Obstetric Privileges For Family Physicians: A National Study

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Background: **We surveyed family physicians in the US to determine how many include obstetric services in their practices and to compare trends over time.**

Methods: **In the 1993 Practice Profile Survey, the American Academy of Family Physicians (AAFP) surveyed a random sample of active members whose mailing address was in one of the 50 states or the District of Columbia. The sample was stratified by nine census divisions; after two mailings 2460 responses were received from the 4400 physicians in the sample (56 percent response).**

Results: **Eighty-seven percent of active members had hospital admission privileges. Although there were regional disparities in the proportion of family physicians with various hospital privileges, overall 94 percent perceived that the privileges afforded them were appropriate.**

Approximately 26 percent of AAFP active members in 1993, compared with 29 percent in 1988, included routine obstetric care in their hospital practices. A higher proportion of family physicians in the West North Central census division had privileges at various levels of obstetric care than did family physicians in other census divisions; for example, while 57 percent of family physicians in the West North Central census division had privileges in routine obstetric care, only 9 percent of family physicians in the East South Central division had these privileges. For those family physicians who did not have privileges for any obstetric care, most indicated that they chose not to include obstetric care in their hospital practices. Family physicians most likely to have had obstetric privileges included those who practiced in nonmetropolitan areas (39 percent of family physicians had privileges in routine obstetric care compared with 21 percent in an urban setting) and those who completed a family practice residency program (33 percent with routine obstetric privileges compared with 13 percent who did not complete a 3-year residency in family practice). (J Am Board Fam Pract 1995;8:120-7.)

The American Academy of Family Physicians (AAFP) has long held the position that the privilege to perform clinical procedures or to engage in clinical activities should be based on the individual physician's documented training, experience, demonstrated abilities, and current competence.[1] The Joint Commission on Accreditation of Healthcare Organizations and the American Medical Association have held similar positions.[2,3]

The AAFP has monitored the hospital privileges of its members beginning with studies initiated in 1969 and continues this sequence with the current study.[4-11] These surveys have revealed that most AAFP members perceive their hospital privileges to be appropriate.

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Among privileges for hospital care, obstetric care bears particular attention. Approximately one-quarter of family physicians include obstetric care in their practices. Nesbitt and colleagues[12] reported that two-thirds of the nation's rural obstetric care providers are family physicians. There are geographic areas, however, where access to obstetric care is absent (in 10 counties in Indiana)[13] or distant (among counties in California, Missouri, and Washington).[12,14,15] In rural northern California, lack of access to obstetric care was associated with poorer birth outcomes.[16] Our study attempts to document the obstetric care provided by family physicians.

Methods

In March 1993 a four-page questionnaire was sent to a random sample of 4400 active AAFP members whose mailing address was in one of the 50 states or the District of Columbia — approximately 10 percent of active members. The sample was stratified by census division (Figure 1). Each census division was sampled at a different rate to

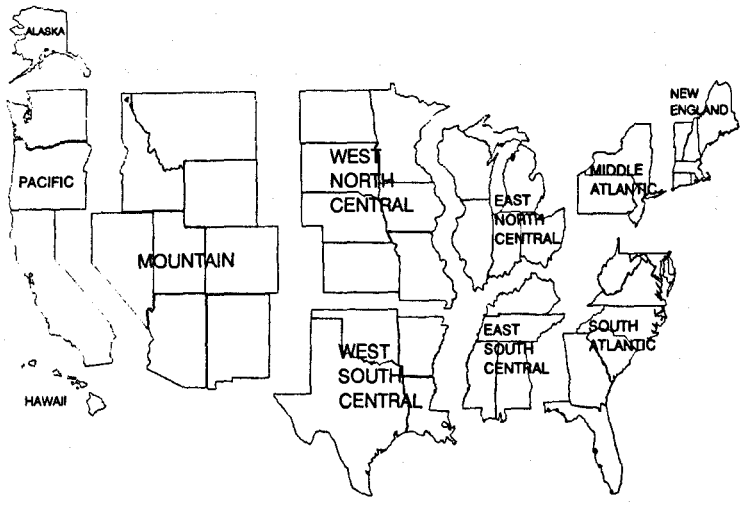

Figure 1. United States census divisions.

obtain sufficient data for each division to ensure comparable results. After a second mailing in May 1993, 2460 responses were received from the 4400 physicians in the sample (56 percent).

