

Obstetric Privileges for Family Physicians: A National Study

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In 1988 the American Academy of Family Physicians sampled 4400 active members whose mailing address was in one of the 50 states or the District of Columbia. The sample was stratified by nine census regions; after two mailings a 76.2% response rate was achieved.

Nine in ten active members have hospital admission privileges. A higher proportion of family physicians in the West North Central census region have privileges at various levels of obstetric care than in other census regions. For those family physicians who do not have privileges for any obstetrics, most indicated that they chose not to include obstetric care in their hospital practices. Family physicians most likely to have obstetric privileges include those who practice in nonmetropolitan areas and those who have completed a family practice residency program. Although disparities in the proportion of family physicians with certain hospital privileges exist among regions, the majority in each region indicated that the privileges afforded them were appropriate.

The American Academy of Family Physicians (AAFP) has long held the position that clinical privileges should be based on the individual physician's documented training or experience, demonstrated abilities, and current competence. This general policy applies to privileges in all areas. The Joint Commission on Accreditation of Health Care Organizations and the American Medical Association hold similar positions.

Some authors have suggested that family physicians are the first to be squeezed out of hospitals by physicians in other fields as the competitive nature of the practice of medicine intensifies.¹ There also has been some evidence that family physicians at university hospitals have greater difficulty obtaining privileges than family physicians at community hospitals.² Malpractice insurance costs continue to climb, causing many family physicians to limit or discontinue their hospital practices—a trend that has serious implications for health care in rural areas.³ The current obstetric malpractice phobia has a deleterious effect on

residency programs attempting to recruit first-year family practice residents.⁴

The AAFP has monitored the hospital privileges of its members beginning with studies initiated in 1969 and continues this sequence with the current study.⁵⁻⁸

METHODS

In March 1988 a four-page questionnaire was sent to 4400 active AAFP members whose mailing address was in one of the 50 states or District of Columbia. The sample was stratified by census region. Each census region was sampled at a different rate to obtain sufficient data for each region to make the estimates meaningful.

After two mailings, the second in May 1988, an overall response rate of 76.2% was achieved—a high response rate, consistent with all AAFP surveys to date. This response rate also was consistent among census regions.

The nonrespondent group appeared to differ from respondents in some areas: nonrespondents were less likely to be a family practice residency graduate, less likely to be a diplomate of the American Board of Family Practice, and less likely to be a US medical school graduate.

To compensate for nonresponse in each census region, all estimates were adjusted not only by the appropriate stra-

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TABLE 1. PERCENTAGE OF ACTIVE AAFP MEMBERS WHO PERFORM OR DO NOT PERFORM ROUTINE OBSTETRIC CARE IN THEIR HOSPITAL PRACTICE BY REASONS AND CENSUS REGION, JULY 1988

| Census Region | Total Number | Performed in Hospital Practice* | Performed Only With Consultation | Reasons Not Performed | | | | | | |
|--------------------|--------------|---------------------------------|----------------------------------|-----------------------|-------------------|-----------------------|------------------------|----------------------|-----------------|-----------------------|
| | | | | Not Desired | Privileges Denied | Liability Prohibitive | No Hospital Department | No Hospital Practice | No Reason Given | Question Not Answered |
| Total | 3352 | 28.7 | 0.3 | 38.6 | 0.5 | 18.1 | 2.6 | 8.3 | 1.8 | 1.3 |
| West North Central | 399 | 59.6 | 0.0 | 20.6 | 0.0 | 14.3 | 1.3 | 2.5 | 1.3 | 0.5 |
| East North Central | 384 | 38.8 | 0.3 | 35.2 | 0.0 | 14.3 | 1.6 | 7.6 | 1.3 | 1.0 |
| Mountain | 394 | 37.3 | 0.3 | 27.9 | 0.3 | 22.8 | 1.0 | 7.9 | 2.0 | 0.5 |
| Pacific | 367 | 30.2 | 0.3 | 35.4 | 0.0 | 21.3 | 0.8 | 10.1 | 1.1 | 0.8 |
| West South Central | 383 | 28.5 | 0.5 | 37.9 | 0.3 | 19.1 | 3.7 | 5.7 | 3.1 | 1.3 |
| New England | 309 | 23.0 | 0.6 | 45.3 | 0.3 | 12.9 | 3.6 | 10.0 | 1.6 | 2.6 |
| South Atlantic | 372 | 12.6 | 0.3 | 45.4 | 1.9 | 19.6 | 4.0 | 12.1 | 1.9 | 2.2 |
| Middle Atlantic | 390 | 11.8 | 0.3 | 52.6 | 0.8 | 16.7 | 4.6 | 9.0 | 2.8 | 1.5 |
| East South Central | 354 | 11.3 | 0.0 | 51.7 | 0.6 | 21.8 | 3.7 | 8.2 | 1.4 | 1.4 |

