Can Physicians Be Induced To Resume Obstetric Practice?

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Abstract: ***Background:*** **Decreased numbers of obstetric providers during the last decade have limited access to obstetric care, especially for some groups of women. Increasing or stabilizing the number of providers could increase access.**

Methods**: A questionnaire was mailed in 1989 to 1965 Washington State family physicians and obstetricians to determine their attitudes toward the practice of obstetrics. Sixty-six percent of physicians responded to the survey.**

Results**: Of those who had quit obstetrics in the previous 3 years, 42 percent of responding family physicians and 19 percent of responding obstetricians would consider resuming. Those family physicians willing to consider resuming their obstetric practices were more likely to have been in practice fewer years, employed by a health maintenance organization (HMO), or located in a rural area. A majority of all respondents cited excessive malpractice premiums and fear of malpractice suit as reasons for stopping obstetric practice. Family physicians willing to consider resuming obstetrics were more concerned about the overall number of obstetric providers in their area. Rural family physicians willing to consider resuming obstetrics listed poor backup or shared call more often as a reason they had quit.**

Conclusions**: Attention targeted to the concerns of family physicians who have been in practice for a short time, who work for HMOs, or who are in rural practice might help induce some physicians to resume obstetrics. (J Am Board Fam Pract 1992; 5:407-12.)**

The decrease in family physicians and, to a lesser extent, obstetricians providing obstetric care during the last decade has resulted in more limited access to obstetric care, especially for rural and poor women in Washington State. Statewide surveys in 1985, 1986, and 1989[1-3] document the attrition of obstetric providers in Washington State. In 1985 malpractice premiums increased dramatically, and the percentage of family physicians practicing obstetrics fell from a reported 61 percent in 1985 to 44 percent in 1986. While the 1989 survey showed a slowing of the loss of obstetric providers, the proportion of obstetric providers willing to accept an unlimited number of Medicaid patients declined between 1986 and 1989. This decreasing number of obstetric providers in the face of increasing Medicaid patients has further stressed those remaining in practice by increasing their obstetric volumes. A similar phenomenon has been reported in other areas around the country.[4-7] Increasing the total pool of obstetric providers is a crucial component of any comprehensive plan to increase access to obstetric care.

In the last few years efforts have been made in Washington State to improve access to obstetric care, and there are signs that these efforts are succeeding. Malpractice premiums have stabilized. Insurers have developed educational programs to help providers reduce their malpractice risk. The Washington State Medicaid program has increased reimbursement for obstetric care and has funded case management and maternity support programs to help providers care for this patient population. Just as these changes were enacted, we surveyed family physicians and obstetricians to gain information about their obstetric practices, their attitudes toward obstetrics and

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Medicaid patients, and their practice characteristics. We have used these data to identify factors that might influence physicians who had recently stopped practicing obstetrics to resume their practice and to prevent physicians from leaving obstetric practice in the first place.

Methods

In fall 1989 we developed and pilot tested a three-page, 18-item questionnaire that was sent to the 1965 family physicians, general practitioners, and obstetrician-gynecologists on current membership lists of the Washington State Medical Association, the Washington Academy of Family Physicians, the Washington Chapter of the American College of Obstetrics and Gynecology, and the Washington State Obstetric Association. Providers who delivered babies of patients on Medicaid in 1988 and who were not on these lists were also included. For the purposes of this study, family physicians and general practitioners are combined and referred to as family physicians.

The goal of the questionnaire was to elicit physician attitudes and practice decisions regarding obstetric care, obstetric malpractice, and the Medicaid obstetric program at the time that a comprehensive new Medicaid maternity access program (First Steps) was beginning in fall 1989 in Washington State. The questionnaire also asked for demographic information, recent changes in obstetric practice, and reasons for the changes. This report focuses on the family physicians who stopped obstetric practice after 1 January 1986.

