The Declining Number of Family Physicians Practicing Obstetrics: Rural Impact, Reasons, Recommendations and Considerations

Descriptive Research

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Summary

Maternity care in the United States is in jeopardy. There is a need for physicians trained in obstetrics, including preconception, prenatal, delivery, and postpartum care. Almost 50% of counties in the United States have no obstetrical provider.[1] The importance and high quality of family medicine obstetrics has been documented repeatedly[2-7], but the number of family physicians providing maternity care in the United States continues to decline.[8-12] This is also an international trend as reported in Australia and Canada.[3,13]

Since family medicine residencies began in 1972, family physicians have been trained to provide obstetrical care, but it was not until the accreditation changes of 1995 that residencies required family practice faculty to participate in this training.[14] This requirement revealed that many faculty of the family medicine programs did not teach or believe in the reality of obstetrics by family physicians.[15] This led to a backlash from some family practice residencies who claimed hospital and community circumstances made teaching delivery skills unnecessary, unaffordable, or politically impossible. This led to a three-tiered proposal for obstetrics skills within family medicine.[16] Tier 3 came to be known as surgical family medicine obstetrics because it included cesarean section training for family physicians.[17-22]

Collectively, these skills remain vital to the health of communities here and in the developing world. More and more family physicians in the United States have stopped delivering babies in rural, underserved areas where family physicians may be the only obstetrical providers.[23-25] With the trend of increasing shortages of both obstetrician-gynecologists (OB/GYNs) and family physicians that provide maternity care, rural areas and underserved communities are at the greatest risk for losing maternity care services.[26,27] Family medicine with obstetrics has emerged as a cost effective solution offering improvements in access, cost, and quality.[2-7, 28,29] For example, in states with the lowest cesarean section rates, almost half of the family physicians deliver babies.[21]

This paper describes reasons physicians stop providing obstetrical care, and this paper makes recommendations for the growth of family medicine with obstetrics.

Background

Fewer medical school graduates are choosing primary care and family medicine, and fewer of those are practicing obstetrics when they enter practice.[8] Sometimes the decrease in family physicians providing obstetrical care may be due to a hospital closing its obstetrical services or even a hospital closing entirely.[10] A decrease in rural maternity care providers has been associated with poor perinatal outcomes.[13] As of 2012, only 10% of family physicians in this country were providing obstetrical care.[11] Family medicine is the only residency that is growing in the United States,[24] OB/GYN is not.[30]

The number of obstetrical providers in the United States continues to decline. A recent paper by Rayburn et al stated that almost 50% of counties in the United States have no obstetric provider, which affects approximately ten million women.[1] Many of these women live in rural, underserved areas where the need for providers is greatest.[1] This deficit increases the

maternal and neonatal morbidity and mortality risk.[1] There is a growing tendency for new OB/GYN residency graduates to congregate in urban areas, which contributes to this maldistribution of providers.[1]

Although there has been a decrease in OB/GYN residencies from 306 to 246 since 1993, the number of OB/GYN residency graduates has not declined. The remaining programs have grown in size to absorb trainees from programs that were closed.[30]

Fewer medical students are choosing OB/GYN as a career. Those that do choose OB/GYN as a career often choose subspecialty training, not general OB/GYN, and these graduates do not practice in rural, underserved areas.[4] There are no current plans to increase residency programs in OB/GYN.[30] The current attrition rate of retiring OB/GYN physicians approximately equals the number of new OB/GYN residency graduates.[30] When physicians stop delivering babies, they rarely return regardless of the circumstances.[9] Hospitals that stop providing obstetric services almost never resume that service. Family physicians are in a unique position allowing them to give up obstetrics and still make a living, unlike most OB/GYNs.

Why Do Family Physicians Stop Practicing Obstetrics?

There are many reasons that physicians stop providing obstetrical care. Table 1 lists some of the reasons found in the literature and others collected by one of the authors (DMA).

Legal: More physicians stop delivering babies because of malpractice litigation than any other reason.[9] The fear of litigation is a legitimate concern of any medical practitioner today; however, it haunts those who practice obstetrics. Most OB/GYN physicians in Alabama report that they have been sued at least once. Even when physicians have done their very best, bad outcomes occur. Regardless of the verdict, physicians leave the courtroom asking themselves, "Is this really worth it?"[9] It is not surprising that many obstetrical providers do not encourage their children who are training to be physicians to specialize in obstetrics. The fear of being sued is pervasive. The suggestion or verbal threat of suit, requests for medical records, subpoenas, letters from attorneys, and correspondence from malpractice carriers can be overwhelming.[9] Numerous suits or even a single exorbitant plaintiff verdict may be sufficient for a physician to quit providing obstetrical care.[9] Certainly, the current legal system has forced a disproportionate financial burden on obstetrical providers that is not commensurate with current financial reimbursement plans.