*Any two statistics within one box are not statistically significant at $P = .025$ using a standardized normal Z test for comparing proportions, a one-tailed test; a proportion contained in any one box is statistically greater at $P = .025$ than a proportion contained in any other box below it

TABLE 2. PERCENTAGE OF ACTIVE AAFP MEMBERS WHO PERFORM OR DO NOT PERFORM COMPLICATED OBSTETRIC DELIVERY IN THEIR HOSPITAL PRACTICE, BY REASONS AND CENSUS REGION, JULY 1988

| Census Region | Total Number | Performed in Hospital Practice* | Performed Only With Consultation | Reasons Not Performed | | | | | | |
|--------------------|--------------|---------------------------------|----------------------------------|-----------------------|-------------------|-----------------------|------------------------|----------------------|-----------------|-----------------------|
| | | | | Not Desired | Privileges Denied | Liability Prohibitive | No Hospital Department | No Hospital Practice | No Reason Given | Question Not Answered |
| Total | 3352 | 11.2 | 12.8 | 45.6 | 1.3 | 14.3 | 2.8 | 8.3 | 2.1 | 1.7 |
| West North Central | 399 | 29.6 | 20.8 | 30.6 | 0.3 | 12.5 | 1.5 | 2.5 | 1.5 | 0.8 |
| Mountain | 394 | 16.0 | 15.5 | 34.8 | 1.5 | 19.5 | 2.0 | 7.9 | 2.0 | 0.8 |
| West South Central | 383 | 13.8 | 9.1 | 44.4 | 2.1 | 15.9 | 3.7 | 5.7 | 3.7 | 1.6 |
| East North Central | 384 | 13.5 | 19.3 | 41.9 | 1.3 | 11.5 | 2.1 | 7.6 | 1.6 | 1.3 |
| Pacific | 367 | 9.3 | 16.3 | 43.6 | 0.5 | 16.1 | 0.8 | 10.1 | 1.6 | 1.6 |
| New England | 309 | 5.2 | 12.3 | 52.1 | 1.3 | 10.7 | 3.9 | 10.0 | 2.3 | 2.3 |
| South Atlantic | 372 | 5.1 | 5.1 | 51.9 | 2.4 | 14.2 | 4.0 | 12.1 | 1.9 | 3.2 |
| East South Central | 354 | 4.5 | 3.7 | 57.3 | 0.6 | 18.1 | 4.0 | 8.2 | 1.7 | 2.0 |
| Middle Atlantic | 390 | 1.8 | 8.5 | 57.4 | 1.5 | 12.6 | 4.4 | 9.0 | 3.3 | 1.5 |

*Any two statistics within one box are not statistically significant at $P = .025$ using a standardized normal Z test for comparing proportions, a one-tailed test; a proportion contained in any one box is statistically greater at $P = .025$ than a proportion contained in any other box below it

tum sampling fraction but also by the response percentage for each stratum. Thus, the estimate for each stratum was weighted by a fraction in which the numerator was the population of the stratum and the denominator was the number of respondents from that stratum.

Tests of significance were performed when appropriate on pairs of percentages using a standardized normal Z test for comparing proportions with one-tail at $P = .025$.

RESULTS

Admission Privileges

In this 1988 study it is estimated that 31,771 AAFP active members of a total population of 34,886 have hospital admission privileges, that is, 91.1%. These results are similar to the results of a 1969 study of members' hospital practices in which 89% of the members reported that they had active staff status in one or more hospitals, 10% held associate staff membership, and 1% did not have hospital staff appointments.⁶ In December 1980 the AAFP surveyed only those active members who had indicated that they were involved in office-based, direct patient care—a subsample of all active members. The results of the 1980 survey indicated that approximately 95.6% of those active members in office-based, direct patient care were estimated to have hospital admission privileges, and 4.4% were estimated not to have hospital admission privileges.⁷

Members' current satisfaction with hospital admission privileges appears to be identical in the last three national surveys performed by the AAFP. Approximately 94.5% of all active members who had hospital admission privileges indicated that the privileges they were granted were generally appropriate. Approximately 4.1% indicated that their hospital privileges were unduly restricted, and 1.4% did not answer this question. These results are similar to those of a 1980 AAFP study in which 95.4% of those physicians with hospital admission privileges indicated that their privileges were generally appropriate and a 1969 AAFP study of the active members in which 96% of the members were satisfied with their privileges.^{6,7}

Obstetric Care

Approximately 28.7% of AAFP active members are estimated to include routine obstetric care in their hospital practices (Table 1). This figure varied widely by census region, as nearly 3 in 5 active members in the West North Central region performed routine obstetric care compared with 3 in 10 in the Pacific and West South Central regions. Approximately 1 in 10 in the South Atlantic, Middle At-

lantic, and East South Central regions included routine obstetric care.

