Maternity Care in Family Medicine: Economics and Malpractice

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Background. The number of family physicians delivering babies in Florida in 1991 was at an all-time low. Concerns about malpractice risk and insurance costs have resulted in only 2% of Florida's family practice residency graduates choosing to deliver babies. The purpose of this study was to compare the practices of family physicians in Florida who delivered babies in private practice (termed the "OB group") with those who did not (the "non-OB group").

Methods. A potential study group of 293 family physicians was mailed an extensive survey that explored 132 variables related to medical practice economics and demographics, lifestyle and satisfactions, and malpractice costs and risks.

Results. The obstetrical (OB) group was significantly more likely than the non-OB group to perform a variety of procedures and report more patients under age 6 years (15% vs 5%; $P=.003$) and fewer patients 65 years or older (19% vs 33%; $P<.001$). Even though the number of patients seen and the number of hours worked were similar, the 1991 incomes were much higher for those practicing maternity care (mean=$164,000 vs $104,000; $P=.04$). Compared with the non-OB group, the OB group was more likely to report that their financial and psychological compensation was adequate ($P<.001$), would be more likely to choose medicine as a profession again (94% vs 60%, $P<.05$), paid more for malpractice insurance (mean=$22,000 vs $11,000; $P=.01$), and reported 30% fewer nonobstetrical malpractice claims.

Conclusions. Family physicians in Florida who deliver babies, as compared with those who do not, are more likely to report (1) increased financial and psychological satisfaction for the same hours worked; (2) increased satisfaction with medicine and family practice; (3) more frequent performance of a wider range of procedures; (4) younger practices serving a greater number of complete families and fewer Medicare patients; (5) a more diverse and comprehensive hospital and office practice; and, despite paying significantly higher malpractice insurance premiums, (6) few obstetrical malpractice claims and lawsuits, and (7) fewer nonobstetrical malpractice claims and lawsuits. (*J Fam Pract 1995; 40:153-160*)

In 1991, the number of family physicians delivering babies in Florida was at an all-time low. From 1981 to 1991, the number of family physicians delivering babies in America decreased by 23%, while the decrease in Florida was 80%. In 1981, 10% of the 1050 active members of the Florida Academy of Family Physicians (FAFP) delivered babies,[1] compared with 37% nationally.[2] By 1984, 7% of 1200 delivered babies,[3] and by 1991 only 2% of 1762 FAFP members delivered babies,[4-6] compared with 29% nationally.[2,7,8]

Medical students and family practice residents overestimate both the cost of malpractice liability insurance and the risk of malpractice lawsuits for providing pregnancy care.[9-14] Fears about malpractice lawsuits and misperceptions about malpractice insurance costs have been demonstrated among Florida's medical students and family practice residents: over 98% of family practice residency graduates choose not to deliver babies in their family practices.[5,13] These students and residents are reported to use these misperceptions as the major reason for choosing

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not to deliver babies. Family practice residents in Florida also have expressed concern about the effects of maternity care on their personal and professional lifestyles.

A small study in one Florida county suggested that family physicians who delivered babies had higher income levels, preferable practice demographics, and higher levels of satisfaction financially and psychologically and had higher malpractice costs (insurance premiums) but fewer malpractice claims and lawsuits. That study recommended that the results should now be compared with those involving a larger cohort.[6] The purpose of this study was to compare medical practice, lifestyle, and malpractice issues for family physicians in Florida who delivered babies in private practice as compared with family physicians practicing in the same communities who did not deliver babies.

Methods

In 1991, the FAFP Task Force on Obstetrics identified 31 FAFP family physicians who delivered babies in nine of Florida's 67 counties.[5] A data file for all FAFP members from these nine counties was obtained from the FAFP. Physicians in part-time practice (<20 hours/week), full-time academic medicine, staff model health maintenance organizations (HMOs), or public health were excluded, so that only FAFP members in full-time (≥20 hours/week) private practice were eligible for the study. In the three counties with fewer than 40 FAFP members, a census of all FAFP members in private practice was conducted. In the six larger counties, each of which had at least 40 FAFP members, a random sample was drawn so that the study group would include approximately 300 physicians and the number of physicians sampled in each county would be proportional to their share of all family physicians in all nine counties.

The extensive 5-page questionnaire contained 132 variables, including demographics, training, office and hospital practice information, procedures performed, economics, malpractice insurance costs, malpractice claim and lawsuit experience, and measures of professional and personal satisfaction. It was tested on a small group of physicians[6] and revised. It was then mailed to 293 family physicians in May 1992; nonrespondents were sent a second questionnaire the following month. The last usable questionnaire was received in November 1992. Data from a total of 145 (49.5%) questionnaires were included in the analyses.