Patients: Patients themselves are a significant part of physicians stopping obstetrics. Patients make unreasonable demands and have unreasonable expectations of their physicians. They may even threaten lawsuits, transfer care to another physician, or register complaints with administration or the hospital if their demands are not met.[9] Difficult, demanding, noncompliant, or litigious patients can be trying to even the most patient, well-intentioned physicians.[9] Inadequate numbers of pregnant patients, especially funded pregnant patients, can make providing obstetrical care financially impossible and can make keeping up one's skills a difficult task.

Table 1: Reasons Family Physicians Stop Practicing Obstetrics

LEGAL	• Malpractice litigation[9] • Verbal threat of a suit[9] • Plaintiff verdict • Numerous suits[9]
PATIENTS	• Patient demands[9] • Difficult patients[9] • Patients transferring to another provider • Inadequate numbers of patients
PERSONAL HEALTH	• Physical exhaustion[9] • Impairment[9] • Debilitating illness[9]
PSYCHOLOGICAL	• Fear of being sued[9] • Fear of peer review[9] • Feeling unappreciated • Perception of not doing a good job • Intimidation by new providers[9] • Intimidation by new procedures[9]
PERSONAL LIFE	• Stresses at home[19] • Childcare issues[19] • Career change[19]
BAD OUTCOMES	• Obstetrical disasters • Fetal demise • Maternal death • Permanent birth injury
HOSPITALS	• Inability to obtain privileges • Closure of hospital[19] • Closure of obstetrical services • Lack of hospital commitment and support
GOVERNMENT REGULATIONS	• Electronic medical records • Computerized physician order entry (CPOE)[34] • Meaningful use[35] • Audits[34,35]
TECHNICAL	• High cesarean section rate • Elective inductions < 39 weeks • Not keeping up with new advances • Waning technical skills • Inability to obtain new technology • Not appreciating one's limitations

Table 1: continued.

FINANCIAL	• Unaffordable malpractice premiums[9] • Decreased reimbursement • Poor practice management • Inadequate financial planning
POLITICAL	• Pressure by OB/GYNs not to deliver[1,15,19] • Refusal of hospital to privilege family physicians • Discouragement by hospital from practicing high-risk obstetrics
EDUCATIONAL	• Insufficient breadth of exposure during training • Inadequate patient numbers during training • Inadequate patient numbers to keep skills up • Not staying current with the standard of care • Never learned ultrasound • Did not become board certified
ATTRITION	• Retirement • Stopped delivering • Moved to another care area • Career change
LACK OF PHYSICIAN SUPPORT	• Lack of new recruits[19] • Lack of call group support[19] • Lack of OB/GYN back-up and referral services • Lack of availability and support from other specialties

Personal Health: Due to increasing age, many family physicians that practice obstetrics and obstetrician-gynecologists choose to end their obstetrics careers. Physicians become physically exhausted and unable to tolerate the long hours and physical demands of staying up all night at a patient's bedside.[9] Time and effort reports at the University of Alabama indicate that some obstetricians work in excess of 120 hours per week.[9] Illness or age may preclude the practice of obstetrics. It is rare to see a physician over the age of 60 who continues to provide obstetrical care. Lack of sleep and prolonged bedside care due to worrisome fetal heart rate tracing can contribute to discouragement.[9] Discouragement and despair often lead to impairment from a variety of causes.[9] Although physicians champion good health with their patients, they seldom take good care of themselves.

Psychological: The fear of being sued is all-encompassing. A suit is a humiliating, expensive, belittling, embarrassing, psychologically draining, and demeaning experience.[9] Suits can extend over years and progress slowly. Physicians fear peer review for concern that their care may fall under scrutiny and may perceive peer review as insinuating poor care. Discouraged and tired, physicians that deliver babies often feel unappreciated for their hard work, long hours, and loss of sleep.[9] Physicians often wonder what they have done wrong when patients transfer their care to another provider.[9] Young, recently trained physicians are a threat to older physicians. The "new kid on the block" always attracts a few long-time patients who want someone new, young, or different.[9] Patient allegiance is becoming a thing of the past.[31] New procedures can be threatening and intimidating to older physicians, especially if they do not plan to learn the new procedures and patients inquire about them.[9]

Personal Life: As a solo practitioner, one of the authors (DMA) once was away from home for three continuous weeks. Absence from home leads to marital problems, childcare issues, and often results in career changes including stopping obstetric services to spend more time at home.[19] Physicians that are away from home a lot miss important parts of their children growing up, which may lead to resentment and dissatisfaction with practicing obstetrics. Family physicians are trained in many areas and, unlike many other specialties, can do well practicing other areas of family medicine. Today, it is unusual to see obstetrician-gynecologists in private practice give up obstetrics and survive on general gynecology unless they have a special niche. Looking back over their careers, physicians that practice obstetrics often regret their choice of specialty. Personal issues often lead to career changes including discontinuing obstetrics.[19] Clearly, work-life balance issues need to be a top priority for the OB/GYN profession as well as those family medicine providers that practice obstetrics.

