Withdrawal from Maternity Care

A Comparison of Family Physicians in Ontario, Canada, and the United States

Jerry Kruse, MD, MSPH, Debra Phillips, MD, and Robert M. Wesley, MA
Quincy and Springfield, Illinois

To determine the relative importance of factors influencing the withdrawal of family physicians from maternity care, two studies, one done in Ontario, Canada, and the other done in the United States, were compared. The proportion of residency-trained family physicians who provide maternity care at the initiation of their careers and the proportion who have given up maternity care are nearly identical in the United States and Canada. Both studies found that about one half of the family physicians who currently provide maternity care were giving consideration to stopping. The reasons underlying this withdrawal were multifactorial. Malpractice issues were the predominant concern of United States family physicians, but the data from the studies indicate that other issues, such as interference with lifestyle and office practice and the effect of attitudes of obstetricians, should not be overlooked. **J FAM PRACT 1990; 30: 336-341**

Family physicians in North America are withdrawing from maternity care at an alarmingly rapid rate.[1–10] Some of the factors that influence this withdrawal include rising malpractice insurance premiums, fear of malpractice lawsuit, interference of intrapartum obstetric care with office hours and lifestyle, rapid technologic changes in modern obstetrics, and negative attitudes of some obstetricians toward family physicians who deliver babies.[1–10] The relative importance of the various factors is not well understood.

Withdrawal from maternity care by family physicians is occurring in both the United States and Canada. The health care delivery systems in these two countries differ in several important ways. A comparison of recent changes in obstetric practice and the reasons underlying these changes in these two countries may, therefore, aid in understanding and overcoming factors that hinder maternity care by family physicians.

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From the Quincy Family Practice Program, Quincy, and the Department of Family Practice, Southern Illinois University School of Medicine, Springfield, Illinois. A portion of this paper was presented at the North-Central Regional Meeting of the Society of Teachers of Family Medicine, Springfield, Illinois, October 23, 1988. Requests for reprints should be addressed to Jerry Kruse, MD, MSPH, Quincy Family Practice Center, 1246 Broadway, Quincy, IL 62301.

This report is a comparison of two studies, one from the United States and one from Ontario, Canada, that describe factors influencing maternity care by family physicians.

METHODS

Two studies of the factors that influence maternity care by family physicians were compared.[1,2] Mailed questionnaires were used to survey family physicians in both studies.

The Canadian Study

In 1986, 1802 randomly selected family physicians and general practitioners who resided in Ontario were surveyed.[1] The sample included both physicians who were members of the College of Family Physicians of Canada and those who were not. The number of respondents after follow-up mailings was 1338, a response rate of 74%. Four hundred fifty-one (34%) of the respondents had been residency trained. Six hundred fifty-three (49%) had been born in 1946 or later. Various demographic and educational data were gathered. The physicians recorded

the details of their practice of obstetrics. Family physicians who had never practiced obstetrics, those who had discontinued obstetric practice, and those who were considering discontinuing obstetric practice were asked to record the reasons that may have influenced them to stop or consider stopping obstetric practice. The physicians were provided a list of reasons and asked the following question: "Please indicate (by checking) which of the following reasons have affected your consideration of stopping or your having stopped obstetrical practice?"

The United States Study

In 1987, a randomly selected national sample of 505 residency-trained family physicians was surveyed.[2] All of the physicians were members of the American Academy of Family Physicians. The response rate after three mailings was 67%. As in the Canadian study, demographic and educational data were gathered, and the details of past and present obstetric practice were recorded by each physician. In the United States study, the physicians who had never practiced obstetrics, those who had discontinued obstetric practice, and those who were considering discontinuing obstetric practice were asked to rate the importance of 10 factors that may have influenced them to stop or consider stopping the obstetric portion of their practice. The physicians rated the importance of each factor on a six-point Likert scale, with 1 indicating that the factor was not at all important and 6 indicating that the factor was very important. To facilitate comparison with the Canadian study, the factors marked 5 or 6 by the United States physicians were considered "important" factors.

There was a slight variation in wording for some of the factors in these two studies, but the meanings of the questions were equivalent in all instances. Throughout the remainder of the article and in all tables, the wording from the United States study will be used.

Obstetric practice patterns and factors influencing the decision to discontinue or to consider discontinuing obstetric practice were compared for the two groups.

RESULTS

The demographic and practice characteristics of the respondents of the two groups are shown in Table 1. Since only residency-trained family physicians were included in the United States sample, a much larger proportion were born in 1946 or later. Also, a larger proportion of the Canadian family physicians practiced in larger cities than did the United States physicians.