The length of the survey instrument and the number of different questionnaires mailed at the same time by the AAFP to its members could have contributed to this lower than usual response rate. The nonrespondent group appeared to differ slightly from respondents in three areas: nonrespondents were less likely to be a family practice residency graduate (67 percent versus 69 percent), less likely to be a diplomate of the American Board of Family Practice (75 percent versus 82 percent), and less likely to be a US medical school graduate (84 percent versus 90 percent). To compensate for nonresponse in each census division, all estimates were adjusted by the appropriate division sampling fraction and by the response percentage for each division. Thus, the estimate for each division was weighted by a fraction in which the numerator was the population of the division and the denominator was the number of respondents from that division. Tests of significance were performed when appropriate on pairs of percentages using a standardized normal z-test (one tailed) at $P=0.025$.

Results

Admission Privileges

In this 1993 study it was estimated that 86.7 percent, (36,178) of active AAFP members (41,728) had hospital admission privileges. Approximately 5.1 percent indicated that they were in practice but had no desire for hospital admission privileges, 1.3 percent gave up privileges when they entered managed care systems, 0.8 percent reported that they were not seeing patients, 5.2 percent gave other reasons for no privileges, and 0.6 percent did not answer the question.

These results differ from the results of a 1969 study of members' hospital practices in which 89 percent of the members reported that they had active staff status in one or more hospitals, 10 percent held associate staff membership, and 1 percent did not have hospital staff appointments.[8] These two studies are not directly comparable, however, because in 1993 questions were asked about privileges, whereas in 1969 questions were asked about hospital staff appointments.

In December 1980 the AAFP surveyed only those active members who had indicated that they were involved in office-based, direct patient care — an 18 percent sample of all active members.[9] The results of the 1980 survey indicated that approximately 95.6 percent of those active members in office-based, direct patient care were estimated to have hospital admission privileges, and 4.4 percent were estimated not to have hospital admission privileges. The results of the 1988 study indicated that approximately 91.1 percent had hospital admission privileges.[11] In all AAFP surveys before 1992, members were not given the current variety of categories in which to respond.

Members' current satisfaction with hospital admission privileges appears to be similar in the last three national surveys performed by the AAFP. Adjusting for a higher than usual item nonresponse rate of 13.0 percent, in the 1993 survey approximately 94.3 percent of all active members who had hospital admission privileges indicated that the privileges they were granted were generally appropriate. Approximately 5.7 percent indicated that their hospital privileges were unduly restricted. These results are similar to those of the 1988 AAFP study in which 94.5 percent of those physicians with hospital admission privileges indicated that their privileges were appropriate, the 1980 study in which 95.4 percent indicated that their privileges were generally appropriate, and

the 1969 study in which 96 percent of members were satisfied with their privileges.[8-11]

Obstetric Care

In 1993, 26.1 percent of active AAFP members, compared with 28.7 percent in 1988, included *routine* obstetric care in their hospital practices (Table 1). This figure varied widely by census division, as more than 1 in 2 active members in the West North Central division performed routine obstetric care compared with fewer than 1 in 10 in the East South Central division.

Family physicians who did not include routine obstetric care gave several reasons. Nationally, 44.1 percent of family physicians did not desire to provide routine obstetric care, while 12.6 percent found the costs of liability insurance or the fear of liability suits to be prohibitive, and 14.9 percent did not have a hospital practice or the hospital did not have an obstetric service.

In the 1980 AAFP study, in contrast, only 5 percent of active members in office-based, direct patient care indicated that they did not perform routine obstetric care because of the prohibitive cost of professional liability insurance. At that time, only one census division reported more than 1 in 10 active members in direct patient care who did not perform routine obstetric care because of professional liability problems. In all other census divisions in 1980, less than 5 percent reported professional liability as a problem. In 1993, however, more than 1 in 10 active members in the Mountain, West South Central, and East South Central census divisions reported that they did not perform routine obstetric care because their professional liability costs were prohibitive (Table 1).

Approximately 1 in 8 active members (12.6 percent) in 1993 included *complicated* obstetric delivery in their hospital practices (Table 2) compared with

Table 1. Percentage of Family Physicians Performing Obstetric Care in Hospital Practices, by Census Division, May 1993.

