care. Surgical gynecology was built upon the correction of these defects.

That we are training more obstetrician-gynecologists than are needed is basic to the total problem. According to the preliminary report of the Graduate Medical Education National Advisory Committee, there will be more than 34,000 full-time equivalent resident and practicing obstetrician-gynecologists in the United States in 1990. They presume the need to be 24,000. Information provided by the American College of Obstetricians and Gynecologists suggests that a figure of about 27,000 is more realistic and that this is not excessive.[3] This estimate is based upon the supposition that our present method of providing care will not change, upon our supplying obstetrician-gynecologists to areas where specialized care is not readily available, and upon the supposition that obstetrician-gynecologists will make significant reductions in the number of hours they work. Unfortunately, most of the underserved areas are those to which trained specialists will not go willingly. Another system for serving these areas must be devised. It is unlikely that obstetrician-gynecologists will be willing to halve their incomes as they reduce their work weeks to 30 hours. They will undoubtedly solve this problem by expanding the already overextended indications for surgery and by increasing fees for other services. Of course, this will confirm the criticisms of our patients and of those in government who control our destinies.

For many years 6% to 7% of graduating medical students have sought obstetric-gynecologic residencies. We responded to a doubling of medical school classes by increasing residency positions. That we now have as many or more applicants than first-year positions is considered by some to be an indication of "success" in recruiting. While we may be successful in attracting medical students, are we being responsible? Are we as-

suring our embryonic colleagues that they will have excellent opportunities for developing and using their professional skills? Are we assuring our patients the best possible obstetric-gynecologic care in the future? Or are we only considering our own interests?

Will the 1,000 or more obstetrician-gynecologists we are producing each year provide better care or will they continue to function as thwarted specialist-consultants? How will they be kept busy—by expanding the reasons for surgery even further or by eliminating house officer patients? How will they work with the increasing number of nurse-practitioners, nurse-midwives, physician-assistants and family practitioners who provide many of the same services? How many obstetrician-gynecologists trained in the present mode will be content to spend almost all their time counseling adolescents, the elderly, and others and providing contraceptive and other routine ambulatory services, and how well will they do these things?

This is one of the most critical periods in the history of our specialty. The decisions we make now will determine whether we survive as the experts in obstetrics and diseases of women or whether we will gradually fade away, as the general surgeons, urologists, medical endocrinologists, family practitioners, and others, who are eagerly awaiting our demise, assume the care of our patients.

We have two choices. We can continue to overproduce inadequately trained obstetrician-gynecologists who will be squeezed between the ever-increasing number of superspecialists, on the one hand, and nurse-practitioners, nurse-midwives, and family physicians, on the other. If we choose this path, our specialty will become less and less attractive as all the challenging endocrine and medical problems, interesting obstetrics, and major operative gynecology are taken over by others. We will be left with normal obstetrics, minor gynecologic operations, and ordinary ambulatory services.

The other, and more logical, choice is to change. One solution might be to expand Silver and associates'[4] proposal for training "gyniatricians" to provide normal obstetric, ambulatory gynecologic, and basic general medical care. An appropriate number of these practitioners could be selected for advanced training on the basis of demonstrated superior ability and performance. It is from this group that we would develop gynecologic surgeons, perinatologists, reproductive endocrinologists, and oncologists.

A second possibility, and the one I favor, is to reduce the number of training programs and house officer positions drastically. Only residencies which have been able to maintain superior training programs in the past would be eligible for consideration. The programs would be designed to produce academicians and true specialist-consultants who would eventually practice in that capacity.

House officers would work closely with nurse-practitioners and nurse-midwives, who would provide most of the "primary care." After mastering basic obstetrics-gynecology, the house officers would concentrate on the patients who need the services of skilled obstetrician-gynecologists. They would learn more reproductive physiology, pathology, general medicine, surgery, preventive medicine, and psychiatry than are now included in most residencies. They would learn to be skillful obstetricians who are completely familiar with the physiologic and medical aspects of obstetrics. They would not have to resort to cesarean delivery simply because they had not been trained to do appropriate forceps and vaginal breech deliveries. They would become competent surgeons, whose knowledge and skills extend far beyond those of the graduates of most present residency programs. There would be less need for superspecialists because properly trained specialist-consultant obstetrician-gynecologists can manage many of the problems that are now referred regularly to those with advanced training.