A comparison of the status of obstetric practice by family physicians in the two countries is shown in Table 2. In this table, the data for nonresidency-trained Canadian family physicians have been separated from that of residency-trained family physicians. The comparison of residency-trained Canadian family physicians and residency-trained US family physicians shows very similar proportions in each of the categories of obstetric practice for the two groups. For each group, similar percentages have never practiced obstetrics (37% for Canadian family physicians vs 35% for US family physicians, *P* not significant), have initially practiced obstetrics, then stopped (20% vs 20%, *P* not significant), currently practice obstetrics and giving consideration to stopping (25% vs 21%, *P*

TABLE 1. COMPARISON OF DEMOGRAPHIC AND PRACTICE CHARACTERISTICS (PERCENT)

Characteristics	Ontario Family Physicians	United States Family Physicians
Residency trained	34	100
Born in 1946 or later	50	92
Sex (male)	80	83
Population of community of practice		
<10,000	17	31*
10,000 to 100,000	36	43†
>100,000	45	26

*Community of practice <15,000.
†Community of practice 15,000 to 100,000.*

TABLE 2. COMPARISON OF OBSTETRIC PRACTICE BY FAMILY PHYSICIANS

Status of Obstetric Practice	Ontario, Canada (1986)		United States (1987)
	Not Residency Trained (N = 887) No. (%)	Residency Trained (N = 451) No. (%)	Residency Trained (N = 329) No. (%)
Never practiced obstetrics	221 (25)	167 (37)	115 (35)
Practiced obstetrics initially, then stopped	285 (32)	90 (20)	67 (20)
Currently practice obstetrics, giving consideration to stopping	199 (22)	113 (25)	70 (21)
Currently practice obstetrics, have not considered stopping	182 (20)	81 (18)	77 (23)

TABLE 3. FACTORS INFLUENCING FAMILY PHYSICIANS' DECISION NOT TO PRACTICE OBSTETRICS OR TO CONSIDER DISCONTINUATION OF OBSTETRIC PRACTICE

	Percent Citing Factor Important*	
	Ontario, Canada (1986)	United States (1987)
Factor	Born in 1946 or Later (N = 274)	Residency Trained (N = 256)
Malpractice insurance premiums	52	73
Fear of litigation	37	53
Interferes with lifestyle	88	57
Interferes with office practice	55	38
Low financial incentive	53	22
Insufficient number of deliveries	35	20
Inadequate training	22	13
Difficulty with obstetrician attitudes	8	20

**For US physicians, those marking 5 or 6 on the six-point Likert scale. For Canadian physicians, those checking factor important.*

not significant), and currently practice obstetrics and have not considered stopping (18% vs 23%, *P* not significant). Both the US and Canadian studies found that roughly one half of physicians currently practicing obstetrics are considering giving up the obstetric portion of their practice.

A comparison of the relative importance of the various factors that may have influenced family physicians against practicing obstetrics was made. Separate data were not available for residency-trained Canadian family physicians. To facilitate comparison of the two studies, the responses of groups of similar age from each study were examined. As shown in Table 3, the groups compared were Canadian family physicians born in 1946 or later and residency-trained US family physicians.

Important differences were noted between these two groups. US family physicians placed more importance on malpractice issues as a reason to discontinue obstetric practice than did their Canadian counterparts. The percentage of physicians citing malpractice premiums and fear of litigation as important was about 20% higher in the US group.

The Canadian family physicians, on the other hand, were significantly more likely to cite interference with personal and family life and interference with office schedules as important. The percentage of Canadian family physicians citing these two factors as important was about 20% higher than that of the US family physicians.

The Canadian family physicians identified the low financial incentive to offer obstetric services as an important reason to shun obstetric practice more frequently than did the US family physicians (53% vs 22%). The US family physicians were far more likely to cite difficulties with obstetricians as a hindrance to their obstetric practice (20% vs 8%).

DISCUSSION

This report compares the factors influencing withdrawal from maternity care for samples of physicians from Ontario, Canada, and the United States. Major differences exist in the health care systems and the distribution of physicians in the US and Canada. These differences may have a significant influence on the delivery of maternity care by family physicians in the US and Canada.

The Distribution of Physicians

Since 1972, Canadian citizens have been covered by a comprehensive national health plan that pays for physician services, hospitalization, and other related services. The socialized nature of medicine in Canada has resulted in more regulation of medical practice and training. Governmental action in Canada can influence the number of physicians in various specialties and the distribution of physicians to a much greater degree than is possible in the US.

