training and experience in this procedure. In the meantime, as our discipline continues to redefine its limits, the boundaries should always be drawn based upon demonstrated benefits to our patients.

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Obstetric Privileges In Family Practice

Recently it has been stated that the proportion of the family medicine literature devoted to obstetrics is inversely related to the percentage of family physicians who provide obstetric care.[1] Although this statement might not be completely true, family medicine literature has a disproportionate focus on obstetrics compared with other areas. What is it about obstetrics that causes so many of us to devote so much time to this area of study? In particular, why do we wait with such anticipation for national survey data regarding the percentage of family physicians still delivering babies? After all, other areas of care, such as surgical assisting or reading privileges for electrocardiograms, do not generate the intense interest that participation rates in obstetrics do. The answers to these questions are complex and must be addressed on several levels.

From a public health standpoint, these statistics are important when considering access to care for the rural and underserved populations for which family physicians serve as the primary providers. Our interest in obstetric participation, however, goes well beyond public health issues. I believe it reflects a feeling that this area of practice approaches the core of family medicine. The frequently quoted phrase "care from womb to tomb" denotes the importance of obstetrics in the continuity of care for families. Maternity care is a direct example of one of the precepts of family medicine, specifically, that care given to one family member must take into account other family members in the delivery of that care. Obviously, this tenet is encountered most dramatically and directly in prenatal care, where the physician must consider both the health of the mother and unborn baby, as well as the importance of the father and, possibly, siblings in the process.

Another reason childbirth can be so important to family physicians is that the event itself creates families. Maternity care is often the first major health care contact young couples have with their physicians. The birth of their child is among the most dramatic events a couple will experience, not only because of the witnessing of a new life coming into the world, but also because bonds develop and strengthen between family members during this event. Participating in this process is a privilege, particularly for the physician who will care for that family in the future. In most cases, these young persons are healthy and happy, and the birth event enhances their happiness. Should an adverse event occur, the opportunity to alleviate suffering can form an intensified bond between the physician and the family. Each year as we read of the declining numbers of family physicians who participate in obstetrics, many of us mourn to some degree those who no longer have the opportunity for this rewarding experience. We might also feel a degree of anxiety that delivering babies might soon disappear as part of the family medicine specialty.

Kahn and Schmittling report a slight decline in the percentage of family physicians with obstetric privileges between 1988 and 1993.[2] At first glance,

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this decline might appear to be a continuation of the downward progression that has been occurring during the past decade. When we consider that in 1992 only 24.2 percent of family physicians had obstetric privileges compared with 26.1 percent in 1993, however, we have reason for cautious optimism that in fact this trend has bottomed out at the beginning of the decade.[3] This possible reversal also can be seen in results that describe rural providers only. In 1988, 43.1 percent of rural family physicians had privileges for routine obstetric care compared with 36.7 percent in May 1992. The results of the survey administered in May 1993 show that 38.6 percent of rural family physicians had privileges for routine obstetric care. Although this difference is most likely not statistically significant, it further suggests the downward trend might have leveled off in areas of the country where the need for family physicians providing obstetric care is most critical.

To understand fully the data presented in Kahn and Schmittling's study, it is necessary first to understand the forces that affect the survey results. An issue that might not be so obvious are the factors influencing the denominator used in calculating these percentages. The denominator used included family physicians who are active members of the American Academy of Family Physicians. This group is constantly changing; moreover, the physicians leaving this group are very different from the physicians entering it. Those leaving tend to be older, non-residency-trained family physicians; those joining tend to be young residency-trained family physicians, a group more likely to provide obstetric care. When the newly trained family physicians who enter this pool obtain obstetric privileges, they have even a greater effect on the percentages than they would if the older physicians were not leaving the pool at the same time.