Bad Outcomes: Bad outcomes, regardless of etiology or fault, make physicians question if it is time to stop delivering babies.[31-33] Obstetrical disasters, such as ruptured uteri, maternal strokes, and maternal deaths; neonatal disasters, such as an undeliverable shoulder dystocia leading to fetal death; permanent birth injuries, such as cerebral palsy, Erb's palsy, fractured cervical spine from a breech delivery; and fetal demise often equate with poor care, poor judgment, poor quality, and lawsuits despite the best efforts of the obstetrical provider. Bad outcomes are often the inciting stimulus to end maternity care or "hang it up." Plaintiffs' verdicts and exorbitantly large monetary awards often cause significant increases in malpractice insurance premiums that are funded by the obstetrical provider. These increases often make it financially impossible for the physician to continue providing good obstetrical care.

Hospitals: Hospitals may not grant family physicians privileges in obstetrics or may grant limited privileges without cesarean section capabilities.[15,19] There is the notion that family physicians delivering babies in rural, underserved areas may be appropriate but not so in urban areas. While it may be possible to provide prenatal care locally and then deliver elsewhere or refer patients for delivery, it is often not worth the extra work. Reimbursement for prenatal care only is compensated at reduced rates, yet requires the provider to pay the same malpractice insurance premiums. Referral sources may be hard to find. Hospital closure or discontinuation of labor and delivery services is a devastating blow to a family physician practicing obstetrics or

an obstetrician-gynecologist, usually resulting in termination of maternity care.[19] Rural hospital closure is not uncommon, especially during periods of unfavorable economic performance due to decreasing reimbursement, lack of providers, loss of malpractice coverage, poor management, poor financial performance, poor service, or lack of funded patients. When hospitals cease providing obstetrical services, they almost never reinstitute those services.

Hospitals may not be able to commit to obstetrical services or invest in advertisement, equipment, or adequate nursing staff. A lack of adequate anesthesia services makes obstetrical care impossible. If a hospital advertises obstetrical care, it must provide those services 24 hours a day. Inadequate blood bank services also limit the capability of physicians to practice obstetrics. Loss of labor and delivery services at a rural hospital can have financial implications for the hospital. Women control health care. If a woman's obstetrical care is good, she will return for subsequent pregnancies, her gynecologic care, and care for her children, spouse, and extended family. If care was not good, she may not return; neither will her family.

Government Regulations: Government regulations such as electronic medical records (EMRs), hospital computerized physician order entry (CPOE), meaningful use, Medicare Administrative Contractor (MAC) audits, and Recovery Audit Contractor (RAC) audits[34,35] are a new challenge for physicians of all specialties. EMRs have been a challenge for the majority of physicians due to cost, decreased productivity, and a slow learning curve. Many have seen the EMR as a reason to quit practicing altogether.

Technical Issues: High cesarean section rates may pose difficulties for physicians at peer review, quality improvement, and with insurance companies. Sometimes older physicians do not agree with current recommendations for management of breech presentation or vaginal birth after cesarean section. Physicians may not keep up with new advances or their hospital may not be able to afford newer technologies. With time, technical skills may wane and physicians may not appreciate their own limitations.

Financial: A major reason that family physicians stop delivering babies is the cost of malpractice insurance.[9,31,32] Obstetrics is a high-risk specialty and, even with an exemplary track record, premiums increase each year and usually plateau at year five. Plaintiff verdicts, settlements, multiple suits, and physician impairment can increase premiums. At some point physicians have to decide from a business standpoint if it is feasible to continue delivering babies.[19] While it would be helpful to provide prenatal care in rural areas, many insurance carriers charge the same rates for partial prenatal care as they do for complete obstetrical care, making such partial care impossible financially. Payer mix, lack of commercial insurance patients, lack of public assistance patients, and decreased reimbursements contribute to decreasing obstetrical care. Better health care coverage for those in rural areas has allowed that subset of patients to travel to urban areas for care. Inadequate financial planning, poor practice management, and decreased income contribute to physicians discontinuing obstetrics as well as practice.