The distribution of physicians is also influenced to a great degree by geographic factors. Vast areas of Canada are sparsely populated, and the need to provide medical services in these areas has influenced the development of a system in which a relatively greater number of family physicians and general practitioners are trained. This greater emphasis upon the generalist, though more pronounced in the sparsely populated provinces, extends to Canadian provinces such as Ontario and Quebec, where the urban-rural population distribution is quite similar to that of the United States.

The distribution of physicians who provide maternity care is shown in Table 4. In this table the higher obstetrician to population ratio in the United States can be clearly seen. Even the most sparsely populated region of the United States, the Plains-Mountains Region, has an obstetrician density of almost twice that of Ontario and Quebec, the two Canadian provinces that boast the highest density of obstetricians.

Relative to the number of obstetricians, there are fewer family physicians in the United States than in Canada. Estimates from the American Academy of Family Physicians and the American College of Obstetricians and Gynecologists indicate that there are now approximately 60,000 family physicians and general practitioners, and 30,000 obstetricians practicing in the United States, a ratio

TABLE 4. DISTRIBUTION OF PHYSICIANS PROVIDING MATERNITY CARE IN CANADA AND THE UNITED STATES

Location	Percent of Maternity Care Rendered by Family Physicians and General Practitioners	Number of Obstetricians per 100,000 Population
Canada	51*	5.7*
Ontario and Quebec	41	6.3
All other provinces	69	4.7
United States	25†	11.9‡
East	—	14.9
South	—	11.0
Midwest	—	10.5
Plains/Mountains	—	10.0
West Coast	—	13.2

*Based on data from Klein et al.[9]
†Data from the National Ambulatory Medical Survey,[11] gathered in 1978 and 1979. It is widely thought that this proportion is lower now.
‡Calculated from 1985 United States Census Estimates and 1985 American College of Obstetricians and Gynecologists membership lists.

of family physicians to obstetricians of 2 to 1. Data from the 1985 College of Physicians and Surgeons of Canada Statistical Report and estimates from the College of Family Physicians of Canada reveal that the family physician-to-obstetrician ratio in Ontario is over 10 to 1. (Approximately 7000 family physicians and general practitioners and 600 obstetricians practice in Ontario).

Thus, the relative numbers and distribution of obstetricians and family physicians differs greatly between the United States and Ontario, even though the urban to rural population ratio is almost identical in these two areas.

Malpractice Insurance

The administration of malpractice insurance and premiums paid for such insurance differ greatly in the United States and Canada. In Canada, malpractice insurance is provided by an agency regulated by the government, the Canadian Medical Protective Association (CMPA). The CMPA fees are uniform throughout the country for physicians within specific specialties. In the United States, malpractice insurance is offered by a variety of insurance companies, and rates vary considerably from state to state.

Principally because of the universal health coverage and through the CMPA, malpractice insurance premiums for physicians are drastically lower in Canada than in the United States for physicians in all specialties of medical practice. The annual malpractice fee for family physicians who practice obstetrics is $1,560 in Canada,[12] and averages $11,389 in the United States.[13] For family physicians who do no obstetrics, the annual fee is $760 in Canada,[12] and averages $6,037 in the United States.[13] (All monetary figures have been converted to US dollars to facilitate comparison.) Thus, Canadian family physicians who practice obstetrics each pay $800 more per year than Canadian family physicians who do not, while US family physicians who practice obstetrics each pay an average of over $5,000 more per year than US family physicians who do not. Again, rates in the United States vary considerably, and some family physicians are required to pay considerably more than the average. For example, the average malpractice premium in 1988 for family physicians in downstate Illinois who deliver babies was $23,650, $12,000 more than their counterparts who did not deliver babies.

Comparison of Factors Influencing Withdrawal from Maternity Care

In both countries, family physicians are withdrawing from obstetric care. Though many factors obviously are responsible for this withdrawal, malpractice issues have been increasingly implicated as the major factor in the United States. As shown in this report, US family physicians are much more likely to cite malpractice insurance premiums or fear of malpractice litigation as factors important in their decision not to practice obstetrics than are Ontario family physicians. This difference is great, yet over one half of the Ontario physicians indicate that malpractice concerns are very important in their decision not to practice obstetrics, even though malpractice premiums are very low in Ontario. Perhaps the fear of malpractice lawsuit is a greater concern for physicians than is the increase in premiums itself. Some physicians may perceive the expression of fear of lawsuit as an indication of weakness or defeat, and, therefore, may be less likely to identify or indicate such a fear on a survey. It is conceivable that such fears may be reflected in the expression of concern over rising malpractice insurance premiums rather than fear of lawsuit itself.