Implementation of this proposal would require that many residency programs be eliminated and that those that survive undergo drastic changes. It would require a longer training period, probably 6 years after graduation from medical school. The program for those planning academic careers would be even longer. They would have to learn administrative and advanced research and teaching techniques in addition to developing clinical skills. This would eliminate some candidates, but that would be an advantage. We could have the pick of the most capable of the applicants who would be willing to expend the effort required to excel.

An idea attributed to Bobby Knight, whom I do not often quote, is that the "will to win" is the most overrated concept in the world. I agree completely with his suggestion that what we need is more people with the will to *prepare* themselves to win. Mediocre candidates in mediocre programs become mediocre obstetrician-gynecologists. We can no longer afford to compromise on quality to expand our numbers.

To accomplish this I propose the following:

1. That we immediately eliminate all ineffective programs. Examples are those which consistently fail to fill their positions and which attract only our least capable students, those whose graduates have always had difficulty passing the examinations given by the American Board of Obstetrics and Gynecology and those chronically on probation.

2. That we approve only programs in which all the professionals needed to provide obstetric-gynecologic care can be trained. This would permit potential obstetrician-gynecologists to learn to work as members of multidisciplinary teams, one of the best ways of providing health care for women.

3. That the members of each department seeking approval prepare objectives outlining their requirements for the education of specialist-consultants and furnish proof that each graduate has met the requirements.

4. That we review programs periodically for assurance that they are continuing to be productive and that new information and new techniques are being incorporated in house officer education. If an approved program fails to maintain its excellence it would be given a single 2-year probationary period to make the necessary changes.

5. That house officers be approved for admission to examinations designed to certify them as specialist-consultant obstetrician-gynecologists only after they have met all the requirements of their institutional programs. Graduates of properly designed and administered residencies rarely fail such examinations.

6. That we require periodic recertification based both on continuing education and on practice evaluation. Many of the hundreds of lucrative postgraduate courses now being given are inappropriate for specialist-consultants. A properly trained obstetrician-gynecologist should be capable of giving many of them. The number of courses should be drastically reduced; they should be constructed by experts and the participants should be pretested and posttested, not for factual knowledge alone but for practice changes instituted as a result of the course.

Who can accomplish this? None of the existing professional organizations alone. A cooperative effort is necessary. To be effective, however, the functions of many of our worthy, but tradition-bound, organizations must be redesigned.

The Directors of the American Board of Obstetrics and Gynecology have great responsibility for the professional development of candidates; they set the standards for admission to the examinations. In my opinion, the standards both for admission and for certification are far too low. It is impossible to train large numbers of true specialist-consultants in our existing residencies, yet 830 were judged by the Board to be capable of serving in that capacity after the two oral examinations in 1980-1981.

The Board could serve more appropriately as our certifying body by making the requirements for admission to the examinations far more rigid and by making major changes in its evaluation system. Instead of relying solely upon written and oral examinations, the office and hospital practices of candidates should be studied in detail and the candidates should be observed in their day-to-day care of patients. This is impossible with the present number of candidates but need not be with an appropriate reduction. The Board, of course, would continue its activities in recertifying practicing obstetrician-gynecologists but, again, using a more discriminating method than the present one.

The basic responsibility of the American College of Obstetricians and Gynecologists is for obstetric-gynecologic practice, not for basic training of obstetrician-gynecologists. Since the only stated objective of the College is "... to foster and stimulate improvements in all aspects of the health care of women which properly come within the scope of Obstetrics and Gynecology,"[3] they should be willing to consider any change that will improve our ability to deliver outstanding services. They might even consider changing the name to the American College of Obstetrics and Gynecology and inviting all professionals who provide obstetric-gynecologic care to affiliate. The precedent for this already has been set by the Nurses Association of the American College of Obstetricians and Gynecologists.

