Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints may prevent this in some cases. The problem is compounded in the case of a bimonthly journal where continuity of comment and redress is difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Obstetrics in Family Practice

To the Editor: The articles in the July-August 1992 issue concerning family physicians and obstetrics by Greer et al.,[1] Nesbitt et al.,[2] and Wall[3] are a useful continuation of the discussion.

As a rural family physician for 17 years who has quit doing obstetrics after 12 years, I offer some comment. The lifestyle, backup, and malpractice cost aspects are clearly important, but fear of malpractice is the overriding issue. It is the ultimate dilemma for rural family physicians. We are barraged daily with horror stories of jury verdicts in excess of the insurance coverage. We scrutinize the cases looking for the treatment flaw that we know we would never commit, but often we find that we could easily have been in the same shoes. The insurance companies and journals harangue us about the need to do everything perfectly, but we know that even so, a jury might give away a large award in a bad outcome beyond our control.

One-half of family physicians have been sued. Those of us who have know that if winning a lawsuit is punishment enough, losing one must be a near-death experience. The average lawsuit winner goes through 3 years of grueling depositions, questionnaires, and accusations of character and professional deficiencies. A good malpractice insurance company will, in a winning case, spend $20,000 for defense costs and notify the defendant in detail of all of the exceptions that might not be covered by the insurance policy. We are often reassured that we will never lose our car or house in case of a large judgment against us. If we lose, we are sparingly reassured that we would probably not lose our insurance coverage or license, and thus *probably* not lose our career.

Why is it a mystery that rural family physicians don't want to be a part of this lottery? Rural family physicians are the lowest paid physicians. The risk of a lawsuit is real and it's not worth it. Rural family physicians do a community service by not doing obstetrics. Resources are scarce in rural communities. There is a real risk to a community of losing one of its few family physicians as a result of a lawsuit and consequently not being able to find replacements because of a community stigma. Major hospital losses in a lawsuit could jeopardize the institution, and even winning a suit is demoralizing to the staff and community.

I like doing obstetrics and I'm good at it, but I lost more sleep worrying over the bad outcomes than I ever did being called in to see patients. The obstetric provider should be responsible for worrying about the patient, not about the destruction of the hospital and the careers of the nurses and physicians.

The only solution is a federal tort system approach to all state and federal tort claims. In addition, the plaintiff should pay all defendant costs plus damages to reputation and mental anguish if the defendant is found not guilty. Any compensation for bad outcomes without fault should be through a completely separate system.

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References

1. Greer T, Baldwin L, Wu R, Hart G, Rosenblatt R. Can physicians be induced to resume obstetric practice? J Am Board Fam Pract 1992; 5:407-12.
2. 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.
3. Wall EM. Family physicians performing obstetrics: is malpractice liability the only obstacle? J Am Board Fam Pract 1992; 5:440-4.

Correction

Volume 5 Number 5 pages 460 and 462. In Table 1, when office sphygmomanometer is compared with office ABPM, diastolic measurement (mmHg) should be 94±2. In Table 3, the headings for the second set of comparisons should be **Office Sphygmomanometer** and **Office ABPM**. We regret the errors.