It is also conceivable that malpractice issues may be cited by physicians even when other factors are more important. Malpractice issues may have become a very convenient, popular, and acceptable excuse to explain withdrawal from maternity care. The true significance of malpractice issues has been questioned in other studies. Smith and Howard[14] studied factors that affect the practice of obstetrics by graduating family practice residents, and found malpractice insurance and legal liability high on the list of reasons for deciding not to practice obstetrics. Klein,[15] in a discussion of this study, pointed out that when residents were asked to suggest ways in which obstetric practice by family physicians could be promoted by organized family practice groups, issues of hospital obstetric privileges and adequate obstetric training topped

the list. Resolution of malpractice issues was cited much less frequently, which suggests that either malpractice concerns are not really so important as family physicians state they are, or that family physicians believe that attempts by organized family practice groups to alleviate malpractice problems are futile.

Even though malpractice issues are a great concern for both US and Ontario family physicians, there are other factors that exert major influence on obstetric practice patterns. With the large differences in malpractice premiums and the burden of malpractice lawsuits that exist between US and Canada, one might expect US family physicians to be giving up obstetric practices at a much more rapid rate than Canadian family physicians. Such is not the case, however. The proportion of residency-trained family physicians who offer obstetric service at the initiation of their careers and the proportion who are giving up obstetric practice are nearly identical in the two countries. This parallel has happened even though there are seemingly more forces that adversely affect obstetric practice in the US than in Canada. It is likely that such factors as the adverse effect of obstetric practice on personal life and office practice, which probably exerts similar effects on obstetric practice in both US and Canada, play a greater relative role in the withdrawal from obstetric care than stated by US family physicians.

Indeed, the adverse effect of the practice of obstetrics upon personal and family life and upon office practice was the most important consideration for Ontario family physicians and a very important one for US family physicians, as well. There are many activities that compete for a physician's personal and professional time. Ruane[16] has recently suggested that the increasing complexity of practice and overhead management places time demands on family physicians that have effectively eliminated sufficient time for many family physicians to maintain an effective obstetric practice. The time consumed in dealing with private insurance companies or governmental agencies and regulations, by quality-assurance activities, and by the ever-expanding needs for continuing medical education, etc, is necessarily expended for a family physician's practice to continue effectively. These issues are urgent concerns, and unfortunately urgent concerns often leave less time for activities, such as obstetric practice, which may be enjoyable for the physician or more important for the physician's patients.

One other factor deserves comment. Obstetric practice, particularly for Canadian family physicians, appears not to be financially attractive. Over one half of the Canadian family physicians indicated that low financial incentive was a major factor influencing their decision to withdraw from maternity care.

Are there solutions to these problems? The malpractice issue is monumental in the United States and is becoming more critical in Canada as well. This issue has impact on several aspects of maternity care. First, the high premiums themselves make obstetric practice less desirable financially. Second, there is the legitimate fear on the part of family physicians of being named in a multimillion dollar lawsuit even when care rendered has been of high quality and appropriate. Third, obstetricians may become less willing to act as consultants for obstetric patients of family physicians for fear of being sued in cases in which they do not have control from the beginning. This concern may, in part, explain the difficulties that US family physicians with high-volume obstetric practices have with obstetricians. Family physicians, together with obstetricians, must set a political agenda for malpractice reform and pursue it vigorously.

The educational agenda is also of great importance. Family practice residency programs must ensure adequate family-centered obstetric training, including exposure of the family practice trainees to family physician role models who deliver babies. Relationships with obstetricians must be strengthened at both the residency and private practice levels. Family physicians must not overlook the real concerns expressed by obstetricians, and must recognize the important role that obstetricians play in the education and practice of obstetrics by family physicians.

Are these problems worth solving? The specialty of family practice was founded both with an idealistic philosophy and because of social necessity. Ideally, maternity care is part of the family-centered nature of family practice. Socially, there is a coming obstetric crisis in which women in medically underserved areas are likely to have inadequate access to prenatal care. If family physicians believe that they should play a role in this social need, and that provision of maternity care emphasizes the family-centered nature of family practice and is indeed good for patients and their families, then the specialty of necessity must take some of the steps suggested above to solve the problems identified in this report.

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