Political: Despite the lack of obstetrical providers nationwide, almost fifty percent of obstetricians do not support the idea of family physicians practicing obstetrics.[1,15,19] Older OB/GYNs tend to support family physicians, but as they retire, who will take their place?[15] Hospitals may decide not to allow family physicians obstetrical privileges, cesarean section privileges, or the ability to care for high-risk patients. The number of family physicians delivering babies continues to drop. So, one has to ask, if we do not have enough obstetrical providers, why would obstetrician-gynecologists oppose family physicians providing obstetrical care? Is it adequacy of training? Is it bad outcomes? Most likely, it is financial. Many obstetrician-gynecologists think it is probably acceptable for family physicians to deliver babies in rural areas but not metropolitan areas.

Educational: Non-fellowship training and apprentice training may not be sufficient to practice obstetrics today. Insufficient patient numbers for training and inadequate breadth of training may not provide a physician with adequate education. Lack of continuing medical education contributes to physician inadequacy in practicing medicine, especially obstetrics. Sometimes physicians just do not "keep up." In some cases, physicians did not learn basic components of practicing obstetrics, such as ultrasonography, instrumental deliveries, or surgical techniques. Patient numbers may be inadequate to afford malpractice insurance or to keep one's skills current.

Attrition: Many family physicians who offer obstetrical care practice for a long time and often in one locale. Due to age and declining health, there comes a time to either stop obstetrics or stop practicing altogether. The challenge is that the number of graduating residents is not keeping up with the number of retiring physicians. Occasionally, physicians move to another location or may be recruited to another location since family physicians are in great demand in this country. Family physicians are trained in many areas and often make a living in multiple areas even if they no longer deliver babies.

Lack of Physician Support: Family physicians may find it difficult to find new physicians willing to practice obstetrics the way that they do. No help and no hope of help can be discouraging. Rural physicians practicing solo eventually wear out physically and mentally and feel that they can no longer practice obstetrics or even practice at all. Physicians need time off from on call, vacation time, and continuing medical education, not to mention hospitalization and surgery for themselves or immediate family members. Any time off requires call coverage, which can be difficult to obtain or unaffordable. Lack of call group support for obstetrics and loss of a partner can be major issues.[19] Lack of OB/GYN back-up and lack of an OB/GYN referral source at a larger center may discourage family physicians from practicing obstetrics, especially in a rural area.

Lack of support and availability by other specialties, such as anesthesia, general surgery, internal medicine, and pediatrics, can have limiting effects on a family physician's practice. While

graduate obstetrician-gynecologists occasionally settle in rural areas, they seldom stay there very long.[5] Most OB/GYN graduates migrate to urban areas after residency.[1] Only half of obstetrician-gynecologists believe that family physicians should deliver babies.[15] The half that do are the older physicians that are retiring.[5] Family physicians preparing for careers in rural, underserved areas that sorely need maternity care need to be able to perform cesarean sections.[36] Some rural areas may not be able to support an OB/GYN but could support two or three family physicians that provide obstetrical care.[25]

Recommendations and Considerations to Continue Practicing Obstetrics

The importance of training family physicians to provide obstetrical care has never been more important. Graduating family medicine residents often lack the experience to practice in rural areas.[18-23] There are a number of recommendations and considerations that may allow family physicians to continue practicing obstetrics.

Family Physicians Are Trained to Provide Obstetrical Care: Obstetrics is part of the family medicine residency curriculum in which residents are trained to provide obstetrical care. Family medicine residency programs have always taught obstetrics with the assumption that some graduates would include maternity care as part of their practice. There are standard, two-month rotations in OB/GYN, six-month obstetrical tracks for those interested in providing maternity care, and junior attendings that could perform cesarean sections with the presence of an attending physician.[16,25] Enhanced obstetrical tracks have been successful in providing additional training in obstetrics. Family medicine obstetrics fellowships are designed to augment the obstetrical training already acquired during residency.[17-21]

Some components of maternity care may be part of many different residencies. Transitional residents may obtain two months of OB/GYN beyond medical school and are capable of performing vaginal deliveries. Pediatrics residents are trained to resuscitate and care for newborns. Some general surgery residents learn to perform cesarean sections. Emergency medicine residents learn how to perform spontaneous vaginal deliveries and resuscitate and immediately care for newborns. Most anesthesiology residents can intubate and resuscitate newborns. Certified OB/GYN nurse practitioners can manage prenatal care. Certified nurse-midwives can provide prenatal care and perform vaginal deliveries but cannot perform cesarean sections. Even plastic surgery fellows can perform a seven-layer closure of an episiotomy.

Only obstetrician-gynecologists and family physicians are trained to perform the full spectrum of obstetrical care including prenatal care, labor, vaginal delivery, cesarean section, resuscitation of the newborn, and postpartum care. The scope of practice of a family physician is much broader than an OB/GYN and includes newborn care.[24,25] OB/GYNs only go in the nursery to visit newborns they have delivered or to perform a circumcision, and even that is decreasing.