Census Division	Total (n)	Performed in Hospital Practice	Performed Only with Consultation	Reasons Not Performed							
				Not Desired	Privileges Denied	Liability Prohibitive	Fear of Liability Suit	No Hospital Department	No Hospital Practice	Reason Not Reported	Not Reported
Total	100.0 (2,460)	26.1	0.1	44.1	0.3	9.0	3.6	2.2	12.7	1.0	0.8
West North Central	100.0 (314)	57.0	0.0	28.3	0.0	5.1	2.2	1.0	5.1	1.0	0.3
East North Central	100.0 (254)	36.6	0.0	42.1	0.0	9.4	3.5	0.4	6.3	1.2	0.4
Mountain	100.0 (288)	34.4	0.0	27.8	0.0	11.8	2.8	3.5	16.7	2.1	1.0
Pacific	100.0 (282)	27.3	0.4	45.4	0.0	8.9	3.2	1.1	11.7	1.4	0.7
New England	100.0 (243)	26.3	0.0	46.9	2.5	7.0	1.6	1.6	11.5	1.6	0.8
West South Central	100.0 (272)	16.5	0.4	43.4	0.0	13.2	8.5	1.8	15.1	0.7	0.4
South Atlantic	100.0 (280)	12.9	0.0	48.9	0.7	7.9	2.1	4.3	21.8	0.4	1.1
Middle Atlantic	100.0 (280)	12.1	0.0	58.2	0.4	8.6	4.3	1.8	12.9	0.4	1.4
East South Central	100.0 (247)	8.9	0.0	53.4	0.8	10.1	3.6	6.9	13.0	2.0	1.2

Note: Includes only active member respondents of the American Academy of Family Physicians. Estimated percentages were adjusted by the sampling fraction and the response percentage for each division.

Source: American Academy of Family Physicians, Hospital Practice Characteristics Survey, May 1993.

Table 2 . Percentage of Family Physicians Performing Complicated Obstetric Deliveries in Hospital Practices, by Census Division, May 1993.

Census Division	Total (n)	Performed in Hospital Practice	Performed Only with Consultation	Reasons Not Performed: Not Desired	Privileges Denied	Liability Prohibitive	Fear of Liability Suit	No Hospital Department	No Hospital Practice	Reason Not Reported	Not Reported
Total	100.0 (2,460)	12.6	11.3	49.0	0.3	6.5	3.5	1.8	12.7	1.2	1.1
West North Central	100.0 (314)	33.1	19.7	32.5	0.3	4.8	1.6	0.3	5.1	1.3	1.3
Mountain	100.0 (288)	17.0	13.9	33.3	0.0	9.7	2.4	3.8	16.7	2.1	1.0
East North Central	100.0 (254)	16.9	16.9	46.9	0.4	5.9	5.1	0.0	6.3	1.2	0.4
Pacific	100.0 (282)	13.5	12.8	50.0	0.0	6.7	2.5	0.7	11.7	1.1	1.1
West South Central	100.0 (272)	9.9	5.1	47.1	0.0	10.3	8.1	1.8	15.1	1.1	1.5
New England	100.0 (243)	6.2	18.1	51.4	1.2	4.9	2.1	2.1	11.5	1.2	1.2
East South Central	100.0 (247)	6.1	1.6	57.9	0.8	8.1	2.8	6.5	13.0	2.0	1.2
South Atlantic	100.0 (280)	5.0	6.1	55.0	0.0	4.6	2.1	3.2	21.8	1.1	1.1
Middle Atlantic	100.0 (280)	2.1	7.9	63.2	1.1	5.4	3.6	1.8	12.9	0.4	1.8

Note: Includes only active member respondents of the American Academy of Family Physicians. Estimated percentages were adjusted by the sampling fraction and the response percentage for each division.

Source: American Academy of Family Physicians, Hospital Practice Characteristics Survey, May 1993.

11.2 percent in July 1988 and 20.6 percent in the December 1980 AAFP study. In this most recent study family physicians in the West North Central census division were far more likely to perform complicated obstetric delivery than family physicians in any other census division. In general, for those census divisions east of the Mississippi, fewer than 1 in 10 family physicians were performing complicated obstetric deliveries. Although the plurality — indeed the majority in five census divisions — did not desire complicated obstetric delivery privileges in their hospital practices, the expense of liability insurance or fear of liability suits had caused about 1 in 10 family physicians to choose not to perform complicated obstetric delivery.