To differentiate urban from rural physicians, we used the ZIP Code of each responding physician's practice. The State of Washington recognizes 44 hospitals in the state as rural (personal communication from V. Gibbs, Director, Office of Rural Health, Washington State, to Gary Hart, 1989). ZIP Codes with population centers closest to a rural hospital were identified as rural. All other ZIP Codes were defined as urban.

Of the 1965 physicians surveyed, 1305 (66 percent) responded. We discarded 42 responses from providers who were not family physicians or obstetrician-gynecologists (mostly emergency department physicians, retired physicians, or physicians' assistants); 1263 family physicians or obstetricians responded to the questionnaire.

Standard t-tests and chi-square tests were used to compare group responses. Although the low number of cases in the subgroups of interest severely limited the ability to determine whether many apparently important differences were, in fact, statistically significant (i.e., not due to chance), 66 percent of all the pertinent Washington physicians were included in this study's results.

Results

Fifty percent of the family physicians and 82 percent of the obstetricians responding were still offering obstetric care to their patients at the time of our survey (Table 1). Of the 949 family physicians who responded to our survey, 163 (17 percent) had stopped obstetric practice on or after 1 January 1986; 21 (7 percent) of 308 responding obstetricians had stopped after this time. Only

Table 1. Obstetric Practice Status of Survey Respondents (n = 1257).

Practice Status	Family Physicians			Obstetricians-Gynecologists
	Rural No. (%)	Urban No. (%)	Total No. (%)	Total No. (%)*
Never provided obstetric care	10 (5)	81 (11)	91 (10)	5 (2)
Stopped obstetric care before 1 January 1986	25 (12)	192 (26)	217 (23)	30 (10)
Stopped obstetric care on or after 1 January 1986	43 (21)	120 (16)	163 (17)	21 (7)
Currently providing obstetric care	128 (62)	350 (47)	478 (50)	252 (82)
Total	206 (100)	743 (100)	949 (100)	308 (101)

*Total may not add to 100%; individual percentages are rounded to nearest whole number. Note: 6 of the 1263 respondents to the questionnaire did not indicate their obstetric practice status.

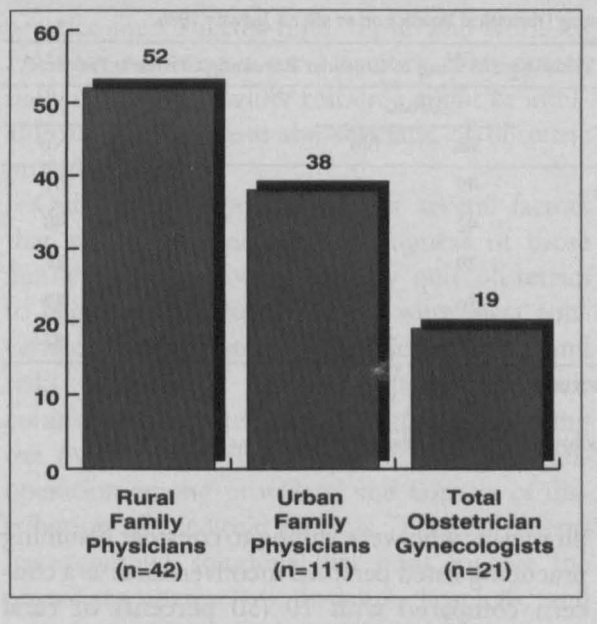

Figure 1. Willingness to consider resuming obstetric practice by physicians who stopped obstetric care on or after 1 January 1986.

91 (10 percent) of the family physicians and 5 (2 percent) of the obstetricians reported that they had never provided obstetric care.

Our analyses focused on the family physicians who had recently stopped providing obstetric care (Figure 1). While 163 family physicians had recently stopped obstetric practice, 4 failed to respond to our question about resumption and 6 did not know whether they would consider resuming an obstetric practice. Of the remaining 153 family physicians who had recently stopped obstetric practice, 64 (42 percent) would consider resuming an obstetric practice. Rural family physicians (22 or 52 percent) were more likely to consider resuming an obstetric practice than urban family physicians (42 or 38 percent). Four (19 percent) of the 21 obstetrician-gynecologists who had stopped their obstetric practices were willing to restart. No other analyses were performed on this small group.

Family physicians willing to consider resumption of obstetrics were in practice for a shorter time than family physicians not willing to consider resumption (Table 2). Rural family physicians on average had been in practice several years longer than their urban counterparts.

Urban family physicians who would consider resuming an obstetric practice were in practice environments that were different from those who would not. Urban physicians practicing in health maintenance organizations (HMOs) were significantly more likely to consider resuming their obstetric practices, physicians in private practice less likely. Of the 17 urban family physicians who worked for HMOs, 11 (65 percent) stated they would consider resuming their obstetric practices, whereas only 28 (31 percent) of family physicians in private practice or in hospital-based or publicly funded clinics would consider resuming an obstetric practice. Seventeen of the 19 family physicians employed by HMOs were practicing in urban areas.

Table 2. Characteristics of Family Physicians Who Discontinued Obstetric Practice on or after 1 January 1986.

Characteristics	Willing to Consider Resuming Obstetric Practice					
	Rural		Urban		Total	
	Yes	No	Yes	No	Yes	No
Years in practice (mean)	15.4*	22.1	12.9†	19.3	13.8†	19.9
	No. (%)‡	No. (%)	No. (%)	No. (%)‡	No. (%)	No. (%)
Practice type						
Private	19 (91)	17 (85)	24 (62)	57 (83)	43 (72)	74 (83)
Health maintenance organization	1 (5)	1 (5)	11 (28)	6 (9)	12 (20)	7 (8)
Hospital, public-funded clinic, other	1 (5)	2 (10)	4 (10)	6 (9)	5 (8)	8 (9)
Totals§	21	20	39	69	60	89

*$P \leq 0.05$.

†$P \leq 0.01$.

‡Total may not add to 100%; individual percentages are rounded to nearest whole number.

§Number of respondents given for type of practice; number of respondents for mean years in practice is slightly higher.

Note: Number of respondents differs from Table 1 because of varying response rates to survey questions. Number of respondents differs from text because 4 respondents did not indicate practice type.

Table 3. Most Important Reasons Family Physicians Reported for Discontinuing Obstetrical Practice on or after 1 January 1986.

Reasons	Percent Responding Who Were Willing to Consider Resuming Obstetric Practice*					
	Rural		Urban		Total	
	Yes	No	Yes	No	Yes	No
Excessive obstetric malpractice premiums	70	75	49	57	56	61
Fear of obstetric malpractice suit	60	50	42	48	48	48
Poor backup or shared call	35	10	29	19	31	17
Personal inconvenience	10†	50	56	46	41	47
Number of respondents‡	20	20	41	67	61	87

*Columns do not add to 100% because each respondent could give two responses.
†$P < 0.05$.
‡Number of respondents differs from Table 2 because of varying response rates to particular survey questions.

Table 3 displays the reported reasons why family physicians had discontinued their obstetric practices. All family physicians, regardless of geographic location or willingness to resume an obstetric practice, listed excessive obstetric malpractice premiums as a major reason for discontinuing obstetric practice. Nearly one-half of all family physicians listed fear of obstetric malpractice suit as another important reason. The importance of personal inconvenience distinguished rural family physicians willing to consider resuming an obstetric practice. Only 2 (10 percent) of rural family physicians who were willing to consider resuming practicing listed personal inconvenience as a concern compared with 10 (50 percent) of rural family physicians unwilling to consider resuming practicing obstetrics. Although not statistically significant, rural family physicians willing to resume practicing obstetrics listed poor backup or shared call as a more important reason (35 percent) than did those who would not consider doing so (10 percent).

Table 4. Percentage of Rural and Urban Family Physicians Rating Community Maternity Resources as Poor or Very Poor.

