

**EDITORIAL**

# Obstetrics in Family Medicine: Can It Survive?

Thomas S. Nesbitt, MD, MPH

For the 30 years family practice has formally been accepted as a primary specialty, it has had a defined scope of practice that includes all conditions and both sexes. Pregnancy is among the most common conditions and is often the first involving young families with the health care system in a meaningful way. The medical literature and government reports have documented the importance of family physicians in obstetrics, particularly in rural areas where these physicians represent the majority of obstetric providers.<sup>1,2</sup> The loss of these providers in rural areas has been associated with adverse effects of birth outcomes.<sup>3</sup>

Despite compelling reasons to provide obstetric care, nearly 4 of 5 family physicians are no longer doing so. In 1978, 46% of family physicians reported having privileges for routine deliveries; that rate declined to 41% in 1987, to 26.1% in May 1993, and to 22.4% in May 2000.<sup>4-7</sup> The numbers also reflect considerable declines for family physicians who practice obstetrics in rural areas. In 1993, 38.6% of rural family physicians had hospital privileges for routine deliveries; in 2000 only 25.5% had these privileges.<sup>5-7</sup>

Why is family physician participation vanishing from a core component of family health care in which, from a rural public health standpoint, family physicians play such a critical role? Clearly multiple factors, many of which have been beyond the control of the individual family physician, have contributed to this decline. Throughout the past 25 years issues related to malpractice litigation and liability coverage have made it difficult for family physicians to provide obstetric care. In 1989 the Institute of Medicine reported that 9 national studies and 23 state studies cited liability concerns as

primary reasons for the loss of obstetric providers.<sup>8</sup> This report concluded that although it was not clear the cost of liability premiums constituted a serious economic burden to obstetric providers, the burden was greater for family physicians than for obstetricians.<sup>8</sup> For instance, in 1992 the average increase in premium for a family physician in California to include obstetrics in his or her practice was approximately \$13,000, or 162% of what family physicians had to pay who did not provide this service to their patients.<sup>9</sup>

More recent studies have suggested that issues other than malpractice are important in family physicians' decisions regarding obstetrics.<sup>10,11</sup> Denied hospital privileges, lack of adequate specialty backup, adequate training, and other factors have been cited as reasons for family physicians not delivering babies. According to recent data from the American Academy of Family Physicians, however, most family physicians who are not delivering babies cite "not desiring" to do so as their reason.<sup>5-7</sup> Studies on what is responsible for these physicians' lack of desire to deliver babies report a variety of reasons, including lifestyle issues as a major factor.<sup>10-12</sup> Why do some areas of practice seem optional whereas others do not? Clearly some decision making when choosing a specialty is based on expectations, expectations that have developed during training.

In 1994, Greenberg and Hochheiser<sup>13</sup> reported that 72% of second- and third-year residents from a sample of 30 residency programs throughout the country were planning to include obstetrics in their practices. This level of interest increased dramatically compared with previous studies on residents' intentions and was considerably higher than the percentage of family physicians delivering babies at that time. They concluded that their results might have indicated a resurgence in obstetrics care. Between the time of that survey and May 2000, the date from which the last statistics are available, however, more than 17,000 new residents graduated, and the percentage of family physicians deliv-

---

Submitted 4 December 2001.

From the Office of the Dean, Regional Outreach, Telehealth and Continuing Medical Education, University of California, Davis. Address reprint requests to Thomas S. Nesbitt, MD, MPH, Office of the Dean, Regional Outreach, Telehealth and Continuing Medical Education, UC Davis Health System, 2315 Stockton Blvd, Sacramento, CA 95817.

ering babies decreased another 4%.<sup>5-7</sup> This finding indicates either that these residents did not translate intentions into practice, or that the attrition among practicing family physicians was greater than the increase from new graduates.

Ratcliffe and his colleagues report in this issue of *JABFP* another optimistic study regarding recent residency graduates and participation in obstetric care.<sup>14</sup> They cite the importance of family physician role models in residency education and discuss the 1997 Residency Review Committee requirement that family practice residency programs have at least 1 family practice faculty member attending births with residents. This study found that more than one half of the programs not meeting this requirement in 1997 met the requirement by late 1998. The authors also report that residency directors indicate an increase from 30.0% to 35.1% of recent graduates delivering babies in the first year of practice compared with findings from a similar study in 1993. This study again strongly suggests that there is an association between an increased role of family physician faculty in obstetric training and the percentage of graduates who actually provide obstetrics in the first year of practice.

The authors further support the validity of this assertion by showing that the more intense the role of family practice faculty in obstetric training, the greater the percentage of residents delivering babies in their first year of practice. Although, as the authors state, this association could have alternative explanations, including medical students with an interest in obstetrics choosing programs that emphasize obstetrics, there is little doubt that strong role models and solid training in obstetrics have an important effect on practice decisions by residents.