Legal: Family physicians are almost never sued. They are at the opposite end of the spectrum of malpractice risk from OB/GYNs.[24] Obstetrician-gynecologists are in the highest malpractice risk category in most states. Family physicians often take care of the entire family in a long-term relationship. There is a stigma associated with suing a family doctor in a rural area; the fear is the doctor will leave and no other physician will be attracted to the area.[24]

Patients: All physicians have patients that are demanding and difficult to deal with. Sometimes it may even be necessary to terminate the physician-patient relationship. Early in the relationship, it is worthwhile to discuss patient expectations and realities, such as after-hours access, on call arrangements, and who may deliver their baby. Sorting this out at the first prenatal visit usually works out better than at the 39th week of gestation. Patients transfer to other providers for many reasons. If these transfers are excessive, it may be necessary for physicians to examine their mode of practice, office staff, telephone access, and even the hospital. A physician needs sufficient numbers to afford to practice obstetrics.

Personal Health: Maintaining adequate health and reasonable work hours is essential to practicing medicine in general and, certainly, obstetrics. Reasonable work hours, call coverage, and time off allow physicians to maintain work-life balance. A community may be able to support two or three family physicians while it could support only a single OB/GYN with no call coverage.[24] Two or three family physicians in a rural area can have a much better quality of life than a single provider, such as an OB/GYN. Physical exhaustion can lead to physician impairment. Collaborative arrangements for call relief, call coverage, vacation, illness, and continuing education can be lifesaving.

Psychological: The fear of lawsuits is real; however, the odds of a family physician being sued are much lower than an OB/GYN. Peer review and quality improvement are an integral part of medicine today and are here to stay. Collaboration with these groups will improve patient care and one's practice in the long run. Mentoring new colleagues and, at the same time, learning new ideas and new techniques from them can be good for all concerned, including patients. There will always be a few patients that want to see the "new kid on the block." Physicians should be open to lifelong learning and be willing to accept the fact that they may be at a disadvantage if there is something new that patients want or becomes the standard of care and they have not learned it. Feeling unappreciated or inadequate may be the result of exhaustion. While obstetrics can be stressful, it also has one of the highest levels of personal satisfaction in medicine due to bringing a new life into the world. Most family physicians that have embarked on training and practicing obstetrics have great personal satisfaction from delivering babies.

Personal Life: Stressors at home are usually the result of not being at home. Arrangements for time off, continuing education, vacation, and professional counseling may help the situation at home. Collaborative agreements can also be helpful to a single provider. Such agreements can provide an avenue for

Table 2: Recommendations & Considerations to Keep Family Physicians Delivering Babies

LEGAL	• Family physicians are almost never sued[26] • Family physician malpractice rates cost less than rates for OB/GYNs[26] • It makes good legal and financial sense to practice obstetrics
PATIENTS	• Clear practice policy for call, after-hours calls, prescriptions, etc. • Clear understanding of practice and call at initial visit • May need to evaluate self, office staff, etc.
PERSONAL HEALTH	• Maintaining adequate work hours, call, off hours • Collaborative arrangements for call, backup, transfer and referral[24] • Maintaining personal health • Practice partners
PSYCHO-LOGICAL	• Numerical odds of a suit are very low • Personal relationship with patient is everything • Involve self with peer review and quality assurance programs • Continue life-long learning • Mentor new physicians and learn from them • Obstetrics has one of the highest personal values of care
PERSONAL LIFE	• On call, vacation, and illness support is essential • Collaborative arrangements for call, backup, transfer, and referral • Professional counseling may be useful • Obstetrics has one of the highest personal values of care
BAD OUTCOMES	• Personal relationship with patient is essential • Family physicians are almost never sued • Obstetrics has one of the highest personal values of care
HOSPITALS	• Obtain full obstetrics privileges including cesarean section • Resolution of privileges before contracts, moving, etc. • Contract needs to include support services like anesthesia • Clear lines of communication between hospital and physicians
GOVERNMENT REGULATIONS	• Meaningful use money to help defray EMR costs • Hospital programs to teach CPOE • MAC and RAC audits are in the hospital arena but coming to physicians • Accurate billing, records, and coding are essential
TECHNICAL	• Know your own abilities and limitations • Experience has great worth with patients • Be involved with life-long learning • Continuing education is essential to staying current • Learn newer techniques or refer to those that do newer techniques • Make patient care the highest priority
FINANCIAL	• Malpractice rates for family medicine are a fraction of that for OB/GYN • Family physicians are rarely sued • Many states have reduced state income taxes for rural physicians • Many states have higher reimbursement for rural obstetric care • Medical scholarship programs forgive indebtedness for rural service
POLITICAL	• Adequate training, possibly obstetrics fellowship training, is important • Clear understanding of level of care to be provided is important • Collaborative agreements
EDUCATIONAL	• Adequate training and maybe obstetrics fellowship training • Board certification, recertification and maintenance certification • Requirement for annual continuing education[37] • Online educational programs
ATTRITION	• Encouragement of medical students to pursue family medicine • Encouragement of family medicine residents to practice obstetrics • Support of programs attracting physicians to rural areas
LACK OF PHYSICIAN SUPPORT	• Community can support 2 or 3 family physicians instead of 1 OB/GYN[24] • Collaborative agreements • Physician re-entry programs[37-39]