In 1993, 4.5 percent of active AAFP members performed Cesarean sections in their hospital practices, slightly down from 5.3 percent in 1988 (Table 3). No family physicians surveyed in the Middle Atlantic census division reported performing Cesarean sections compared with 11.1 percent in the West North Central division. Notably, in the earlier 1980 AAFP study approximately 13.2 percent of family physicians in office-based, direct patient care included Cesarean sections in their hospital practices.

The majority of family physicians in all but one census division reported that they do not perform Cesarean sections because they do not desire to do so. Of the active members 8.4 percent stated they do not perform Cesarean sections because the liability premiums are prohibitive or because of the fear of liability suits. In the West, 9.2 to 17.3 percent did not perform Cesarean sections because liability insurance premiums were prohibitive or because they feared liability suits, whereas in census divisions on the East Coast this figure drops to 4.5 percent to 8.1 percent with the West North Central intermediate at 5.7 percent. Perhaps liability had been an issue for Cesarean sections several years ago on the East Coast, and many physicians who have not performed Cesarean sections for

Table 3. Percentage of Family Physicians Performing Cesarean Sections in Hospital Practices, by Census Division, May 1993.

Census Division	Total (n)	Performed in Hospital Practice	Performed Only with Consultation	Reasons Not Performed							
				Not Desired	Privileges Denied	Liability Prohibitive	Fear of Liability Suit	No Hospital Department	No Hospital Practice	Reason Not Reported	Not Reported
Total	100.0 (2,460)	4.5	3.4	63.7	1.6	5.6	2.8	2.0	12.7	2.7	1.1
West North Central	100.0 (314)	11.1	8.9	59.6	2.5	3.8	1.9	1.0	5.1	5.4	0.6
Mountain	100.0 (288)	8.3	4.2	45.1	3.1	9.7	2.1	5.9	16.7	3.1	1.7
West South Central	100.0 (272)	7.4	2.6	51.8	0.7	9.6	7.7	1.8	15.1	2.2	1.1
Pacific	100.0 (282)	7.1	5.3	62.4	0.7	6.0	3.2	0.7	11.7	1.8	1.1
East South Central	100.0 (247)	3.2	0.8	62.3	1.6	6.9	1.2	6.5	13.0	3.2	1.2
East North Central	100.0 (254)	2.4	3.1	74.8	2.4	4.3	2.8	0.0	6.3	3.1	0.8
South Atlantic	100.0 (280)	0.7	1.4	63.9	0.4	3.9	1.8	2.9	21.8	2.1	1.1
New England	100.0 (243)	0.4	1.6	72.8	2.9	4.1	0.4	2.1	11.5	2.9	1.2
Middle Atlantic	100.0 (280)	0.0	0.7	72.5	2.1	4.3	2.5	1.8	12.9	1.4	1.8

Note: Includes only active member respondents of the American Academy of Family Physicians. Estimated percentages were adjusted by the sampling fraction and the response percentage for each division.

Source: American Academy of Family Physicians, Hospital Practice Characteristics Survey, May 1993.

several years no longer perceived liability as their problem.

Residency-trained Family Physicians

In every census division family physicians who had completed family practice residency programs were more likely to provide routine obstetric care than were family physicians who had not completed a residency program (Table 4). In all divisional comparisons reaching statistical significance, residency-trained family physicians were more likely to perform routine obstetric care, high-risk obstetric care, complicated obstetric delivery, obstetric vaginal birth after Cesarean section, and obstetric induction and labor augmentation. Residency-trained family physicians in the West North Central division were more likely to perform each of these obstetric procedures than were family physicians in any other division.

Rural versus Urban

Physicians in rural settings in all divisions were more likely to have most categories of obstetric privileges than were physicians in urban settings (Table 5). Physicians in rural areas were nearly twice as likely to have routine obstetric privileges compared with family physicians in urban areas (38.6 percent compared with 20.9 percent). Similarly, 24.5 percent of family physicians in rural areas included complicated obstetric delivery compared with only 8.1 percent in urban settings. Perhaps the most dramatic difference was in performance of Cesarean sections between urban family physicians (1.5 percent) and rural family physicians (12.2 percent).

Discussion

The methods used in this 1993 study and those used in the study performed by the AAFP in 1988 are comparable but not the studies performed in

Table 4. Percentage of Types of Obstetric Patient Care in Hospital Practices of Family Physicians, by Census Division and Family Practice Residency Training, May 1993.