Physicians who reported they were still actively delivering babies were called the OB group, and respondents who either never had delivered or were no longer delivering babies were called the non-OB group. Comparisons between the OB group and the non-OB group were conducted using a two-tailed *t* test for comparing group means and chi-square analysis to compare reported frequencies of various practice characteristics.

Results

Practice Demographics and Diversity

The FAFP database revealed no statistically significant demographic differences between the questionnaire's respondent and nonrespondent groups. The OB group and non-OB group were statistically similar in age (43 vs 47 years), sex (88% vs 83% male), board certification (94% vs 86%), percentage with MD degree, region of medical school or residency training, percentage residency trained, and percentage trained in international medical schools. Although the non-OB group had more years in practice in Florida (13 vs 9; $P=.05$) and more years since receiving the MD or DO degree (19 vs 15; $P=.05$), total years of practice in their current city were similar (8 vs 10; $P=.08$).

The practice arrangements were not statistically different ($P>.05$, based on a test of differences between independent proportions), but there was a tendency for the OB group to be in family practice groups of ≥2 physicians (63% vs 34%, $P<.05$). The non-OB group showed a tendency toward solo (35% vs 13%) and multispecialty practices (15% vs 6%). In both groups, approximately 20% of the physicians reported "other" practice arrangements. Both groups reported seeing the same number of patients per week; the number of total professional work hours per week spent by each group either in or out of the office was not statistically different (Table 1).

The OB group was significantly more likely than the non-OB group to do most of the procedures included in the survey (Table 2) and reported more patients under age 6 years (15% vs 5%, $P=.003$) and fewer patients 65 years or older (12% vs 28%, $P<.001$). There was no statistical difference between the two groups regarding percentage of patients seen in other age groups. The OB group reported caring for significantly more complete families (70% vs 37%, $P<.001$) than did the non-OB group.

The patient problems seen in the office were different, with the OB group reporting more obstetrics (10% vs 0.1%, $P<.001$), pediatric sick visits (9% vs 5%, $P=.02$), pediatric well visits (8% vs 3%, $P<.001$), and sports medicine (5% vs 3%, $P=.03$), and significantly fewer visits for cardiology (8% vs 14%, $P=.02$), counseling or psychiatric care (4% vs 7%, $P=.01$), gastroenterology (5% vs 8%, $P<.001$), pulmonary medicine (3% vs 8%, $P<.001$), and

Table 1. Comparison of Family Physicians Who Deliver Babies (OB Group) and Those Who Do Not (Non-OB Group) by Patients Seen, Hours Worked, and Income

Work Variable	OB Group Physicians (n=16)	Non-OB Group Physicians (n=129)	*P* value*
Patients seen/week, %			NS (χ^2)
≤100	38	42	
101–125	25	33	
126–200	19	20	
≥200	19	6	
Hours/week in-office†	45.0	39.2	NS (t)
Hours/week out-of-office‡	15.6	12.0	NS (t)
Total hours worked/week	60.6	51.2	NS (t)
Weeks worked/year	47.1	49.1	
Hours worked/year§	2854	2514	
Total billings, $	636,500	318,664	.01 (t)
Total collections, $	440,153	261,798	.02 (t)
Total overhead, $	199,750	149,620	NS (t)
Income, $	163,750	103,993	.04 (t)

**P value from two-tailed t-test (t) or chi-square test (χ^2).*
†Total estimated hours per week in office spent seeing patients and on administrative responsibilities.
‡Total estimated hours per week seeing patients out-of-office (home, resthome, nursing home, emergency department, hospital, etc) and out-of-office administrative (hospital coding, charts, etc.) and meeting time (non-CME).
§Obtained by multiplying (total hours/week worked) × (number of weeks/year worked).
NOTE: Not all physicians responded to all survey items; the number of physicians listed is the maximum number who responded to any of the survey items.

Table 2. Comparison of Family Physicians Who Deliver Babies (OB Group) and Those Who Do Not (Non-OB Group) by Procedures Performed

Procedure	OB Group Physicians, % (n=16)	Non-OB Group Physicians, % (n=129)	*P* value*
Procedures performed more frequently by the OB group			
Neonatal circumcision	100	18	<.001
Endometrial biopsy	94	78	<.001
Skin cryosurgery	94	55	.008
Flexible sigmoidoscopy (0–30 cm)	81	42	.008
Breast cyst aspiration	75	37	.009
Cervical biopsy	75	16	<.001
Cervical cryosurgery	75	14	<.001
Colonoscopy (30–60 cm)	69	28	.003
Vasectomy	69	7	<.001
Closed reduction of fractures	63	15	<.001
Colposcopy	63	7	<.001
Excisional breast biopsy	63	6	<.001
Dilation and curettage	63	3	<.001
Post-partum tubal ligation	50	3	<.001
Exercise stress test	38	11	.017
Upper gastrointestinal endoscopy	19	2	.009
Colonoscopy (>60 cm)	13	0	.007
Procedures performed with equal frequency by both groups			
Excision of skin lesions	94	78	NS
Polypectomy-sigmoidoscopy	31	11	NS
Nasolaryngoscopy	25	11	NS
Flexor tendon repair	13	3	NS

