Editorials

Family Practice Residents And Future Obstetrics Practice

Few issues in family medicine have generated as much discussion in the past decade as has the area of obstetrics. Despite the focus on obstetrics in family medicine and a national crisis related to access to maternity care, the percentage of family physicians delivering babies has dropped to below 25 percent.[1] In 1991 the Society of Teachers of Family Medicine president Alan David suggested it was "time for a decision" regarding obstetrics in the specialty of family medicine. He noted that "residency programs continued to educate and train family practice residents in obstetrics, while fewer residency graduates plan to practice obstetrics."[2] He stated that the discipline is being threatened and somewhat tarnished by our ambivalence and indecision regarding obstetrics. The paper by Greenberg and Hochheiser in this issue of *JABFP* suggests the decision to include obstetrics in family medicine might be in the process of being made.[3] The 72 percent of family practice residents in the Greenberg and Hochheiser study who indicated an intent to practice obstetrics is higher than figures in previous studies regarding residents' intentions on obstetrics practice and considerably higher than the 32 percent of residency-trained family physicians in practice who currently deliver babies.[1,4,5]

What is the explanation for this apparent remarkable revival in the commitment to obstetrics by these family physicians-in-training compared with their colleagues who are now in practice? Assuming that the survey instrument accurately measured true intentions, at least two potential explanations can account for these findings. The first and most optimistic explanation is that attitudes regarding obstetrics practice have in fact changed, and this high percentage of residents who intend to practice obstetrics will translate into *actual practice decisions.* The authors suggest that this change might be a result of the "renewed commitment of residency programs" to training and encouraging residents to include obstetrics in practice. If true, the percentage of family physicians practicing obstetrics should begin to increase. Although an increase would be gratifying to many in medical education who have worked to restore obstetrics to family medicine, unfortunately, this explanation is not the only one possible for these findings. In 1988 Ferentz, et al.[5] published the results of a national survey of 319 3rd-year family practice residents, which indicated that nearly 60 percent intended to seek privileges in obstetrics. In 1988, however, 40 percent of residency-trained family physicians were practicing obstetrics in the United States.[6] This rate dropped to 32 percent by May 1992, indicating either that there was very high attrition among practicing family physicians or that many of those residents who indicated they *intended* to practice obstetrics did not follow through on those intentions.[1] It is likely this drop was due to a mixture of both.

A second, and therefore more likely, explanation is that the responses in this survey were heavily influenced by the idealism of residents, and their responses actually indicated a desire to deliver babies in practice if given a reasonable opportunity in the community where they choose to locate. These intentions in many cases will not translate into actual practice decisions, however, because of the multitude of perceived or real barriers that residents will encounter as they prepare to enter practice.

Even if many of these residents find the barriers to practicing obstetrics too great to overcome at this time, the value of this study is not decreased. These results clearly indicate that the increased attention to obstetrics in family medicine is paying off, because an extremely high percentage of residents in their 2nd and 3rd years not only are interested in obstetrics but state an intention to practice obstetrics upon leaving their residency training. Promoting this level of interest is an essential first step in restoring obstetrics practice to family medicine.

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The findings from this study suggest, however, a major time commitment in the curriculum is necessary to promote this level of interest in obstetrics among residents. Those intending to practice obstetrics had an average of more than 5 months of required obstetric rotations. Furthermore, a major reason for wanting to include obstetrics stated by 96 percent of respondents intending to practice obstetrics was their belief that "obstetrics is an important component of family health," which suggests that a considerable amount of the time devoted to obstetrics in residency training must be part of the resident's own continuity practice. Finally, the authors also pointed out that encouragement to practice obstetrics by the residency program is an important component in the training process, which confirms previous work by Smith and Howard.[5]

Besides describing the current level of interest in obstetrics by family practice residents and how residency programs can promote this interest, this study makes an even more important contribution by describing "the point at which the process breaks down," the point when residents actually decide not to follow through on their interest. This breakdown occurs when residents encounter barriers as they attempt to apply their intentions to actual practice at the community level. Some barriers are perceived to be more important than they really are. A classic example is the issue of malpractice liability, which has commonly been cited as a major barrier for family physicians practicing obstetrics even though the malpractice environment has improved greatly. Greenberg and Hochheiser[3] report that malpractice liability issues are still perceived by many residents as a major barrier to providing obstetric care. Larimore,[7] however, recently found that family practice residents overestimate the 1st-year insurance cost for obstetrics by 350 percent, a misconception that can start as early as medical school.[8] Furthermore, family physicians who provide obstetric care and who are sued are more likely to be sued for a nonobstetric case than one involving an obstetric patient.[9]