Family physicians who did not include routine obstetric care gave several major reasons for not including it. Nationally, 38.6% of family physicians did not desire to provide routine obstetric care, while 18.1% found the costs of liability insurance to be prohibitive, and 8.3% did not have a hospital practice.

In the 1980 study performed by the AAFP, only 5% of active members in office-based, direct patient care indicated that they did not perform routine obstetric care because of the prohibitive cost of professional liability insurance. At the time of that study only one census region reported more than 1 in 10 active members in direct patient care who had given up routine obstetric care because of professional liability problems, whereas in all other census regions in 1980, less than 5% reported professional liability as a problem. In 1988, however, nearly 1 in 5 active members in the Mountain, Pacific, West South Central, South Atlantic, and East South Central census regions reported that they had given up routine obstetric care because their professional liability costs were prohibitive.

Approximately 1 in 10 active members included complicated obstetric delivery in their hospital practices (Table 2) compared with 20.6% in the December 1980 AAFP study. In this most recent study a family physician in the West North Central census region is almost twice as likely to perform complicated obstetric delivery as a family physician in any other census region. In general, for those census regions east of the Mississippi, fewer than 1 in 20 family physicians are performing complicated obstetric deliveries. Although the plurality—if not the majority in some census regions—do not desire complicated obstetric delivery privileges in their hospital practices, the expense of liability insurance has caused approximately 15% of family physicians in each census region to discontinue complicated obstetric delivery.

Approximately 1 in 20 active members include high-risk obstetric care in their hospital practices. In 1980 approximately 15.1% of active members in office-based, direct patient care included high-risk obstetric care. Again, there is considerable variation by region, ranging from 16% in the West North Central to 0.5% in the Middle Atlantic region performing high-risk obstetrics.

Approximately 1 in 20 active AAFP members perform cesarean sections in their hospital practices. This figure ranges from 14% in the West South Central region to 0.3% in the Middle Atlantic region. In the 1980 AAFP study approximately 13.2% of family physicians in office-based, direct patient care, included cesarean sections in their hospital practices.

The majority of family physicians in each census region report that they do not perform cesarean sections because they do not desire to. Approximately 1 in 10 active mem-

TABLE 3. PERCENTAGE OF ACTIVE AAFP MEMBERS WHO CARE FOR OBSTETRIC PATIENTS AT VARIOUS LEVELS, BY FAMILY PRACTICE RESIDENCY TRAINING AND CENSUS REGION, JULY 1988

| Census Region | Routine Care | Complicated Delivery | High Risk | Cesarean Sections |
|-----------------------|--------------|----------------------|-----------|-------------------|
| Total | | | | |
| Residency trained | 39.9 | 14.3 | 9.3 | 5.3 |
| Not residency trained | 16.4* | 7.8* | 3.9* | 5.5 |
| New England | | | | |
| Residency trained | 31.0 | 6.4 | 3.2 | 2.1 |
| Not residency trained | 10.7* | 3.3 | 2.5 | 0.8 |
| Middle Atlantic | | | | |
| Residency trained | 15.6 | 1.4 | 0.5 | 0.0 |
| Not residency trained | 7.3* | 2.3 | 0.6 | 0.6 |
| East North Central | | | | |
| Residency trained | 54.8 | 18.3 | 13.5 | 2.9 |
| Not residency trained | 19.4* | 8.0* | 4.0* | 2.9 |
| West North Central | | | | |
| Residency trained | 70.8 | 34.0 | 20.1 | 11.5 |
| Not residency trained | 47.3* | 25.0 | 11.7* | 15.4 |
| South Atlantic | | | | |
| Residency trained | 17.8 | 6.1 | 3.3 | 0.0 |
| Not residency trained | 5.3* | 3.3 | 0.7 | 1.3 |
| East South Central | | | | |
| Residency trained | 18.4 | 6.1 | 4.9 | 3.7 |
| Not residency trained | 5.2* | 3.1 | 2.1 | 2.6 |
| West South Central | | | | |
| Residency trained | 43.5 | 20.5 | 16.1 | 18.6 |
| Not residency trained | 17.2* | 9.0* | 5.4* | 10.9* |
| Mountain | | | | |
| Residency trained | 48.9 | 20.4 | 14.5 | 9.0 |
| Not residency trained | 22.7* | 10.5* | 6.4* | 11.6 |
| Pacific | | | | |
| Residency trained | 50.6 | 14.2 | 8.0 | 6.8 |
| Not residency trained | 11.7* | 4.8* | 2.7* | 4.3 |

*Statistically significant at $P = .025$ using a standardized normal Z test for comparing proportions, a one-tailed test

bers have given up cesarean sections because the liability premiums are prohibitive: in the Mountain census region, approximately 1 in 5 have given up cesarean sections because liability insurance premiums are prohibitive; in census regions on the East Coast this figure drops to less than 1 in 10—perhaps liability was an issue for cesarean sections several years ago on the East Coast, and many physicians who have not performed cesarean sections for several years no longer perceive liability as their problem.