referrals and transfers for patients; coverage for time off, vacation, CME, and illness; or even relief from a large volume of patients. As stated above, obstetrics does have one of the highest levels of personal satisfaction.

Bad Outcomes: Bad outcomes do occur even with the best of care in all specialties of medicine. Obstetrics is often highlighted because of a young mother or newborn baby in contrast to an elderly sick patient whose demise is expected. From a practical standpoint, family physicians are rarely sued because of their long-term relationships with patients and families.

Hospitals: Hospital privileges, including cesarean section capability, must be resolved early in any agreement. Family physicians often have difficulty obtaining cesarean section privileges, and the ability to perform a cesarean section is essential to practicing modern day obstetrics. This should be resolved before a physician signs a contract and moves to a certain area. Commensurate with privileges is adequate hospital support with anesthesia services, nursing, blood bank, laboratory, etc. Call coverage and physician backup is also important. Even when all these issues have been resolved, hospitals still close obstetrical services, usually for financial reasons, or even close entirely. Everyone involved is affected when hospitals close: patients, physicians, employees, and the entire community. Clear lines of communication between hospital administration and physicians are essential.

Government Regulations: Government programs, most of which are mandatory, are here to stay. Electronic medical records are not just a good idea, they are mandatory. There is meaningful use money available to help defray some of the cost of EMRs. Most hospitals have educational programs to teach CPOE to physicians, since hospitals stand to benefit the most from them. MAC and RAC audits are also here to stay. While hospitals are dealing with both now, these audits are coming to physicians' offices in the near future. Accurate billing, records, and coding are essential to defend a physician's work.

Technical: Most technical issues fall into two areas: keeping up one's skills and having the ability to learn new ones. Physicians should know their own abilities and limitations and make patient care the highest priority. Continuing education and sufficient patient numbers are important in keeping current skills sharp. To stay current, physicians must be willing to learn new techniques and adjust to the current standard of care. Experience has great worth with patients. Physicians should appreciate that small hospitals may not be able to provide all technological advances. If a physician cannot learn a newer technique, the physician should develop a referral plan to those who can offer the service.

Financial: In many states, the cost of malpractice insurance for family physicians practicing obstetrics is significantly less of what OB/GYN physicians pay. Whereas a small community may not financially support an OB/GYN, it can support two or three family physicians that also practice obstetrics. It makes good business sense for family physicians to practice obstetrics. Malpractice costs less. Reimbursement is greater. Overhead is significantly less. The addition of obstetrics to a family medicine practice usually includes only the costs of malpractice insurance and perhaps an ultrasound machine.[24] In Alabama, there is a credit available that may reduce state income taxes for a physician practicing in a rural area. Some public assistance programs also reimburse physicians in rural areas at higher rates for prenatal care and delivery. Many medical scholarship programs forgive indebtedness associated with a doctor who practices in a rural, underserved area.

Political: Many OB/GYNs feel that it is acceptable for family physicians to deliver babies in rural areas but not in urban areas. Most of the threat felt by OB/GYNs may be financial. Hospitals may not be able to support labor and delivery units or the cost of high-risk obstetrics. Clear understanding and agreement between physicians, nurses, and administration on which patients the hospital can care for and which patients need to be transferred is essential. Collaborative agreements for referral and transfer can help. Adequate training and probably obstetrical fellowship training is important for obtaining privileges.

Educational: Adequate family medicine training and probably obstetrical fellowship training will be important in the future. Board certification, recertification, and maintenance of certification are also important in most hospitals. Many recertification programs can be completed online. Most states require annual continuing medical education to maintain privileges. Many states, including Alabama, have annual educational programs covering new and cutting edge information in obstetrics.[37] There are many online educational programs available as well.

Attrition: Growing older, giving up practice including obstetrics, and retiring is inevitable. Medical students who are interested in family medicine and possibly obstetrics need to be encouraged. It is essential to continue to recruit both family physicians and obstetrician-gynecologists to practice obstetrics. OB/GYNs and family physicians will have to work together to address the shortage of obstetrical providers.