Census Division	Respondents (n)	Routine Delivery	High-Risk* Delivery	Complicated Delivery	Cesarean Sections	Vaginal Birth after Cesarean Sections	Induction and Augmentation	Dilatation and Curettage	Tubal Ligation
Total									
Residency trained	1688	32.6	8.8	14.8	4.4	21.9	25.0	20.9	5.6
Not residency trained	772	13.2†	3.9†	8.1†	4.6	8.4†	11.2†	19.1	7.5
New England									
Residency trained	206	29.1	3.4	6.3	0.5	17.5	17.0	7.8	0.5
Not residency trained	37	13.5†	2.7	5.4	0.0	8.1	8.1	5.4	0.0
Middle Atlantic									
Residency trained	196	13.8	1.5	2.0	0.0	5.6	5.6	3.6	0.5
Not residency trained	84	8.3	0.0	2.4	0.0	1.2†	3.6	3.6	1.2
East North Central									
Residency trained	180	45.6	13.3	20.6	2.8	30.6	37.2	28.3	3.3
Not residency trained	74	14.9†	5.4†	8.1†	1.4	10.8†	12.2†	20.3	4.1
West North Central									
Residency trained	202	67.8	22.3	37.6	9.9	50.5	61.4	52.0	10.9
Not residency trained	112	37.5†	8.9†	25.0†	13.4	27.7†	34.8†	42.0	16.1
South Atlantic									
Residency trained	195	16.4	4.1	5.6	0.5	10.3	9.7	5.1	1.0
Not residency trained	85	4.7†	2.4	3.5	1.2	2.4†	3.5†	3.5	2.4
East South Central									
Residency trained	151	9.9	5.3	6.6	2.0	5.3	9.9	9.9	3.3
Not residency trained	96	7.3	3.1	5.2	5.2	3.1	6.3	10.4	7.3
West South Central									
Residency trained	169	20.1	6.5	12.4	9.5	13.6	18.9	17.2	11.8
Not residency trained	103	10.7†	2.9	5.8	3.9	3.9†	10.7	26.2	13.6
Mountain									
Residency trained	216	43.1	10.2	20.4	9.3	27.8	26.4	30.1	10.6
Not residency trained	72	11.1†	5.6	6.9†	5.6	5.6†	8.3†	20.8	8.3
Pacific									
Residency trained	173	38.7	9.2	17.3	6.9	28.3	29.5	28.9	9.8
Not residency trained	109	11.0†	3.7	7.3†	7.3	9.2†	9.2†	24.8	9.2

Note: Includes only active member respondents of the American Academy of Family Physicians. Estimates were adjusted by the sampling fraction and the response percentage for each division.

*Abnormal condition usually existing prior to admission, such as hypertension, diabetes, heart disease, and pre-eclampsia.

†Statistically significant at $P=0.025$ using a standardized normal z-test for comparing proportions, a one-tailed test.

Source: American Academy of Family Physicians, Hospital Privileges Survey, May 1993.

1980 or earlier. In the 1980 study the population surveyed included only those active members previously known to be in office-based, direct patient care. All active members of the AAFP were included in the 1988 and 1993 studies regardless of practice arrangement or base. It would be anticipated that lower percentages for both hospital privileges and obstetric care would be evident in the latter two studies. As a result, although comparisons between similar statistics in the three studies could in some cases be used to indicate trends, they are not directly comparable and should be quoted with this explanation.

This study reflects the hospital practices of the target population, active members of the American Academy of Family Physicians. Because of this limitation of the study, however, there might be some question as to its representation of all family physicians.

Professional liability problems continue to plague the profession. It is unknown from this study how many academy members indicated

Table 5. Percentage of Types of Obstetric Patient Care in Hospital Practices of Family Physicians, by Census Division and Practice Location, May 1993.

Census Division	Respondents (n)	Routine Delivery	High-Risk† Delivery	Complicated Delivery	Cesarean Sections	Vaginal Birth after Cesarean Sections	Induction and Augmentation	Dilatation and Curettage	Tubal Ligation
Total									
Urban*	1,409	20.9	4.3	8.1	1.5	12.5	14.7	15.0	2.9
Rural*	705	38.6‡	14.4‡	24.5‡	12.2‡	28.1‡	33.4‡	35.1‡	15.4‡
New England									
Urban	115	20.0	3.5	3.5	0.0	12.2	10.4	2.6	0.0
Rural	92	34.8‡	3.3	7.6	0.0	18.5	23.9‡	13.0‡	0.0
Middle Atlantic									
Urban	196	10.7	1.5	2.0	0.0	3.6	4.6	2.6	1.0
Rural	37	29.7‡	0.0	5.4	0.0	10.8	8.1	10.8	0.0
East North Central									
Urban	167	29.3	5.4	10.2	1.2	16.8	20.4	18.6	0.6
Rural	60	48.3‡	23.3‡	33.3‡	6.7	40.0‡	46.7‡	48.3‡	13.3‡
West North Central									
Urban	148	50.0	14.2	25.0	1.4	33.8	43.2	35.8	3.4
Rural	135	65.2‡	23.0	45.2‡	23.0‡	51.1‡	61.5‡	61.5‡	23.7‡
South Atlantic									
Urban	164	12.2	3.0	4.3	0.0	6.7	6.1	3.0	0.0
Rural	74	12.2	2.7	4.1	1.4	6.8	8.1	6.8	4.1
East South Central									
Urban	118	5.9	1.7	2.5	0.0	3.4	5.9	4.2	0.8
Rural	102	13.7	7.8‡	10.8‡	6.9‡	5.9	12.7	18.6‡	9.8‡
West South Central									
Urban	167	10.8	1.2	4.2	2.4	4.8	10.2	13.8	7.2
Rural	65	33.8‡	18.5‡	27.7‡	24.6‡	23.1‡	33.8‡	46.2‡	33.8‡
Mountain									
Urban	133	26.3	3.8	9.0	3.0	18.0	14.3	22.6	3.8
Rural	101	42.6‡	14.9‡	24.8‡	15.8‡	26.7	31.7‡	37.6‡	18.8‡
Pacific									
Urban	201	22.4	4.5	10.0	4.0	15.4	16.4	24.4	7.0
Rural	39	56.4‡	23.1‡	41.0‡	25.6‡	51.3‡	48.7‡	46.2‡	25.6‡

Note: Includes only active member respondents of the American Academy of Family Physicians. Estimates were adjusted by the sampling fraction and the response percentage for each division.

*Respondents were asked to indicate city and county of practice. "Urban" and "Rural" were determined based upon federal definitions of counties as either metropolitan or nonmetropolitan, except in New England and other selected cities where township or city determines a metropolitan area.

†Abnormal condition usually existing prior to admission, such as hypertension, diabetes, heart disease, and pre-eclampsia.

‡Statistically significant at $P=0.025$ using a standardized normal z-test for comparing proportions, a one-tailed test.

Source: American Academy of Family Physicians, Hospital Privileges Survey, May 1993.

"not desired" when in reality they chose not to request or perform a particular hospital privilege because their liability insurance was prohibitive or because they feared liability suits.

The variation between census divisions in hospital privileges of family physicians could be attributed to differences in community size, hospital size, training, personal clinical interest of the family physician, ratios to population of the various other specialists, and local variations in expectations of practice scope of the various specialists, including family physicians. The variations among census divisions in percentages of family physicians with specific hospital privileges should be viewed in this perspective: the vast majority in each census division reported that they believed hospital privileges they were granted were appropriate.

Nevertheless, that only 1 in 4 family physicians delivers babies has important implications for the profession, its scope of practice, and its training

criteria. More importantly, there are serious implications for access to obstetric services and birth outcomes in rural areas preferentially served by family physicians.

The American Academy of Family Physicians recommends that family practice residency programs have full-time faculty with obstetric privileges who supervise residents and teach obstetrics in the residency. Through such role modeling it is hoped that more graduating family practice residents will include obstetrics in their practices. Early evidence of the validity of this hypothesis is encouraging.[17]

The percentage of women entering and graduating from family practice residency programs increases each year. The entering family practice residency class in 1993 consisted of more than one-third women. Further research could determine whether an increasing proportion of women family physicians will result in an increasing proportion of family physicians who deliver babies.

Perhaps the most dramatic prediction of the likelihood of more family physicians delivering babies lies in the growing number and percentage of practicing family physicians who are residency trained. Nearly one-third of residency-trained family physicians include routine obstetric care in their practices compared with 13.2 percent of nonresidency-trained family physicians (Table 4) and 26.1 percent of all family physicians (Table 1). Future reports can be expected to show a concomitant rise in the percentage of family physicians delivering babies. The challenge, then, is to increase the number and percentage of residency-trained family physicians delivering babies, which can be expected to help address the need for obstetric services, particularly for rural America.

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