Questions arise as to the eventual goal of family physicians' participation in obstetrics and whether addressing new graduates' decisions regarding obstetric practice alone will achieve this goal. A reasonable short-term objective would be to have an increase in the absolute number of family physicians providing obstetrics, an outcome that might be able to be achieved in the near future. Although the percentage of family physicians with routine obstetric privileges decreased from 26.1% to 22.4% between 1993 and 2000, the denominator for these studies increased by approximately 10,000 physicians. Multiplying 22.4% times the total number of family physicians shows that during this time the absolute number of family physicians with rou-

tine obstetrics privileges actually decreased by less than 1,000 physicians. If 35% of new graduates provide obstetrics in their practices, as reported in this study, and assuming 3,000 family practice residency graduates per year, approximately 1,000 new providers per year would be practicing obstetrics. Furthermore, the percentage of graduates including obstetrics in practice can be increased as the numbers of family physician faculty within each program and depth of their participation increase.

If obstetrics in family practice is to survive, however, there must be a two-pronged attack aimed both at training in and at stemming attrition from obstetrics by practicing family physicians. In other words, we need to pay as much attention to patching the holes in the bucket as we do to pouring more water into the bucket.

Better research must be conducted to find out when and why family physicians decide to stop delivering babies and what factors might help them delay this decision. In the meantime, efforts must be stepped up to support those family physicians currently delivering babies. Such efforts would include increased support for and participation by family physicians in the successful Advanced Life Support in Obstetrics course. This innovative training course in obstetric emergencies has the potential for enhancing not only the confidence of family physicians but also quality of obstetric care they provide. Survey data from course participants indicate a higher level of confidence in managing obstetric emergencies and a stated increased likelihood of continuing to provide obstetric care.<sup>15</sup>) Of the more than 18,000 participants in this course, more than 6,000 have been practicing family physicians.

In addition, it is essential that representative organizations clearly articulate the importance of family physicians providing obstetric care for the health of the populations that we serve, and these organizations must recommit themselves to this cause. In the last few years, the American Academy of Family Physicians has made efforts to remove barriers for family physicians receiving privileges in obstetrics. A joint statement has been developed between the American Academy of Family Physicians and the American College of Obstetricians and Gynecologists acknowledging that obstetrics privileges should be based on training and competence rather than specialty. Joint guidelines on the content of obstetric training have also been devel-

oped. These efforts lend support to family physicians providing obstetric care if they have received adequate training and are competent to do so, and they might prove to be positive steps in stemming the attrition that has occurred within the past two decades.

The care of patients and families throughout the life cycle has always been integral to the definition of family practice. The rapid decline in the percentage of family physicians participating in obstetrics has threatened the core mission of the specialty and put patients at risk in many rural areas. Changes in educational policies, the persistent commitment of family medicine educators, and the support of professional organizations can help reverse this trend and maintain this important area of practice within the specialty.

## References

1. Health care in rural America. Washington, DC: Congress of the United States, Office of Technology Assessment, 1990.
2. Nesbitt, TS, Baldwin LM. Access to obstetric care. *Primary Care* 1993;20:509–22.
3. Nesbitt TS, Connell FA, Hart LG, et al. Access to obstetric care in rural areas: effect on birth outcomes. *Am J Public Health* 1990;80:814–8.
4. Rosenblatt RA, Cherkin DC, Schneewiss R, et al. The structure and content of family practice: current status and future trends. *J Fam Pract* 1982;15:681–722.
5. Facts about family practice. Kansas City, Mo: American Academy of Family Physicians, 1988.
6. Facts about family practice. Kansas City, Mo: American Academy of Family Physicians, 1994.
7. Facts about family practice. Kansas City, Mo: American Academy of Family Physicians, 2001.
8. Institute of Medicine. The effect of professional liability on the delivery of obstetrical care. Washington DC: National Academy Press, 1989.
9. Norton SA. The malpractice premium costs of obstetrics. *Inquiry* 1997;34:62–9.
10. Nesbitt TS, Arevalo JA, Tanji JL, Morgan WA, Aved B. Will family physicians really return to obstetrics if malpractice insurance premiums decline? *J Am Board Fam Pract* 1992;5:413–8.
11. Grumbach K, Vranizan K, Rennie D, Luft HS. Charges for obstetric liability insurance and discontinuation of obstetric practice in New York. *J Fam Pract* 1997;44:61–70.
12. Smith MA, Green LR, Schwenk TL. Family practice obstetrics in Michigan. Factors affecting participation. *J Fam Pract* 1989;28:433–7.
13. Greenberg DM, Hochheiser LI. Family practice residents' decision making regarding future practice of obstetrics. *J Am Board Fam Pract*. 1994;7:25–30.
14. Ratcliffe SD, Newman SR, Stone MB. Obstetric care in family practice residencies: a five-year follow-up survey. *J Am Board Fam Pract*. 2002;15:20–4.
15. Beasley JW, Damos JR, Roberts RG, Nesbitt TS. The advanced life support in obstetrics course. A national program to enhance obstetric emergency skills and to support maternity care practice. *Arch Fam Med* 1994;3:1037–41.