Lack of Physician Support: A community may be able to support two or three family physicians while it could only support a single OB/GYN with no call coverage.[24] While OB/GYN physicians do occasionally go to rural, underserved areas, they rarely stay there very long.[19] A family physician in a rural area provides many services including newborn care and care for the rest of the family.[24] Two or three family physicians in a rural area can have a much better quality of life than a single provider. Family physicians often practice in rural areas.[26] When call coverage is not available, collaborative arrangements can be made for transfers or practice coverage with general surgeons, experienced labor and delivery nurses, anesthesiologists, Certified Registered Nurse Anesthetists (CRNAs), gynecologists that have practiced obstetrics, paramedics, scrub technicians, and other medical specialists. Family medicine obstetrics blends these with the additional dimension of family support such as grandmothers.

Physician re-entry into the workforce is a major emphasis of the American Congress of Obstetricians and Gynecologists.[37-39]

There is limited data on physician re-entry into clinical practice, but OB/GYN physicians occasionally leave the practice of medicine for retraining, continuation, military service, and personal reasons which may also be applicable to family physicians.[39] Availability of part-time work allows time for family needs. Since most OB/GYN residents today are women, the availability of part time work provides a new opportunity for those who wish to re-enter practice.[39] With the declining number of physicians that provide obstetrical care in this country, any provider who wishes to re-enter practice and is willing to participate in the re-entry process is needed. The same would be applicable for family physicians that practice obstetrics. OB/GYNs and family physicians practicing obstetrics and working together is the only answer to addressing the shortage of obstetrics providers in this country.

Discussion

There are many reasons that family physicians stop practicing obstetrics. Obstetrician-gynecologists occasionally stop delivering babies and attempt to make a living only practicing gynecology, usually unsuccessfully. Unless an OB/GYN has a special niche, practicing gynecology only is a difficult task. This is not the case with family medicine. Most family physicians can practice in many areas successfully without practicing obstetrics. Family physicians are often the only obstetrics providers in rural, underserved areas. Table 2 provides recommendations for support of family medicine with obstetrics.

Graduating OB/GYN residents typically settle in urban areas. If they go to rural areas, they seldom stay there very long. There is not a shortage of OB/GYNs but only a maldistribution of them. The only group of obstetrical care providers that is growing is family physicians fellowship trained in obstetrics.[17-21,36] OB/GYNs and family physicians practicing obstetrics should work together to address the shortage of obstetrical providers in this country. Family medicine physicians trained in obstetrical and newborn care is the answer to reducing maternal and perinatal morbidity and mortality in rural, underserved areas.