It is important to keep in mind the relative size of the denominator compared with the numbers of physicians who can affect the numerator each year. For example, a recent study in the *JABFP* indicated that a remarkable 72 percent of 2nd-year and 3rd-year residents intend to provide obstetric care upon graduation.[4] Even if these intentions translate into actual practice, the change that can be effected each year in the overall percentage of family physicians providing obstetric care is minimal. Following this example, approximately 2500 graduates each year would mean an addition of approximately 1800 new family physicians providing obstetric care; however, an additional 700 family physicians who do not do obstetrics would also enter the denominator pool. During the same year approximately 1000 to 1200 family physicians will retire and drop out of the denominator pool. Again, for the sake of argument, assume that none of those retiring family physicians currently has obstetric privileges. Even in this extreme example, the overall increase of family physicians providing obstetric care would be only 3 percent annually. This example also assumes that all those physicians who are currently providing obstetric care will remain in full-time family practice. Using this best-case scenario, having one-third of family physicians practicing obstetrics by the turn of the century would represent a remarkable accomplishment.

At least two major factors will affect whether this degree of improvement will be possible. The first has to do with the attrition of family physicians currently providing obstetric care. The second factor is the degree to which residents' reported high rates of interest in obstetrics will translate into actual practice.[4] I believe the issues influencing both of these groups of physicians are similar. Malpractice liability is an issue, particularly in some areas of the country; however, as Kahn and Schmittling report, family physicians routinely do not cite malpractice liability as a major reason for not providing obstetric care.[2] Of greater concern is that *not desiring* obstetric privileges was the most frequently cited reason family physicians gave for not obtaining obstetric privileges. Within this category are undoubtedly many reasons, including lifestyle issues and concerns about competence. As the authors state, this group might also include some who secretly have liability concerns. I believe it is also likely that this group includes those who do not wish to fight the turf battles or buck the status quo that exist in their medical groups and hospitals.

It is very difficult for practicing physicians or new graduates to enter into an adversarial relationship with other physicians in their group or their community. These turf battles, which in many communities have been smoldering for years, have flared dramatically as managed care changes the practice environment. Given the overwhelming practice responsibilities managed care has brought to many family physicians, it is

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often tempting for them simply to forgo an area of practice when challenged, unless the economic incentives to continue are compelling. Many new graduates are entering larger practice groups or communities where the prevailing practice styles do not include family physicians providing obstetric services. In fact, from a purely economic standpoint obstetrics might not be an efficient use of the family physicians' time when obstetricians with declining surgical demands might be sitting idle. Nevertheless, family physicians must define the scope of their specialty using criteria based on what is good for the patient and what is professionally satisfying for themselves rather than on the medical economics of other specialties or because they wish to avoid turf battles.

Despite the increased discussion of turf battles in the medical press, there has been progress in clarifying some of the relevant issues. A recent legal opinion, available through the American Academy of Family Physicians, states that privileges must be based on training and demonstrated competence, not on specialty affiliation.[5] Hospital staff physicians who attempt to restrict privileges based on their own economics, rather than on competence and training, are violating antitrust laws. Family physicians who have had the training and who can demonstrate competence have the legal right to obstetric privileges.

In California the news is even more encouraging. In October 1993 the Executive Committee of the American College of Obstetricians and Gynecologists, District IX, and the California Academy of Family Physicians released a joint statement in which they acknowledged that family physicians, certified nurse midwives, and obstetricians all provide prenatal, intrapartum, and postpartum care.[6] Their statement went on to say that a collaborative and cooperative practice environment should exist among these groups. It is, however, incumbent upon family physicians to develop those collaborative and cooperative practice arrangements, which clearly define scope of practice, back-up arrangements, and referral protocols. By doing so, quality of care is optimized, and disputes that later might lead to privileging battles for new physicians can be avoided.

Even with the support of the courts and professional organizations, changing the prevailing climate of obstetric privileges for family physicians will require that *all* family physicians, whatever their scope of practice, be supportive of those family physicians who wish to maintain their obstetric privileges or obtain new ones. Within our residency programs, we must continue the momentum by assuring an appropriate percentage of our curriculum is devoted to maternity care, and we must provide our trainees with the encouragement and the opportunity to work with family physician role models in both the prenatal and intrapartum setting. We must also help our residents select practices that facilitate obstetric care, as well as counsel them regarding obstetric privileging issues.

Maternity care is an essential part of the care of families and must be permanently secured as an integral component of family medicine. The current medical care environment, which emphasizes primary care, gives us a unique opportunity to accomplish this goal, but reaching it must come through efforts by practicing family physicians, family medicine educators, and those working within our specialty organizations. We hope that studies such as that of Kahn and Schmittling[2] will continue to let us know how we are doing.

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