My Report

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5. How would you describe the goal of your practice as an OB/GYN?

Text Response
patient care - advocacy
Provide good quality care locally
Deliver quality care to women in our community and be sure that they have a caring, listening, attentive physician, despite all the hurdles that the new insurance plans are putting in front of us, as well as government regulations.
taking excellent care of pts throughout their life
Providing excellent care to women
Deliver the best evidence based quality care to our patients
To give the best quality healthcare we can to our patients.
Provide long-term service to women, offer family planning services, minimally invasive surgery and office procedures
improve the health of those we serve
Efficiently deliver patient centered care based on best practices and best available evidence
I work as an OB/GYN Hospitalist at a busy private hospital
Convienent Compassionat Care
provide safe quality care to women
cure gynecologic cancer
To relieve the distress of frightened patients through knowledge ,action and kindness
to provide excellent, evidence-based, humanistic, personal care to my patients
To provide the best quality of care possible for my patients.
High quality care, patient satisfaction.
provide exceptional, up to date care and educate my patients in a way that allows them to navigate changes throughout their life with an improved quality of life
Take excellent care of women
Deliver quality, comprehensive women's health
Providing health care for women of all ages
Infertility diagnosis and treatment
To provide the best possible health care for women at ALL the stages of her life.
Safe care
Provide excellent care to women across their lifespan.
High quality care to the sickest pregnant patients in the area. Teach future Ob-Gyn's
Great care that is patient centered and evidence based.
I am in medical education - so to help residents become great OB/GYN's. Also to take good care of patients and for them to have good experiences with their care.
provide good care to female patients
I am in an office based gyn practice that opened about a year ago. Our goal is to provide compassionate and quality care in a relaxed setting for our patients, with ready access to physicians and rapid appointment availability.
My goal is to give oversight to my residents who are treating the underserved population in our area and also to maintain my own private practice.
Safe care based on evidence supported practices in a mutually respectful, collegial, satisfying, and culturally sensitive fashion. A lot of buzzwords, but I expect to be respected and I in turn respect my co-workers and patients who have differing perspectives. It's a team sport and while health care delivery needs to be scientifically sound, the way care is provided needs to take a lot more into consideration than just the

science.
To provide comprehensive medical care for women throughout their lifetime.
residency
To help women maintain their health
Provide the best up to date care for women Gyn and ob possible in a caring manner
Provide quality care to patients.
Continued care for women throughout heir life cycles.
To provide care to women in pregnancy that is safe, evidence-based, and cost-effective, resulting in optimal outcomes and a positive, highly-satisfying experience for the new mother.
To provide excellent and compassionate medical care for all patients.
to provide excellent, compassionate OB/Gyn care to the women of our community
Mainly High risk OB Very minimal numbers of low-risk
to provide the best and most up to date care to women
Provide standard care to indigent populations.
To provide excellent obstetric and gynecologic care to women of the Roanoke Valley and surrounding areas, to identify and intervene on complications to promote the best outcomes possible for both mother and fetus, to improve the quality of life for women dealing with gynecologic issues.
To provide the best care possible to my patients in an environment that is safe, welcoming, and efficient.
To provide high quality medical care while educating patients and their families about maintaining health and preventing disease and illness
provide excellent health care for women in central virginia
To provide the best care possible to my patients.
Provide quality care with evidenced based medicine for woman throughout their lives.
To provide gynecologic care to women of all ages to the best of my ability.
best medicine - keeping up w ob/gyn and gen female med - and finally having the good sense to ignore the nonsense being pushed on us principly by the GREEN JOURNAL and other such ,e.g. VBAC which has per Langdon's study an HIE rate of 8/10000 v s elect repeat c/s of zero, or not starting mammo till, or allowing the second stage of labor to exceed 2 hours (a Newfoundland study of 121000 pts showed exceeding 2 hours caused significant morbidity including HIE, ERBS palsy, maternal infection, and pp hemorrhages to name a few. There is also the 80 hour rule which is turning out under trained residents. My goal : to prevent the nonsense being published from harming my patients.
Provision of comprehensive gynecologic and obstetric care.
BEST AND TESTED MEDICINE
Quality patient care.
To provide quality obstetrical and gynecological care to all patients. To maintain good communication skills to interact with patients. Educate patients in regards to all medical topics pertaining to women's health. Maintain all updated medical equipment and medical knowledge to ensure less evasive procedures for quality of care.
Excellent patient care, quality improvement, education and professional development
To provide competent, compassionate care to women of all ages
Safe and accurate care of OB patients
provide excellent care to women in all phases of their life
I am a midwife.
To provide comprehensive ambulatory primary gynecologic care to university students.
Manage labor and delivery unit as a hispitalist
Practice good medicine and listen to pts

I am a CNM for triage at SPAH. Our goal is to triage patients effectively and prioritize care while providing a great customer service experience for our patients.
give the best care possible
Provide safe, acute and emergency care obstetrical and gynecological services to the community
practicing caring and the highest quality .
Quality care, safe mother and baby, preferably with the delivery experience that the patient wants (tub labor, shower, intermittent monitoring, etc.) if safe.

Statistic	Value
Total Responses	70

11. What has made your experiences with Certified NURSE Midwives (CNMs) positive?

Text Response
excellent use of her time and ours/allows me to be more productive. she has more time to spend with the patient which enhances the patient experience
caring toward patient
Their dedication to patient care and awareness of limitations of their scope of practice
Highly qualified and experienced CNM with common goal of safe deliveries.
Open communication. Making sure the patient selection is appropriate for CNMs.
people pathways and processes
great collaborative
very little.
CNMs are so good at providing personal, individualized care - often better than physicians are able to be (whether due to training differences or demands of a surgical practice etc). In my experience they have been very evidence focused. The CNMs I work with have great clinical judgment and the collaboration is very rewarding - the women we care for together get all the benefits of CNM care with the ability to easily add more advanced MD care when needed. In my practice in particular we have been able to care together for even very complicated patients who desire CNM care; I just step in for the heavy medical issues.
their major focus on pt education is in line with my philosophy
The vast majority of bad outcomes have been on CNM consultations. CNMs wait too long to consult a physician.
Our midwife
Working with them in the beginning of our working relationship to establish mutual understanding.
The ones I work with our well trained with considerable experience in caring for pregnant women.
True collaborative care
Based on prior job site. Currently the CNM deliveries are not covered by my hospitalist group. This will be changing. Basically, it was a clear understanding that the Midwife patients are THEIRS. Their patients were their own and fell under their scope of care. If something changed, then I would be consulted to either establish care or to offer assistance. I did NOT supervise them, nor did I establish a doctor/patient relationship for their patients just by virtue of being on labor and delivery. On the other hand, I have urgently delivered a couple patients that were 'not mine', by virtue of walking by a room when the vertex was crowning...no different than for another MD/DO patient situation. And, vice versa. We always had a collegial relationship. No one had an axe to grind, and we respected each other's skill set, which happened to overlap.
I have collaborated with Nurse midwives in the care of patients that they identify as "theirs" and they have helped our community with unassigned and indigent care for the entirety of my practice lifetime now 28 years. The relationship has been symbiotic, professional, and respectful. They are part of my peer group.
She stays up to date, we work together following ACOG guidelines, has more time to educate pt and help them during labor, helps alleviate some of my duties since I'm on call so much
Shared goals for best practice and outcomes
It frees me up to do other and more complicated obstetrics and gynecology.
Trust relationship between the doctors and CNMs in our practice.

nothing

Statistic	Value
Total Responses	22

12. What would you change about your collaborations with Certified NURSE Midwives (CNMs)?

Text Response
nothing at this time
None
Increase
making sure there is a clear understanding of what happens if the physician is not satisfied with CNM management.
nothing
none
I would educate them better. I would like to see them put themselves out more for the patients. I would like to see humble doctors communicating with humble midwives
Nothing
more regular opportunities for addressing issues in clinical care
I am changing jobs in 2016 so that I will no longer practice with CNMs
Wish she could do all the deliveries and still feel like I'm providing good emotional support for the patients
Nothing
not much
Better informed consent for midwife patients who sometimes have inappropriate expectations.
It would be nice to do so again. Going forward, and as this is a different jurisdiction than previously, I would like to ensure that autonomy is respected both in practice and with regards to legalities. The CNMs are independent and licensed in their own right. I should not be expected to 'sign off' on anything, or have an implied responsibility for their actions any more than they should have the same for me.
At this point, nothing.
One not as up to date and reliable as the other
Nothing
I would like to employ more of them.
Nothing, We have had them working in our practice for over 15 years and has really worked well and developed a true collaboration to make the model work well for us and for patients.
Communication & conference of patient plan of care
would work w a cnm only if the nurse was close supervised by me (and partners) and her practice was limited to what I approve
Some CNMs are working without appropriate supervision.One CNM transferred a patient whom she had been trying to induce with cytotec with intermittent auscultation in her office. It was an elective induction with an unfavorable cervix at 38w. She was far more aggressive at challenging my care and counseling than most of the CPM's. Of note, we have no CNMs in our group, so these are all patients transferred from outside CNMs, who sometimes accompany their patients to our facility on transfer.

Statistic	Value
Total Responses	23

13. If a problem arises between you and a Certified NURSE Midwife (CNM), which of the following best describes the steps you would take to resolve that issue? Select ALL that apply.

#	Answer		Response	%

Other (please describe below)
It's hard to deal with the 'dump and disappear brigade'
Have in past/will in future, answered thusly

15. What are the challenges to working with Certified NURSE Midwives (CNMs) in your work setting; what makes it harder?

Text Response
relying on someone elses "eyes" in the care of a patient that is ultimately my responsibility. litigation concerns
None
Have to provide back up coverage
No problems with CNM but sometimes conflict with unreasonable expectations of their patients
no major challenges
We have worked continuously on our people processes and pathway skills over the last 20 years and continue ot refine them today. Chance of imporvement favors a prepared mind
none
This is a dumb question. I have 2 midwives with whom the answer is 10 and three the answer is 2 This is a comment about the previous question. Challenges are Arrogance and a lack of critical facility in their thinking.
It's rare, but at times other hospital staff (MDs from other specialties, hospitalist OBs, RNs, etc) have inadequate respect for the work the CNMs do, making it less smooth to provide good patient care together.
none
CNMs do not recognize dangerous FHR tracings, they do not encourage their patients to keep an open mind and let them know that a vaginal delivery cannot be promised or that a Cesarean delivery is fine if needed.
Not being physically present to take care of emergencies
Trust and communication - if not established. Acceptance of them by hospital staff.
Work well together
Current job site without CNMs there regularly. Current ones are in a single practice and have their own MD which does not involve the hospitalist (me). I have 'been there' when their referral MD was unavailable, but only answered a question, once. Based on prior sites, and watching as new midwife program starting, I can see the biggest challenge is for the staff in general (doctors, nurses, admin) being unsure how to think of the CNM as autonomous providers. They are not PAs or NPs, and this is confusing to many. Also, not all MD/DOs are comfortable or willing to work with them as referral resources, which makes linear thinkers (administrators) have a hard time coping--just as not all surgeons will accept all referrals, neither will all OB/Gyns take on Urogyn, robotics or midwifery pt referrals. Educating the patients and staff that CNMs are independent licensed practitioners is key.
They sometimes have patients with risk that is unsuitable to the midwife model. Transitioning those patients from the patient perspective as well as knowing when to do so can provide logistic problems.
2 different levels of experience (one is fairly new and not aware of some guidelines, meds, limitations). Communication could be better sometimes
I am relatively new to having direct collaboration with CNM's so have not encountered any problems or barriers.
My partners or not is excepting of the collaborative practice with midwives.
Sometimes it is difficult to allow them full control of labor process, but over the years this has gotten easier. With electronic fetal monitoring that you can access on our phones

makes it easy to watch labor tracings etc. When hiring a new CNM, takes a while to understand their practice patterns, but we have had a stable group of 4 CNMs for a while now and everyone really works together.
unclear delineation of responsibilities
some are independent and not under md supervision - an acceptable station
The CNMs that we work with are not in our group, they are outside providers who accompany patients on transfer to our facility. I have had wonderful experiences with hospital-based CNMs in the past and have a high degree of trust in their skills, but the CNMs I have worked with recently (birth center-based) have not been adhering to the standard of care.

Statistic	Value
Total Responses	23

16. What are the facilitators to working with Certified NURSE Midwives (CNMs) in your work setting; what makes it easier?

Text Response
having them be hospital based and employed by my practice. culture is the same then
N/A
Collaborative relationship and agreement on safety goals
open communication
We have tipped over our silos and established collaboarative teams to facilatate comunication between clinitians.
communication and clinical processes in place
If they are my employees. If they are intelligent. if they don't have a chip on their shoulder. Iftheyare not shift wrkers
We work in the same office and are generally treated as equivalent providers by most support staff (except for obvious differences regarding surgical practice)
mutual respect for each other abilities
Comfort level with the nurse midwife's level of expertise and nursing staff on the unit
Communication, practice guidelines.
Plenty of work. Appreciate her work ethics
Just starting to find out.
Support of the hospital.
We collaborate a lot on care
Willingness to try different ways.
The general high quality of their work.
Need to be honest and have a clear model of expectations of what should be done at visits so it is fairly uniform for patients and providers. 3 of 4 of our CNM were L and D nurses prior and have excellent judgement. Trust in their judgement to call with questions etc makes it easier for everyone.
clear communication of any potential issues, and review of plan of care at onset of patient presentation to hospital
the mw belonging to a md practice

Statistic	Value
Total Responses	20

20. What has made your experiences with Certified PROFESSIONAL Midwives (CPMs) positive?

Text Response
The one in our area "doesn't know what she doesn't know;" therefore putting patients and infants at risk by trying to take care of them beyond her scope of practice. We get the bailout situations where the damages have already been done. It is very difficult to work with the less educated in our profession, especially when you try to help and educate and they continue the same practice.
Did not have a positive experience
i don't know the difference between cnm and professional cnm
These people are dangerous, they bring patients to the hospital that have labored too long and are in dire need of professional medical help.
Our relationship with CPM's is a forced one based on the legislation that has created the licensure of their profession. Their model is home birth which is generally contrary to OB/GYN training and medical models. That being said, we have a situation that will not go away. The positives have been the recent openness of the CPMs to transfer care effectively and the openness and awareness of our hospital administration to the need to care for patients transferred from CPM care. We do not work directly with any of the CPMs in our community. We only inherit their problem patients.
In our community, the CPM's are willing to seek consultation and to bring women to the hospital at appropriate times; this has not always been the case but has been for the last 3-4 years. I have found that in general the women they care for are risk-appropriate.
Some CPMs bring their patients to the hospital when they have complications and some support the physician-patient relationship by preparing the patient for the possibility of additional interventions and helping to calm the patients down.

Statistic	Value
Total Responses	7

21. What would you change about your collaborations with Certified PROFESSIONAL Midwives (CPMs)?

Text Response
I would like to see them have a stronger fund of knowledge and adhere to the principle of taking care of low risk patients.
They need to understand the safety concerns and choose their patients wisely. We do not have an agreement, they just use our hospital and staff to manage their complications
they must have more training
see above
I am switching jobs in 2016 to no longer work with CPMs
I would improve the lines of communication. I would try to open the door to foster their understanding that some patients are not good candidates for their model of care and that transfer during prenatal care rather than emergently in labor may be a better solution. Understanding the limits of your abilities is a hard lifelong lesson both for physicians, midwives and everyone. The problem for many of the CPMs I have observed and many physicians for that matter as they are not immune to this trap is that "They don't know what they don't know."
Our local CPM community uses our hospital for women who need to be transferred in labor, but not for outpatient services (lab, ultrasound, consults). We have extended that invitation. It would smooth the process of intrapartum transfer if some prior records were available.
The patients who are transferred by CPMs often have had inadequate prenatal care - no gestational diabetes testing, no group B strep testing, no ultrasounds. One midwife brought me a patient with vaginal bleeding in labor and when I asked if the patient had a previa she said "She declined to have any ultrasounds, but I didn't feel anything spongy when I checked her cervix, so I don't think so." This is absolutely not appropriate care, especially for a patient who is 45 minutes from our hospital at the time of the check. Some midwives interrupt my counseling and surgical consent process, giving the patient incorrect and contradictory information. They start pushing with patients without notifying the nurse, they argue with our attendings in front of patients about our standard of care, and one even intentionally delivered an infant without any other staff in the room.I try to be friendly and respectful to encourage them to bring their patients here when there is a problem, but I am deeply concerned about the care these patients are receiving from CPMs.

Statistic	Value
Total Responses	8

24. What are the challenges to working with Certified PROFESSIONAL Midwives (CPMs) in your work setting; what makes it harder?

Text Response
The CPMs are delivering planned out of hospital births and only present to us at the hospital when problems arise. The patients do not trust or know us and it stinks to deal with that. Bad situation and no relationship. One of my colleagues was sued for one of these CPM failed home birth cases and it has sent shivers down all if our spines. We ObGyns want healthy baby and moms. Being sued disrupts everything and in the case I am pointing to, despite a positive verdict for the doctor, it made the doc look like a bad guy.
They send patients after they have failed in their attempts to deliver them. Often, the situation is already out of control or the EGA is >42 wk. The fact they have limited information and continue to care for patients ACOG lists as high risk is so very distressing.
Inconsistent practices and lack of insight on choosing the right patients for the setting knowing who they are
These people are much worse than CNMs
We do not have any interaction with them until a disaster involving one of their patients presents.
We don't really work with them. They transfer patients with problems. Communication is the issue. We don't even have a feel for what is out there in undelivered problems.
If I were answering only for my local community, I could score higher, but interacting with patients of CPMs from non-local communities has not always been as positive.
CPMs bring us their patients when things are already going wrong Patients have not had appropriate prenatal care, so we are playing catch-up and don't know what we are getting into

Statistic	Value
Total Responses	9

25. What are the facilitators to working with Certified PROFESSIONAL Midwives (CPMs) in your work setting; what makes it easier?

Text Response
Few - they are willing to discuss cases after the fact; however, I rarely see a change of practice.
Nothing
see above
Hospital administration is working on opening the lines of communication.
willingness to talk through issues surrounding a specific patient.
The CPMs who regularly bring us patients have started bringing prenatal records when they bring patients in. They don't do the same prenatal care that we would, but at least it's something.

Statistic	Value
Total Responses	6

26. What is the scope of practice of a midwife when working with a physician?

Text Response
collaborative care
Low risk healthy mom and baby
low risk patients -at least it should be
CNMs can see uncomplicated ob pts in the office and take care of uncomplicated ob pts in the hospital
seeing and counseling patients, deliveres
Low risk low intervention patients
Team practice just as with any other provider.
Offer care to low-risk patients, enable patients to be seen quicker especially for problem visits, enable physicians to spend more time doing procedures
routine obstetrical care
uncomplicated, low risk term deliveries
which midwife CNM or other
uncomplicated routine vagina delivery
individually defined in good faith with input and acceptance from both parties
It depends on the arrangement between the particular midwife and physician. In my practice, CNMs provide prenatal care and manage labor without input or direction unless needed; some complications (preterm deliveries, preeclampsia, well controlled gestational diabetes, etc) are just run by the physician and others (insulin dependent diabetes, need for diuresis or electrolyte repletion, cardiac problems, etc) are managed by the physician while the CNM can still manage labor if the patient desires. Regarding labor abnormalities, the CNM calls when needed and some CNMs are experienced enough to call a C-section; others consult and the physician makes the call. In the GYN setting, midwives provide well-woman care and refer for potential surgical consultation as needed; they informally consult for any issues that aren't straightforward. Some do colposcopies and endometrial biopsies; all do IUD placements.
I do not work with midwives as there are none at CRMH.
Uncomplicated obstetric care.
everything I do except surgical interventions and some minor office procedures
Deliveries are overseen by physician physician is responsible for operative deliveries and cesarean sections Midwife's responsibility to notify physician for any concerning findings
Routine prenetal care, problem visit evaluation, management of labor and delivery unless operative delivery indicated
To help with the care of obstetric patients in the office and hospital. Attend normal vaginal deliveries and call when assistance is needed or the labor becomes abnormal in any way.
I do not do obstetrics
We have started a midwife program at the primary hospital of delivery. I am excited because I really believe midwives and OBs can enhance each other's practice and work together to optimize a woman's choices, experiences and outcome.
Manage stable, chronic OR healthy patients in clinic and hospital setting, as well as act as surgical assist in Cesarean Sections.
Manage obstetric patients and be present at low risk deliveries. Routine office gyn care.
we use them to assist in prenatal care and on L&D to triage patients
We currently do not have any midwife's in labor and delivery. I would be open to this but

it is not our current structure. We do have NPs in our prenatal clinics.
dont know
The midwife should be highly qualified to perform deliveries, should be confident with decision making, but should be smart enough to ask for assistance when it is needed.
Don't know about the CPM
With a CNM it is currently dictated by a collaborative agreement with their physician base. For A CPM it is dictated by Virginia code and regulated by the Board of Medicine.
collaborative, ideally primarily low risk labor patients and triage
Providing health care and collaborating as needed
Triage, vaginal births, inductions, run more significant issues by me or I manage
Pretreat patients
NA
In our hospital, patients of the midwives are admitted to the attending physician but managed by the midwives. We collaborate and consult.
I assume coverage of labor and delivery, however, our practice does not include midwives.
Current practice - no involvement of CNM
to labor and deliver pt's and to know when intervention is necessary
A midwife should be caring for uncomplicated obstetric patients, with oversight of a physician, and referring all unusual events/complications to the physician for care.
They have full scope of managing normal prenatal care and delivery. They should consult a physician for any patients that fall outside the scope of a low-risk pregnancy or delivery, or for any patient that requires operative management of their labor, delivery, or postpartum course.
prenatal care, management of labor, delivery and the postpartum period under the direct supervision of a physician
NA, as I am not working with midwives at present
I think that is defined from their national organization but should be adapted to the specific CNM midwife physician group.
Both should know his or her limitations based on specialty and training.Asking patients to consume or ingest their placenta does not advance the practice of Midwifery or Obstetrics.
It is what you determine it to be. Some simply use them as a physician extender. We use them as CNM and they have some of their own patients that deliver in a true midwifery model. They also help us deliver our practice patients in regular Labor and Delivery.
While I no longer practice Obstetrics, I still employ a CNM (she just happens to practice as a NP). When our practice was delivering babies, my CNM was invaluable. She brought many years of experience and knowledge with her when she joined our practice. Patients loved her and even requested her for their delivery. She was very capable of handling most situations, but knew when to call if she needed assistance.
Considering her skill and the doctor's wishes to do what she is told
Our practice neither hires nor supervises any midwives at our hospital, I cannot answer this question.
PRACTICE WITHIN THE DICTATES OR HERE SUPERVIZING OB
In office
collegiality, collaboration, cooperation While I do not currently practice, I worked within my practice with CNMs over 5 years.
do what she/he is approved to do by the practice which employs the mw
Care for relatively uncomplicated patients Provide routing prenatal care and attend uncomplicated vaginal deliveries, with immediate physician backup available in case the

need for operative vaginal or cesarean delivery arises.

Statistic	Value
Total Responses	54

29. Which of the following are areas of conflict when collaborating with a Certified NURSE Midwife (CNM)? Select all that apply.

Other (please describe below)
I am in charge and have the final say if the cnm wishes to collaborate with me . Obviously this is not an issue it's a condition of collaboration
HAVE WORKED W

30. Which of the following are areas of conflict when collaborating with a Certified PROFESSIONAL Midwife (CPM)? Select all that apply.

Other (please describe below)
having to deal with the complications that may arise from a home birth
Midwife /Professional midwife define your terms .All CNMs are the same . I don't work with lay midwives
I have concerns regarding training and safety - I know some CPMs are excellent but worry that some are inadequately trained to recognize medical complications, and most of the dangerous/inappropriate home births I've heard about have involved CPMs.
None yet!
most are not as well trained as ob's, have far less exprience and in the absence of close supervision have poorer results. I have personally attended 3 mothers who had intra partum deaths under poorly supervised MW's
inadequate prenatal care provided by CPMs (no ultrasounds, no glucola, no GBS)

34. What would make it more likely that you would comply with recommendations from the Virginia Chapter of ACOG?

Text Response
scientific evidence
If they are logical and safe for the patient and the unborn baby.
when it is clear and confirms with the standard of care in my community
N/A
I am very likely
less concern for liabilty
make sure they are as evidence based and objective as possible
Clear strong studies to support recommendations and protocols
one does not "comply" with recommendations. One "complies" with regulations, rules, laws, orders, commands, etc. I do not recognize VAACOG as having the authority to govern me or any other physician
nothing
Agreement with recommendations among colleagues
The sharing of positive clinical experiences by other practices.
If it were a national standard, not state.
Sufficient data
If the recommendations agreed with ACOG's recommendations in general and the current literature.
Depends on the tecommendations
Coincide with standards of care
nothing
If their recommendations agree with my practice
tort reform
If it's evidence based.
If they apply to my practice.
n/a
As long as reasonable and evidence based
The recomendations
NA
If they are consistent with my practice goals, and are evidence proven.
evidence-based recommendations
if they use evidence based medicine to make there recommendations
If I strongly agree with the recommendation, I will very likely comply with the recommendation. If I strongly disagree with the recommendation, I would then have to consider my personal, professional, and ethical obligations to excellent patient care as they may conflict with the recommendation, and then decide to comply if compliance does not compromise my care for patients and the quality of my patients' outcomes.
Difficult to comment on because I am not sure what recommendations you are referring to. I am likely comply with recommendations that improve safety and quality of care for my patients.
The appropriateness of the recommendation.
As long as they understand that their control of Obstetrics is threatened by those with less training.For example Obstetricians are not qualified to do Brain surgery etc. My unpublished scientific study is that three mothers with uncomplicated prenatal and labor course are still alive because they were delivered in a hospital equipped and staffed for

such emergencies.
Better and scientificalcy based on hard data: do no VBAC's - the HTE rate is at least 800% higher e.g 8/10000 w VBAC's vs 0/10000 with repeat c/s, support draining wounds in the obese, promote the return of forceps skills, and for God's sake read all the literature before jumping on the politically correct and forsaking what has been true since the 1920's: once a c/s always a c/s and limit stage 2 to two hours. The literature shows both are still true today in spite of all the haranges with which we are bombarded. Until the section or the College are populated w fewer know-it-alls they will be of no use to me and dangerous for my patients. I speak with a record of 8000 deleveries with no HIE, no. Erb's palsies or any serious complications.
SCIENTIFICALLY BASED ADVICE WHICH WOULD AT A MINIMUM DISCOURAGE VBAC'S (THE HIE RATE FOR VBAC'S PER DR LANDON'S STUDY SHOWED A HIE RATE OF 8/10000 VS 0/1000 FOR ELECTIVE REPEAT C/S. ANY OB WILLINGLY PARTICIPATING IN A VBAC IS ENCOURAGING A HIGHLY UNSAFE PRACTICE WHICH VIOLATES NON NOCERE. OR STOP HARPING ON THE C/S RATE AS THERE IS NO SCIENTIFICALLY ACCEPTED CORRECT NUMBER. MY OWN FEELING IS THA THE C/S RFATE SHOULD BE HIGH ENOUGH TO PRECLUDE EVER DELIVERING AN HIE BABY OR AN ERB'S PALSY - MY RATE HAS MET THIS CRITERIUM WHICH AFTER 8000+ DELIVERIES MKES ME ONE HELLOA LOT SMARTER THN THE CURRENT CROP OF RECOMMENDERS. DOES ANYONE REALLY BE LIEVE NO C/S SHOULD BE CONSIDERED UNLESS THE EFW IS 5000 GRAMS. ONLY 6 TO 7 BABIES/10000 ARE THIS LARGE AND THE RECOMMENDATION A CATEGORY 3: NO SUPPORTING EVIDENCE - JUST OPINION. IF THE VA CHAPTER IS TO BE OF USE TO ME IT NEEDS TO BASE ITS RECOMMENDATION ON HARD FACTS NOT ON POLITICALLY CORRECT, UNSOUND OPINIONS OF ARROGANT ACADEMICS THE GREATG MAJORITY OF WHICH DO FAR FEWER DELIVERIES THAN THE OVERWHELMING NUMBER OF PRACTICING OB'S: 150 TO 180 PER YEAR.
their being knowledgeble of best medicine which is often not what academics and hence the college recommend so much of the politically correct medicine is wrong and if the Va chapter just aped the ACOG it would not lead to the best medicine e.g. supporting the 80 hour resident work week which removes 4000 hours from training

Statistic	Value
Total Responses	36

35. What would make is less likely that you would comply with recommendations from the Virginia Chapter of ACOG?

Text Response
lack of evidence based recommendations
If they were liberal for the sake of being popular, and not focused on good practice and safe procedure.
when it doesnt reflect my community standards
N/A
If they are not evidence based
if I felt recommendations increased health risks or my liabilty
unclear and unproven recommendations/guidelines
that you as an organization consider physicians so lowly such that they would "comply" with VAACOG
nothing
If I did not believe recommendations were evidence based
The personality or clinical performance of a particular clinician.
Absence of data and liability
Disagreement with current literature
See above
Morally conflicted with personal belief Not following with standard of care
nothing
If their recommendations are against my training and practice
lack of tort reform
If it's not evidence based.
If I felt that the recommendation presented a danger to my patient in my setting.
n/a
No evidence on a rec
If the Chapter recommends Obstetricians to work w CPM or CNM, undermining our autonomy.
The recomendations
NA
If they are inconsistent with the way I practice and my group practices.
any recommendations that I assume liability for the care given by a CPM
if it is a consensus opinion
See above. Values conflicts.
If I feel the recommendation has a negative impact on the care I would provide to my patients.
recommendations different from that of national ACOG offices
The recommendations are in conflict with the needs of my community.
If they stray from the recommendations of the ACOG
If they no longer support the use of CNMs in our practice.
see above: they like the College, the GREEN JOURNAL, and the COMMITTEE OPINIONS e.g. such as do not consider a c/s unless the EFW is 11lbs or greater are not even close to having merit.
APING NON SENSIBLE RECOMMENDATIONS FROM WHAT IS NOW A DYSFUNCTIONAL COLLEGE. CONSIDER THE DISASTER THE 80 HOUR WEEK HAS CAUSED. THREE SUB SPECIALTY DIRECTORS WROTE IN THE GREEN JOURNAL THAT TODAY'S RESIDENTS ARE SIGNIFICANTLY UNDER PREPARED.

YET THE COLLEGE NEVER PUT THIS TO VOTE TO 25000+ REGULAR OB/GYN'S, THE VERY MEMBERS IT IS SUPPOSED TO REPRESENT. NOR DID THE COLLEGE PUT TO VOTE THE NEW MOC PROCESS TO THE VERY MEMBERS IT IS ALSO IS SUPPOSED TO REPRESENT. CLEARLY THE COLLEGE DOES NOR REPRESENT ME NOR THE OTHER REGULAR OB/GYN'S. INSTEAD IT IS THE WHOLY OWNED AGENT OF EMPLOYED ACADEMICS. THE COLLEGE RECOMMENDATIONS WILL NEVER BE USEFUL TO US

the are wrong or inferior to other standards e.g. supporting VBAC's which have an 800% increase in hie ((8/10000 vs 0/1000 for elective repeat C/S.

Statistic	Value
Total Responses	37