Residency-Trained Family Physicians

In general, family physicians who had completed family practice residency programs were more likely to have obstetric privileges than were family physicians who had not completed a residency program (Table 3). The following are statistically different: routine obstetric care, complicated obstetric delivery, and high-risk obstetrics.

Some notable differences occur in various census re-

TABLE 4. PERCENTAGE OF ACTIVE AAFP MEMBERS WHO CARE FOR OBSTETRIC PATIENTS AT VARIOUS LEVELS, BY RURAL/ URBAN AREA AND CENSUS REGION, JULY 1988

| Census Region | Routine Care | Complicated Delivery | High Risk | Cesarean Sections |
|--------------------|--------------|----------------------|-----------|-------------------|
| Total | | | | |
| Urban | 22.9 | 5.9 | 3.2 | 2.3 |
| Rural | 43.1* | 23.2* | 15.3* | 12.6* |
| New England | | | | |
| Urban | 17.1 | 4.3 | 2.9 | 2.1 |
| Rural | 41.9* | 10.5 | 5.8 | 2.3 |
| Middle Atlantic | | | | |
| Urban | 11.9 | 1.3 | 0.0 | 0.0 |
| Rural | 18.2 | 3.6 | 0.0 | 0.0 |
| East North Central | | | | |
| Urban | 31.2 | 7.3 | 4.6 | 0.5 |
| Rural | 60.9* | 33.3* | 24.1* | 9.2* |
| West North Central | | | | |
| Urban | 48.6 | 14.4 | 7.5 | 4.8 |
| Rural | 69.8* | 42.9* | 23.6* | 19.8* |
| South Atlantic | | | | |
| Urban | 10.4 | 4.9 | 2.4 | 1.2 |
| Rural | 15.0 | 5.0 | 2.0 | 0.0 |
| East South Central | | | | |
| Urban | 8.5 | 1.4 | 0.7 | 0.7 |
| Rural | 16.4* | 9.4* | 7.0* | 6.3* |
| West South Central | | | | |
| Urban | 21.4 | 7.3 | 3.6 | 6.3 |
| Rural | 39.7* | 26.4* | 23.1* | 30.6* |
| Mountain | | | | |
| Urban | 21.0 | 5.9 | 1.6 | 1.6 |
| Rural | 58.4* | 28.5* | 24.1* | 18.2* |
| Pacific | | | | |
| Urban | 27.4 | 5.7 | 3.9 | 3.9 |
| Rural | 44.9* | 22.4* | 12.2* | 16.3* |

*Statistically significant at P = .025 using a standardized normal Z test for comparing proportions, a one-tailed test

gions. For example, approximately 70.8% of all residency-trained family physicians in the West North Central region include routine obstetric care in their hospital practices compared with only 47.3% of family physicians in the same region who were not residency trained. Similarly, approximately one in two residency-trained family physicians in the Pacific region (50.6%) include routine obstetric care in their hospital practices compared with only 11.7% of family physicians in this region who are not residency trained.

Rural vs Urban

Physicians in a rural setting were more likely to have a particular hospital privilege than were physicians in an urban setting (Table 4). For example, physicians in a rural area were twice as likely to have routine obstetric privileges compared with family physicians in an urban area (43.1% compared with 22.9%). Similarly, approximately 1 in 4 family physicians in a rural area (23.2%) included

complicated obstetric delivery compared with 1 in 20 family physicians (5.9%) in an urban setting.

Discussion

The methods used in this 1988 study are not comparable to those used in the last study performed by the AAFP in 1980. In the 1980 study the population surveyed included only those active members previously identified in office-based, direct patient care. All active members of the AAFP were included in this 1988 study regardless of practice arrangement or base; therefore, although comparisons between similar statistics in the two studies may be used to indicate trends, they should not be considered entirely accurate.

Professional liability problems continue to plague all physicians regardless of specialty. It is unknown from this study how many Academy members indicated "not desired" when in reality they chose to give up a particular hospital privilege several years ago because their liability insurance was prohibitive.

No attempt in this study has been made to explain the variety of hospital privileges afforded family physicians based upon census region. Many factors contribute to the significant differences: community size, hospital size, training, and personal clinical interest of the physician as well as ratios to population of the various specialists.

The variations among census regions in percentages of

family physicians with specific hospital privileges should be viewed in perspective. The vast majority in each census region registered no complaints, reporting that the hospital privileges they were granted were appropriate.

Response rates in this study were sufficiently high to reflect accurately the hospital practice of the target population, active members of the American Academy of Family Physicians. Because the study was thus limited, however, there may be some question as to representation of all family physicians.

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