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References

1. Rayburn WF, Klagholz JC, Murray-Krezan C, Dowell LE, Strunk AL. Distribution of American Congress of Obstetrician and Gynecologists fellows and junior fellows in practice in the United States. *Obstet Gynecol.* 2012;119(5):1017-22.
2. Allen W. Obstetric care in a rural family practice. *J Am Bd Fam Pract.* 1989;2(1):30-3.
3. Reid AJ, Carroll JC, Ruderman J, Murray MA. Differences in intrapartum obstetric care provided to women at low risk by family physicians and obstetricians. *CMAJ.* 1989;140(6):625-33.
4. Rosenthal TC, Holden DM, Woodward W. Primary care obstetrics in rural western New York. A multi-center case review. *N Y State J Med.* 1990;90(11):537-40.
5. ME, Sills D, Connor PD. Perinatal outcomes: a comparison between family physicians and obstetricians. *J Am Board Fam Pract.* 1995;8(6):440-7.
6. Barclay AM, Knapp DP, Kallali KJ. The provision of delivery services by graduates of four Kansas family practice residencies. *Kans Med.* 1996;97(1):19-23.
7. Bowman RC. Continuing family medicine's unique contribution to rural care. *Am Fam Physician.* 1996;54(2):471-4, 479, 483.
8. Loafman M, Nanda S. Who Will Deliver Our Babies? Crisis in the Workforce. *Am J Clin Med.* 2009;6(2):11-6.
9. Avery DM, Avery KT. Why do physicians stop practicing obstetrics? *Medicolegal OB/GYN Newsletter.* 2006.
10. Cohen D, Coco A. Declining trends in the provision of prenatal care visits by family physicians. *Ann Fam Med.* 2009;7(2):128-33.
11. Tong ST, Makaroff LA, Xierali IM, et al. Proportion of family physicians providing maternity care continues to decline. *J Am Board Fam Med.* 2012;25(3):270-1.
12. Blanchette H. The impending crisis in the decline of family physicians providing maternity care. *J Am Board Fam Med.* 2012;25(3):272-3.
13. Loy CS, Warton RB, Dunbar JA. Workforce trends in specialist and GP obstetric practice in Victoria.*Med J of Aust.* 2007;186(1):26-30.
14. Rodney WM. Obstetrics in family practice. *J Am Board Fam Pract.* 2002;15(3):255-6.
15. Topping DB, Hueston WJ, MacGilvray P. Family physicians delivering babies: what do obstetricians think? *Fam Med.* 2003;25(10):737-41.
16. Coonrod A, Kelly BF, Ellert W, Loeliger SF, Rodney WM, Deutchman M. Tiered maternity care training in family medicine. *Fam Med.* 2011; 43(9):631-7.
17. Peterson LE, Blackburn B, Phillips RL, Puffer JC. Structure and characteristics of family medicine maternity care fellowships. *Fam Med.* 2014;46(5):354-9.
18. Norris TE, Acosta DA. A fellowship in rural medicine: program development and outcomes. *Fam Med.* 1997;29(6):414-20.
19. Rodney WM, Martinez C, Collins M, Laurence G, Pean C, Stallings J. OB fellowship outcomes 1992-2010: where do they go, who stops delivering, and why? *Fam Med.* 2010;42(10):712-6.
20. Eidson-Ton WS, Nuovo J, Solis B, Ewing K, Diaz H, Smith LH. An enhanced obstetrics track for a family practice residency program: results from the first 6 years. *J Am Bd Fam Pract.* 2005;18(3):223-8.
21. Chang PC, Leeman L, Wilkinson J. Family medicine obstetrics fellowship graduates: training and post-fellowship experience. *Fam Med.* 2008;40(5):326-30.
22. Bowman RC: Rural practice and obstetrics fellowships for family physicians [Letter to the Editor reply]. *Am Fam Physician.* 1997;55(8):2603-4.
23. Acosta DA. Impact of rural training on physician workforce: the role of postresidency education. *J Rural Health.* 2000;16(3):254-61.

24. Avery DM. Why family physicians should practice obstetrics. *Am J Clin Med.* 2008;5(1):32-4.
25. Rodney WM, Crown LA, Hahn R, Martin J. Enhancing the family medicine curriculum in deliveries and emergency medicine as a way of developing a rural teaching site. *Fam Med.* 1998;30(10):712-9.
26. Hueston WJ. Specialty differences in primary cesarean section rates in a rural hospital. *Fam Pract Res J.* 1992;12(3):245-53.
27. Norris TE, Pirani MJ, Reese JW, Rosenblatt RA. Are rural family physicians comfortable performing cesarean sections? *J Fam Pract.* 1996;43(5):455-60.
28. Hueston WJ, Lewis-stevenson S. Provider distribution and variations in statewide cesarean section rates. *J Community Health.* 2001;26(1):1-10.
29. Hueston WJ. Site-to-site variation in the factors affecting cesarean section rates. *Arch Fam Med.* 1995;4:346-51.
30. Fisher TK. Maternity Care Work Force Analysis. CPM Symposium. March 18, 2012. Adapted from Rayburn WF. The Obstetrician-Gynecologist Workforce in the United States: Facts and Implications. 2011.
31. Larimore WL, Sapolsky BS. Maternity care in family medicine: economics and malpractice. *J Fam Prac.* 1995;40(2):153-60.
32. Norris TE. Family practice OB: to be or not to be? Liability is the question. *J Am Board Fam Pract.* 2003;16(6):565-6.
33. Nicholson JM. Risk adjustment in maternity care: the use of indirect standardization. *Int J Women's Health.* 2010;2:255-62.
34. Compliance 360 Claims Audit Manager for CMS Medicare RAC Audits. Managing RAC, MAC and other Medical Claims Audits. Compliance 360 Website. http://www.compliance360.com/RAC/
35. CMS Announces New Recovery Audit Contractor Program to identify improper Medicare payments. Centers for Medicare & Medicaid Services Web site. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2008-Fact-Sheets-Items/2008-10-06.html.
36. Avery DM. A new certification for FPs. *J Fam Pract.* 2011; 60(3):E1-3.
37. Cass I, Gordon LA, Kilpatrick S. Lessons learned in physician reentry. *Obstet Gynecol.* 2012;120(2 Pt 1):360-4.
38. Martin JN, Scarrow PK. Reentering obstetrics and gynecology. *Obstet Gynecol.* 2012;120(2 Pt 1):217-8.
39. Manriquez M, Cookingham LM, Coonrod DV. Reentry into clinical practice in obstetrics and gynecology. *Obstet Gynecol.* 2012;120(2 Pt 1):364-9.