**P value derived from chi-square test.*
NOTE: Not all physicians responded to all items; the number of physicians listed for each group is the maximum number who responded to any of the survey items.

rheumatology (3% vs 5%, *P*=.02). There were no differences in the percentages of outpatient practice devoted to dermatology (4% to 5%), endocrinology (3% to 4%), hematology (2%), infectious disease (6% to 10%), oncology (2%), gynecology (10%), neurology (2% to 3%), orthopedics (5%), and urology (3%).

In-hospital practice demographics were different, with the OB group reporting more nursery care (11% vs 5%, *P*<.01), obstetric care (16% vs 0%, *P*<.001), general pediatrics (8% vs 4%, *P*<.01), surgical services (10% vs 2%, *P*<.01), and less emergency department care (4% vs 20%, *P*<.001) and general adult medicine (37% vs 68%, *P*<.001). Intensive care unit practices were similar for the two groups (9%). These differences in hospital practice demographics were not associated with any significant difference in after-hours time spent in patient care (Table 1).

Practice Satisfactions and Dissatisfactions

Using a five-point Likert-type scale (ranging from 1=strongly agree to 5=strongly disagree), the OB group was more likely than the non-OB group to report that their financial compensation was adequate (mean, 2 vs 3; *t*=4.10, *P*<.001), and that their psychological compensation was adequate (mean, 2 vs 3; *t*=5.35, *P*<.001): 75% of the OB group reported agreeing that their financial compensation was adequate, as compared with 47% of the non-OB group, and 88% of the OB group reported adequate psychological satisfaction, compared with 41% of the non-OB group. The OB group was more likely to answer yes to the question, "If you had it to do again, would you choose medicine as your profession?" (94% vs 60%, *P*<.05). Both groups were statistically similar in their positive response to the question, "If you had it to do again, would you choose family practice as your profession?" (63% vs 51%, *P*=.20); however, those in the OB group with 6 or more years in practice were more likely to say that they would go into family practice again (78% vs 41%, *P*=.05).

The OB group was more likely to report that they enjoyed "working with the entire family" (63% vs 22%,

Table 3. Malpractice Claim and Malpractice Lawsuit Experience of Family Physicians Who Deliver Babies (OB Group) and Those Who Do Not (Non-OB Group)

Malpractice claim and lawsuit data (self-reported)	OB Group Physicians (n=16)			Non-OB Group Physicians (n=114)		
	OB cases	Non-OB cases	Total cases	OB cases	Non-OB cases	Total cases
Total malpractice claims, n	4	9	13	1	146	147
Total malpractice lawsuits, n	1	8	9	0	135	135
Malpractice claims per 100 years of cumulative physician practice, n	2.9	6.5	9.4	0	9.8	9.8
Malpractice lawsuits per 100 years of cumulative physician practice, n	0.7	5.8	6.5	0	9.1	9.1
Average years of physician practice per malpractice claim	34.8	15.4	10.7	1488	10.2	10.1
Average years of physician practice per malpractice lawsuit	139	17.4	15.4	1488	11.0	11.0

NOTE: Not all physicians responded to all survey items; the number of physicians listed for each group is the maximum number who responded to any of the survey items.

P=.02) and fewer of the OB group reported "governmental and other third-party interventions, red tape, and hassles" (43% vs 70%, P=.04); yet of all the third-party payer groups cared for by the two groups (indemnity plans, preferred provider organizations, health maintenance organizations, independent provider organizations, Medicaid, Medicare, and self-pay patients), the only difference seen was that the OB group practices had fewer Medicare patients (12% vs 28%, P<.001). The OB groups included a higher percentage of physicians likely to be dissatisfied with the level of stress and lack of time (44% vs 37%, P>.05) and professional liability insurance (PLI) costs (25% vs 9%, P>.05) associated with their practices, although these differences did not reach statistical significance.

The professional dissatisfactions, when examined by years in practice, revealed that the OB group with 1 to 5 years in practice reported less "government and third-party red tape and hassles" (20% vs 53%, P=.02), but greater stress and lack of time (80% vs 13%, P<.001). These dissatisfactions were not statistically different after 5 years of practice.

When asked to rank their greatest dissatisfactions with private practice, malpractice issues (ie, PLI cost and fear of malpractice suits) were ranked second in both groups after government and other third-party interventions, red tape, or hassles. Dissatisfaction with malpractice cost and risk was one of the three most dissatisfying components of private practice in both groups (44% of the OB group and 54% of the non-OB group, P>.05). Although not statistically different, a greater percentage of the OB group tended to report dissatisfaction with PLI costs (25% vs 9%, P>.05), and a greater percentage of the non-OB group tended to report more "fear of malpractice suits (44% vs 19%, P>.05).

Practice Economics

Even though the number of patients seen per week and the total number of hours worked per week were not statistically different between the OB group and the non-OB group, the 1991 incomes were significantly different (mean, $164,000 vs $104,000, respectively, P=.04). This difference persisted for the total mean billings ($636,000 vs $319,000, P=.01) and collections ($440,000 vs $262,000, P=.02), although total overhead expense ($200,000 vs $150,000, P>.05) was not statistically different.

Malpractice Cost and Risk

Although the OB group paid more for malpractice insurance (mean=$22,000 vs $11,000, P=.01), physicians in this group were unlikely to report malpractice claims or lawsuits for the obstetrical portion of their practice (Table 3). The OB group reported 4 OB malpractice claims in 139 years of total practice experience (ie, 2.9 OB malprac

tice claims per 100 physicians years or one OB claim per 35 years of physician practice) and only one OB lawsuit, in which the family physician reported prevailing. Of the 54 family physicians in the non-OB group who had delivered babies in practice prior to 1991 but had discontinued doing so by 1992, none reported ever having had an OB malpractice claim or lawsuit. Thus, the FAFP members surveyed who had delivered babies in practice prior to 1992 had 1627 years (139 years, OB group; 1488 years, non-OB group) of total practice experience delivering babies in Florida with only 5 OB malpractice claims reported, equating to about 0.3 OB malpractice claims per 100 physician years of practice or one OB claim per 325 years of physician practice (Table 3).

The OB group reported 6.5 non-OB claims per 100 physician years of practice as compared with 9.8 in the non-OB group (or one non-OB malpractice claim per 15.4 years of practice as compared with the 1 per 10.2 years reported by the non-OB group), in spite of performing a significantly greater number of procedures in the office and in the hospital.

Discussion

Practice Demographics and Diversity

Since physicians tend to drop obstetrics from their practices as they age,[15,16] it was expected that the non-OB group would have been both much older and in practice much longer than the OB group. The failure of our study to demonstrate this expectation may be because 98% of Florida's family practice residency graduates do not deliver babies in private practice,[4–6,13,17] therefore increasing the percentage of younger physicians in the non-OB group. The practice arrangement differences reported are similar to those of other reports comparing family physicians who do or do not deliver babies,[18,19] who report that family physicians delivering babies are more likely to be in group practices than family physicians who do not deliver babies. The percentage of solo-practice physicians in the non-OB group (33%) is smaller than both the national average (40%) and the Florida average (55%). The reason for the lower-than-expected percentage of family physicians in solo practice may be that this study group was made up primarily of nonrural physicians, and family physicians in nonrural locations are more likely to practice in groups than those in rural locations.[8,20–22] The non-OB group had a higher percentage (53%) of family physicians who had never delivered babies than either the 44% reported in Florida in 1984[3] or the 19% reported nationally.[19] This difference may affect some of the reported differences, as physicians who never deliver babies in practice are more likely to have a lower income, be less satisfied with their practice, and have a less diverse practice than those who do deliver babies.[6,14]

The medical literature indicates that family practice residents, medical students, and practicing physicians perceive that maternity care would significantly disrupt their lifestyle, personally or professionally or both.[13–15,17,18,21–26] This study, along with others,[14,19] suggests that because the OB group statistically works the same number of total out-of-office and in-office work hours per week and the same number of total work hours per year, these predictions may be unfounded. The OB group, however, reports taking 2 weeks per year more vacation time than does the non-OB group. Family practice residents and medical students desiring to deliver babies in practice but wondering if doing so would result in significant lifestyle disruptions may find these data reassuring.

Several practice diversity differences were noted: the OB group reported more complete families, more pediatric patients (well and sick, outpatient and inpatient), and more sports medicine than did the non-OB group. As a result of the increased number of pediatric patients and the reduced number of patients over age 65, the OB group had younger practice populations, a finding that confirms the reports of others.[6,19,27,28] The suggestion that the medical practice of family physicians not providing maternity care resembles general internal medicine[29,30] is also confirmed by these data.

Practice Satisfaction and Dissatisfaction

These data suggest that family physicians delivering babies are more likely to report financial and psychological satisfaction than are their colleagues who do not deliver babies. Other data have suggested the same,[6,31] while showing significant dissatisfaction with medicine in general and family practice in particular among family physicians not delivering babies.[2,6,31] These data, however, do not imply cause and effect. Do satisfied physicians deliver babies, or does delivering babies result in a high level of satisfaction? Is greater satisfaction a result of fewer "hassle factors" from third-party payers such as Medicare among physicians who practice OB and thus have a significantly lower percentage of Medicare patients? