Present Status of Obstetrics in Family Practice and the Effects of Malpractice Issues

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A survey of 800 active members of the American Academy of Family Physicians 1985–1987 membership directory was conducted for the purpose of determining the impact, over time, of malpractice issues upon the practice of obstetrics by family physicians. The survey response rate was 60.4 percent.

Almost 20 percent of all respondents reported that they have never provided obstetric care of any type. Another 40 percent have provided obstetric care previously but have now discontinued this care, while the remaining 40 percent currently offer obstetric care to their patients.

The proportion of respondents who discontinued the practice of obstetrics because of increased risk of malpractice litigation increased significantly over the years from 1947 to 1986 (P = .0084). The proportion of respondents who discontinued obstetric practice because of increased malpractice insurance costs also increased significantly from 1945 to 1986 (P = .0002). The proportion of those entering practice during the past five years who decided not to offer obstetric services because of malpractice risks was significantly greater than the proportion entering practice earlier (21.0 percent vs 2.0 percent, P = .0090). Although the current patterns of obstetric practice showed regional variation, the accelerating impact of malpractice risk and insurance cost on these patterns was similar throughout the nation.

The changing role of the practice of obstetrics by family physicians is receiving widespread attention. The specialty itself is concerned with the perception that family physicians are rapidly discontinuing the practice of obstetrics. Scherger[1] has suggested that the family physician who delivers babies is an "endangered species." Klein[2] has stated that "obstetrics is too important to be left to the obstetricians."

A frequently cited reason for the abandonment of obstetrics by family physicians is the so-called malpractice crisis.[3–5] Several other causes for the "deobstetricalization" of family practice have been suggested. Scherger[1] points out that the nation's lower birth rate, combined with an increased number of obstetricians and nurse midwives, has made obstetrics more competitive. Smith and Howard[6] note that a significant number of family practice residents cite inadequate training in obstetrics as the principal factor leading to the decision to exclude obstetrics from their future practices. Other research has mentioned the need to cancel office hours to attend deliveries, time management difficulties in general, a lack of family practice faculty role models performing deliveries, and concerns over infringement upon personal and family time as additional reasons for the growing number of residency-trained family physicians who decide against offering obstetric services.[2,6,7]

Although the decline in the practice of obstetrics in family medicine has received much publicity, a national study evaluating the effects of malpractice issues on the current status of obstetric practice in family medicine has yet to be done. The purpose of the study reported here was to assess the present status of obstetrics among a national sample of active members of the American Academy of Family Physicians with particular emphasis upon the extent to which malpractice issues have affected the practice of obstetrics by this group over time.

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METHODS

Survey Methods

During late 1986 and early 1987, a survey was performed through a series of mailings to 800 active members of the American Academy of Family Physicians (AAFP) randomly selected from the AAFP 1985–1987 membership directory. In 1986, the American Medical Association estimated the number of family physicians and general practitioners in the United States at 68,000.[8] In the same year, the AAFP estimated its active membership to be 47,000.[9] Thus, 69.1 percent of the estimated total of family physicians and general practitioners were active members of the academy during the survey period.

The questionnaire sent to this sample group was three pages in length, contained 17 questions, and generated 29 variables. The survey was conducted along standard lines with three mailings spaced at two- to three-week intervals. All members of the sample were sent a questionnaire at the first mailing, with nonrespondents only receiving questionnaires during the succeeding two mailings.

The focus of this study addressed several items asked on the questionnaire. First, respondents were requested to describe the role of obstetrics in their practices and were given five response options: never provided obstetric care; provided obstetric care in the past but no longer do so; provide prenatal care only; provide full obstetric services excluding cesarean section; or provide full obstetric services including cesarean section. The second question asked those physicians who have never provided obstetric services and those who once offered obstetric services but no longer do so to identify their primary reason for not offering these services. The categories provided for these answers included malpractice risk and premium cost as well as lifestyle concerns and issues related to office practice. In addition, those no longer providing obstetric services were asked to give the number of years since they had last provided these services.

All individuals surveyed were further asked whether they had completed family practice residency training. The level of practice activity was assessed by asking how many years the physician had been in practice, the number of patients seen in a typical week, and the total number of hours spent in the practice of medicine each week. Sex and region of the nation in which respondents and nonrespondents practice medicine were tabulated to determine differences, if any, between respondents and nonrespondents along these lines.

Statistical Methods

The impact of malpractice issues upon the decision of whether to provide obstetric services upon entering practice or to discontinue providing these services once in practice were assessed with logistic regression. For example, for those making these decisions based upon the desire to avoid the risk of malpractice litigation, the logistic analysis proceeded as described below. First, for each year the number of physicians who decided to discontinue providing obstetric services that year was determined. Then, for each year the number who discontinued because of increased risk of a malpractice lawsuit was determined. Finally, the proportion who discontinued because of increased risk of malpractice litigation was calculated for each year by dividing the number who discontinued because of this risk by the total number who discontinued the practice of obstetrics that year. Because of the number of physicians who discontinued obstetric practice in some years was quite small, a smooth curve was fitted to get a clearer picture of the trend over time of the impact of the malpractice risk on discontinuation of obstetric service. Logistic regression was used to find the smoothed curve and to determine whether the curve provided a significant fit to the data. Thus, the percentage who discontinued because of malpractice risk was predicted from the logistic regression model.

The advantage of the logistic regression approach is that it weighs the data points for each year to take into account the number of physicians for whom data were available each year. The logistic regression analysis was also used to assess the affect of malpractice insurance premium costs over time on the decision to discontinue obstetrics, as well as the impact of malpractice issues on decisions not to offer obstetric services upon entrance to practice. For all logistic regression analysis performed, interaction terms were included to determine whether the results differed as a function of family practice residency-trained status (residency trained vs not residency trained) and respondent's region of the country (East, South, Midwest, Plains-Mountains, and West). Differences in the status of obstetrics between family physicians graduating from residency during the past five years and those who graduated from residency more than five years ago were assessed by a chi-square test for significant differences in proportions. Differences between respondents and nonrespondents with regard to sex were assessed with chi-square tests as well.

RESULTS

Of the 800 randomly selected physicians in the sample, a total of 768 actually received the questionnaire. Repeated efforts to locate the remaining 32 physicians failed; thus, the survey coverage rate was 96.0 percent. Of those receiving a questionnaire, a total of 464 returned completed, usable questionnaires producing a response rate

TABLE 1. ROLE OF OBSTETRICS BY REGION

Role of Obstetrics	East No. (%)	South No. (%)	Midwest No. (%)	Plains/Mountains No. (%)	West No. (%)	National Total No. (%)
Never provided	19 (35.8)	40 (32.0)	10 (8.7)	9 (9.4)	12 (16.7)	90 (19.5)
No longer provided	24 (45.3)	52 (41.6)	39 (33.9)	36 (37.5)	35 (48.6)	186 (40.3)
Prenatal care only	3 (5.7)	2 (1.6)	0 (0)	3 (3.1)	4 (5.6)	12 (2.6)
Provide, excluding cesarean section	5 (9.4)	19 (15.2)	60 (52.2)	27 (28.1)	16 (22.2)	127 (27.5)
Provide, including cesarean section	2 (3.8)	12 (9.6)	6 (5.2)	21 (21.9)	5 (6.9)	46 (10.0)
Total	53	125	115	96	72	461
No response						3

of 60.4 percent. Respondents and nonrespondents did not differ significantly with regard to their sex or geographic location except that physicians from the eastern region of the nation were less likely to return their questionnaire than were physicians from other regions.

Approximately 40 percent of all respondents provide some level of obstetric care to their patients (prenatal care only, full-service obstetrics excluding cesarean section, and full-service obstetrics including cesarean section). Another 40 percent no longer provide obstetrics, though at one time they did. The remaining respondents (19.4 percent) have never provided obstetric services (Table 1). Regional variation in obstetric practice was readily apparent. While 50 percent or more of family physicians in the Midwest and Plains-Mountain regions continue to provide obstetric care, the number doing so in the eastern, southern, and western areas is well below this figure (Table 1).

The majority of those surveyed who have discontinued the provision of obstetrics have done so within the past six years. Those respondents who were recently residency trained (within the past five years) appear to be less likely to offer obstetric care initially after residency as compared with those who finished residency more than five years ago. The more recent residency graduates reported that 30.6 percent have never offered obstetric service compared with a 19.5 percent rate for the older group (P = .0497) (Table 2).

Malpractice issues appeared to play a major role in the decision to discontinue the provision of obstetric services. The proportion of respondents who discontinued obstetric practice because of increased risk of malpractice litigation increased significantly over the span of years from 1947 to 1986 (P = .0084). Similarly, the proportion who discontinued obstetric practice because of increased malpractice insurance costs increased significantly from 1947 to 1986 (P = .0002). These relationships between year of discontinuation of service and proportion who discontinued because of malpractice risks or costs were not significantly different for respondents who were residency trained and those who were not (P = .2230 and P = .6484, respectively).

TABLE 2. ROLE OF OBSTETRICS BY NUMBER OF YEARS IN PRACTICE OF RESIDENCY-TRAINED PHYSICIANS

	Years in Practice	
	Five Years or Fewer No. (%)	Six Years or More No. (%)
Never provided	38 (30.6)	32 (19.5)
No longer provide	21 (16.9)	51 (31.1)
Prenatal care only	4 (3.2)	6 (3.7)
Provide, excluding cesarean section	47 (37.9)	57 (34.8)
Provide, including cesarean section	14 (11.3)	18 (11.0)
Total	124 (99.9)	164 (100.1)

χ^2 = 9.5036; P = .0497

Malpractice issues also appeared to play a role in the decision of those respondents who had never offered obstetric services. The proportion of respondents who decided not to offer obstetric services because of the risk of malpractice litigation increased at a borderline significant rate as a function of the year they entered practice (P = .0566). The proportion entering practice in the last five years who decided not to offer obstetric services because of malpractice risks, however, was significantly greater than the proportion entering practice earlier (21 percent vs 2 percent, P = .0090). Finally, the proportion of respondents who decided not to offer obstetric services because of increased malpractice insurance costs was not significantly related to the year of entry into practice (P = .4827). Residency-trained and non-residency-trained respondents were not significantly different with respect

to these two relationships (P = .5294 and P = .6021, respectively).

Although the patterns of obstetric practice varied from region to region, the increasing impact of malpractice issues on these patterns was nationwide. Respondents from each region indicated an increasing influence of malpractice concerns over time on decisions with respect to the provision of obstetric care. No statistically significant difference existed between regions in regard to the accelerating impact of malpractice issues on the abandonment of obstetrics by family physicians.

DISCUSSION

The results reported here lend support to the growing concern over the impact of malpractice issues on the willingness of family physicians to offer obstetric care. While 40 percent of today's family physicians provide obstetric care, another 40 percent did so previously but have now discontinued this service. Of this latter group, approximately one half have discontinued obstetrics within the past five or six years.

Although Klein[2] has maintained that the impact of malpractice issues on the declining role of obstetrics in family medicine is largely a scapegoat, results of this study suggest that malpractice issues are an increasingly powerful influence in this regard. The effect of malpractice concerns is particularly powerful in the decision to discontinue obstetrics by those already in practice. This study indicates that those physicians who have recently discontinued obstetric care have been more likely to do so for reasons related to malpractice issues than have physicians who discontinued this service at an earlier date. In addition, physicians who recently entered practice were less likely to offer obstetric services because of the risk of malpractice lawsuits than were physicians who entered practice in earlier years. Costs of malpractice premiums are no more important a factor today than in earlier years regarding the decision not to offer obstetric services upon entering practice; this finding may be because physicians entering practice are not as personally aware of costs as physicians in an established practice.

The finding that regional differences exist in the percentage of family physicians who offer obstetric care is not surprising. In every region, however, it appears that the negative impact of malpractice concerns on obstetric practice patterns is accelerating. If current trends continue, one might expect that all regions will eventually mirror the pattern seen in the eastern region of the United States.

On the positive side, family practice training programs appear to be succeeding in encouraging most residency graduates to include obstetrics in the scope of their future practices. While the proportion of newly graduated family physicians who offer this service is shrinking somewhat, the majority of these graduates still offer these services upon beginning practice. The fact that 70 percent of residency graduates over the past five years have elected to provide obstetrics initially is in itself reassuring to training programs, given the negative publicity obstetric practice has received. It seems that the training and role modeling provided by family practice residencies are still sufficient. The major problem to be addressed appears to be the discontinuation of this service after practice begins. The future of efforts aimed at continuing the viability of obstetrics within family medicine should focus much more attention on the alleviation of malpractice disincentives rather than simply the encouragement of residents to offer obstetric care to be complete family physicians.

Obviously there are a number of factors related to the status of obstetrics in family practice. Each factor requires its own measures to ensure the continued healthy status of obstetrics among family physicians. It may be that rectifying the malpractice issues will fail to entice physicians currently not offering these services to begin offering (or resume offering) them, but it is essential that family physicians of the future be presented with practice circumstances amenable to their offering obstetric services.

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