One of the most important responsibilties for the American College of Obstetricians and Gynecologists is continuing education. Ideally, the College would combine its vast resources with those of other organizations to develop postgraduate educational programs for all the professionals involved in providing health care for women.

In its youth the Association of Professors of Gynecology and Obstetrics was an organization within which plans for sweeping changes in the system might have been made. Departmental representatives were principally chairmen and senior faculty members who had the ability to alter their own programs. Most of the attendants at APGO meetings now are more junior faculty members who have neither the experience nor the perspective to plan and implement such major changes. The principal role for APGO may be that of helping young people prepare themselves for progressively more responsible academic positions. No other organization has assumed this important responsibility.

The Council on Resident Education in Obstetrics and Gynecology has played an important role in improving resident education. Its main emphases have been on helping directors in community hospitals find solutions to their problems, on developing educational resources, and on preparing in-training examinations. If inferior independent programs are phased out, one of the important responsibilities of CREOG will be as-

sumed by university program directors. Mastering of defined departmental objectives, based upon those already developed by the Council, will eliminate the need for a general examination.

The Residency Review Committee, which has the first opportunity to influence the quality of resident education, has demonstrated again and again its inability either to improve inferior programs significantly or to eliminate them.

Who then can institute change? No significant improvement will ever be made until those who have been most successful in resident education, the directors of university programs, agree that there are serious problems in the system and take the steps necessary to correct them.

I suggest that a system designed to educate obstetrician-gynecologists with all degrees of skill, to certify them for practice, and to plan for their continuing education be developed by The American Gynecological and Obstetrical Society, the American Board of Obstetrics and Gynecology, and the American College of Obstetricians and Gynecologists. Individuals representing the essential phases of obstetric-gynecologic education, administration, practice, and research are members of these organizations.

The principal role of The American Gynecological and Obstetrical Society would be in medical student and house officer education and in coordinating the numerous studies upon which changes must be based. This would include many functions for which APGO and CREOG are now responsible. The chairmen and senior faculty members of most university departments are Fellows of the Society, thus providing a natural forum for planning and implementing an entirely new approach to the education of obstetrician-gynecologists.

The American Board of Obstetrics and Gynecology, whose Directors represent all areas of obstetrics and gynecology, would have to redefine the requirements for certification as a specialist-consultant obstetrician-gynecologist and redesign its certifying system to make sure the criteria are being met. House officers would enter the certifying process only after they had mastered the objectives established for their own programs, which, of course, would have to be acceptable to the Board.

The Board would also administer required periodic recertifying examinations designed to evaluate the ability of obstetrician-gynecologists to continue to practice as specialist-consultants. Such examinations would include practice evaluation with particular reference to the inclusion of new knowledge and techniques in patient care.

The American College of Obstetricians and Gynecologists, in addition to many of its present activities, would become the principal source of continuing education, offering structured and integrated programs to replace the heterogeneous assortment now available. The courses should be designed to stress the intellectual capacities of the individuals taking them. Too few of the present courses offer true challenges to specialist-consultant obstetrician-gynecologists.

A system of education, certification, and surveillence, based upon the suggestions I have made, would provide assurance not only that we are graduating competent specialist-consultants but that they are enhancing their skills as the years go by. This could accomplish nothing less than to improve patient care, to provide a satisfying professional existence, and to assure a continuing supply of outstanding candidates for our specialty. If we do not make radical changes, we can anticipate increasing fragmentation of obstetric-gynecologic care and a steadily diminishing role as specialist-consultants.

I am at least as aware of the difficulties in implementing these suggestions as is anyone else in this room. I am convinced that it must be done. I also believe that this is an appropriate project for the American Gynecological and Obstetrical Society to initiate. Most of those who are responsible for obstetrics-gynecology teaching, certification, and practice are Fellows and our successors will join us. I challenge the officers and the Fellows of the American Gynecological and Obstetrical Society, which has hopes of being more than a forum for the presentation and discussion of scientific papers, to consider my suggestions seriously. The decisions concerning the future of our specialty are ours to make and the time for change has come.

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