Access to Obstetric Care: A Growing Crisis

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Several months ago, I became a grandfather; both mother and infant continue to do well. Both she and I had taken it for granted that prenatal care would be easily available; that delivery facilities would be readily accessible, comfortable, and convenient; that her professional care would be caring and competent; and that her health insurance would cover the majority of the costs involved.

Fortunately for all of the family, those expectations proved accurate. In contrast, as reported by Onion and Mockapetris in this issue of The Journal,[1] such fulfillment is hardly uniform, either in the state of Maine or elsewhere across the nation. A "crisis" of availability of obstetric services is emerging across the 50 states. As reported by the National Commission to Prevent Infant Mortality (chaired by US Senator Lawton Chiles), both family physicians and obstetricians are withdrawing from the field. Senator Chiles cites studies by the American Academy of Family Physicians that 23.3 percent of its members had stopped delivering babies in 1986 because of the malpractice situation.[2] At the same time, the American College of Obstetricians and Gynecologists (ACOG) reported that 12.3 percent of its members had also stopped delivering babies in 1985—an increase from 9 percent in 1983; that figure was recently updated at 12.4 percent more withdrawals for 1987.[3] If such a dropout rate were maintained for a decade, the entire membership would cease and desist obstetrical practice!

It seems that such stoppage of obstetrical services by the medical profession must be seen as the primary issue for concern. That issue must then be subdivided, as it affects the two medical disciplines involved. The implications for each are as significant as any that have occurred this century; the issue threatens the future of both obstetricians and family physicians. Along those lines Rosenblatt[4] recently emphasized the metamorphosis of obstetric services as provided by family physicians over the past generation—with only 25 percent of family physicians in California continuing to do obstetrics, and big dropouts are being reported in Georgia, Arizona, Washington and, most recently, in Ohio, where participation was down to 21 percent in 1987 and predicted to fall to 16 percent by 1989! Rosenblatt sees an opportunity for family physicians to be more actively involved in the care of normal pregnancies, perhaps in consort with well-trained midwives, leaving all others to obstetricians in the referral centers. Admitting that such an approach fits the category of "radical and unrealistic," he then stresses that the current scene is simply not viable—that something must be done. The question, of course, is what?

As a representative of the American Academy of Pediatrics, I recently joined with Dr. Elsie Korman, who represented the American Academy of Family Physicians, at a meeting with the American College of Obstetricians and Gynecologists' (ACOG) Committee on Professional Liability as it also continues to search for solutions to the malpractice problem. That college has demonstrated remarkable perspicacity over the past several years in creating and staffing a separate department in its Washington office to gather information from a wide range of sources across the country. It has been involved in the analysis of these data, the development of hypotheses about causes and possible solutions of the identified problems, and the implementation of strategies to bring about change. One of ACOG's actions bears mention here.

No malpractice suit can exist in the absence of expert witness testimony. A review of past cases clearly demonstrates that such testimony often represented opinions that were 17 or more standard deviations from the norm of professional practice. Ignoring the reassuring claims of the defense bar that their members can consistently destroy the credibility of such testimony, ACOG developed and then adopted principles of performance to which it expected its members to adhere—whether they testified for the plaintiff or the defense. These principles also call for all members to be willing to submit copies of depositions or testimony for peer review, with the goal in mind that the resultant findings might go a long way to inform professional colleagues about who has a tendency to exaggerate, and to inform younger physicians about appropriate standards for testifying with actual case reports of what really has been said. Furthermore, ACOG hopes to

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document what change, if any, transpires as a consequence—ie, it proposes to find out whether such actions prove beneficial. The time is certainly ripe for such action what with one professor of obstetrics having recently been indicted for perjury in a Dalkon shield suit and a former professor of pediatrics being found by a reviewing court so afflicted with lying that the court declared a Bendectin case a mistrial.[5,6]

Anyone who has been involved with the malpractice field cannot help but be aware that over the years much untested dogma has dominated the belief systems of "obstetric territory." Far too many experienced experts seem totally confident that they, and only they, know just what should be done to address any given problem. Take, for example, the uncertainty factor underlying the current indications for cesarean section in one's own institution; do those indications really have a tested scientific base, or are the good guesses about what might be helpful driven all too often by the "Don't just stand there, do something" mentality? Consider the wisdom involved in a recent case in which a postpartum patient suspected of having reactivated her pelvic inflammatory disease received five different antibiotics in the name of medical science over less than 48 hours, all on an outpatient basis and all in the absence of any positive cultures or any laboratory evidence of inflammation. Reflect on the pleas for re-reanalysis of the so-called causes of cerebral palsy with the strong suggestion that prenatal rather than natal factors are primary, without any mention that such speculation might have just a touch of conflict of interest built in.

These kinds of nonsense can no longer be paraded in the medical corridors as responsible professional behavior. Moreover, failure to chase such magical methods can no longer be cited as negligence. It is time to learn a lesson from our colleagues in anesthesiology. After objectively analyzing why they had been sued, they agreed that, henceforth, leaving the operating room with the patient under general anesthesia constituted indefensible behavior and that it could no longer be tolerated. Up until that time, coffee and a few quick puffs were taken for granted in far too many institutions. Today, a far more rational standard of behavior is delineated for one and all. Such action does not promise perfection, but it certainly demonstrates one approach to careful clinical care. Is it not time to take a comparable approach to the field of obstetrics—agreeing in advance that certain practices are deemed as reasonable, with others being optional at best, and that practitioners should be held to adhering to the reasonable standard, no more, no less?

This concept is catching hold in the field of immunization. If specific items are mentioned for a proper consent, and if the needle is inserted in a reasonable fashion, then the practitioner is to be considered as abiding by the standard of care and protected against allegations of negligence. In actuality, runaway professional expectations may be even more significant than bloated public expectations, and such are recognizable in the mouthings of some expert witnesses.

Such an approach makes far more sense than do some others that have already been implemented in one or more states. For example, some legislators have adopted recommendations that they reactivate the concept of "sovereign immunity," making the delivering physician an agent of the state and thus totally sheltered from suit. Without some additional blanket compensation mechanism, the patient can only lose under such arrangements. Simply put, this solution is not fair, and it serves to fuel the medical liability fight while offering only a short-term solution at best. Others are contemplating variations on that theme, including establishing compensation funds that have narrow avenues of access, aimed at protecting one small segment of those at risk but appearing to do a lot more. Again, this approach would work for the short term and be bound to disappoint many; furthermore, it reminds us that today's problems are all too often yesterday's solutions.

One final comment: Onion and Mockapetris seem to imply active discrimination against family physicians and hint that obstetricians-gynecologists may be responsible. History would certainly suggest such an inference—shades of the "cognitive vs procedural" argument going on as Harvard's group wrestles with a new "relative value scale." Just as both the cognitive and noncognitive groups are likely to be involved in a lose-lose outcome, interspecialty battles in the obstetric arena are, in my opinion, bound to be equally nonrewarding. Rather, as perhaps never before, the two specialties ought to seek some common remedies and involve pediatrics so that its practitioners will refrain from compounding this already complex arena. In the absence of such professional efforts, we can count on government to feel compelled to intervene, with the likelihood that only more unnecessary paper work will supervene.

References

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