Community Maternity Resources	Willing to Consider Resuming Obstetric Practice*	
	Yes	No
Overall number of providers	30†	13
Cooperation among providers	19	9
Number of providers for Medicaid patients	55	58
Fairness of Medicaid patient distribution	48	53
Availability of obstetric on-call backup for Medicaid patients	29	33
Access to obstetric consultant for Medicaid patients	28	29
Quality of obstetric nursing services at physician's hospital	2	1
Number of respondents (range)‡	48–61	53–75

*Only those family physicians and general practitioners who stopped obstetric practice on or after 1 January 1986 are included.
†$P < 0.05$.
‡Number of respondents varied depending on nonresponse to each question.

When asked about community maternity resources, 30 percent of all family physicians willing to consider resuming an obstetric practice listed the overall number of providers in their area as poor or very poor ($P < 0.05$). Physicians who were concerned about the overall number of providers were more likely to consider resuming their obstetric practice (Table 4). Although not significant, a greater percentage of physicians willing to consider resuming an obstetric practice were also concerned about the cooperation among providers.

The number of providers for Medicaid patients and the fairness of Medicaid patient distribution were of concern to many family physicians regardless of their willingness to resume their obstetric practice. Fewer physicians expressed dissatisfaction with availability of on-call backup and obstetric consultation for Medicaid patients.

Discussion

This study suggests that there might be subgroups of established family physicians who would be willing to resume their obstetric practices. These groups include those physicians in

practice for a shorter time, those who work for HMOs, and those in rural practice. This potentially untapped provider resource might be available to help alleviate the shortage of obstetric providers.

Our survey responses suggest several factors that might influence the willingness of those family physicians who recently quit obstetrics to begin again. The physicians were most concerned about obstetric malpractice costs and risks and about certain aspects of their communities' obstetric care systems, including the overall number of obstetric providers, cooperation among providers, and fairness of distribution of Medicaid patients. These problems have complex solutions that must involve the physicians themselves, insurers, hospitals, and communities.

A maximal impact will occur if those groups most likely to resume practice are targeted. An impressive 52 percent of rural family physicians indicated a willingness to consider resumption of obstetric practice. Although the number of rural family physicians is less than urban physicians, each physician's impact on the provision of obstetric care can be great in rural areas, where physicians are often in short supply and serve a wide geographic area. In urban areas, HMOs could take the lead in developing practice arrangements that encourage family physicians to practice obstetrics. Hospitals seeking to increase their obstetric deliveries might approach those family physicians who have recently quit obstetrics and work with them, as well as current community obstetric providers and malpractice insurers, to create a practice environment that would attract these family physicians back to obstetrics.

Reasons of personal inconvenience might carry more weight than is reflected in this survey. Physicians, especially those from rural areas, might find it difficult to report that they stopped their obstetric practice primarily because of personal inconvenience when access to obstetric care has become a major statewide concern. Family physicians might also be discontinuing their obstetric practices for reasons not addressed by our questionnaire, including inadequate obstetric volume, closure of their hospital obstetric unit, or inadequate obstetric practice skills.

Our study has limitations in at least three areas. First, a retrospective analysis of earlier decisions by respondents can be biased by the passage of time. Second, because our state did not have a complete provider database of licensed obstetric practitioners, our survey sample could have been incomplete and thus not representative of all practitioners in the state. Third, our survey results could be biased by the nonresponse of certain subgroups. Nonrespondents from a mailing list similar to ours have been investigated previously by telephone survey.[3] This effort found that more than 40 percent of the sampled nonrespondents were either no longer in active practice or could not be found. Of those who were contacted and still practicing medicine, a slightly lower percentage of these nonrespondents were not currently practicing obstetrics compared with respondents. Thus our response rate is likely higher than the reported 66 percent, and the percentage of Washington State physicians providing obstetric care is likely lower than reported.

There are a number of Washington State family physicians who have recently quit their obstetric practice who would consider resuming it. Efforts should be made in the appropriate areas to encourage them to do so. Improving the obstetric practice climate might also encourage more family physicians to include obstetrics when they enter practice and stem the loss of physicians who currently practice obstetrics.

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