Misperceptions related to liability issues are partially the result of a rapidly changing malpractice climate. For instance, in California, where the number of family physicians delivering babies has decreased dramatically, malpractice insurance premiums for family physicians including obstetrics have decreased by 70 percent relative to reimbursement since 1986.[10] Even so, malpractice issues remain commonly cited for family physicians not delivering babies in that state. A study reported in *JABFP* last year investigated family physicians who stated they would return to obstetrics if malpractice insurance rates decreased.[10] The authors found that none of these physicians, in fact, was willing resume an obstetrics practice once those rates declined. The reasons given by these physicians for not wishing to deliver babies had changed, and some of these reasons raise even more concern than those related to malpractice. Specifically disturbing were those concerns related to lack of support for doing obstetrics from their hospital staff and their families, as well as lack of support from other family physicians in their communities, even from family physicians in their own practice groups.

Some residents currently entering practice are likely to face these same barriers to practicing obstetrics raised by community convention or practice arrangements in the organization with which they choose to associate. With the majority of family physicians not delivering babies currently, a decrease in the percentage of solo or small-group family practices, and an increase in larger family practice and multispecialty groups, it will be much more difficult for a family physician to dictate the scope of a new practice. Nevertheless, the current overwhelming demand for family physicians makes this situation open to change. Clearly, with private health organizations spending hundreds of thousands of dollars in recruitment costs and still reporting a shortage of primary care physicians, top executives and medical directors should be willing to fight the necessary internal battles to allow family physicians to deliver babies in their facilities if doing so would mean more success in recruitment efforts.

In any event, advocates of obstetrics in family medicine must take advantage of the increased interest in obstetrics reported by Greenberg and Hochheiser by assuring that family practice residents not only have the necessary training, skills, and encouragement to do obstetrics but also accurate information on malpractice liability issues and appropriate counseling regarding contract negotiation and practice options. Residents should be advised about lifestyle and other is-

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sues, including the importance of an adequate call-group size, the optimal number of obstetric patients to care for at a given time, and how to secure appropriate specialty backup. At a higher level, it must be made clear to health care organizations who are courting the favor of family medicine and family practice residents that obstetrics is a part of the specialty and that past practices and other specialists' beliefs will not dictate the scope of family practice. Finally, as a practice alternative to these organizations, desire to do obstetrics could be used as an incentive to direct residents to practice in rural areas, where the need for obstetric providers is great and the barriers are minimal.

As the health care system goes through the dramatic changes that are likely to occur during the next couple of years, it is critical that family medicine clearly define itself not only in its philosophy toward health care but also in the scope of practice that it includes. The argument is still being made by some in academic family medicine that obstetrics be dropped as a requirement of residency education. If the scope of family practice does not include the basic elements of health care for families (in fact, normal pregnancy is one of the most common reasons that persons seek medical care in the outpatient setting in the United States), it severely weakens the argument that family physicians should serve as the cornerstone of health care in this country. If family medicine educators, practicing family physicians, and those in organized family practice are ambivalent about the role of obstetrics in family medicine and, therefore, fail to be committed fully to converting residents' intentions to practice obstetrics into practice realities, we risk tarnishing the image of the specialty in what very well could be its golden age.

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Practice Guidelines For The Management Of Vague Patient Complaints?

Somatic symptoms that do not have a discrete organic cause account for almost one in every seven primary care outpatient encounters in the United States.[1] As clinicians, however, we often feel uncomfortable when caring for the patient with such undifferentiated symptoms as fatigue or headache. Given the traditional focus of medical education on specific disease states, most of us struggle with patients who have so-called "vague complaints" and would readily admit to greater skill in caring for patients whose disorders are better defined.

Next to fatigue, dizziness is the most common nonpain symptom reported in the ambulatory setting.[1] Dizziness is also one of the most com-

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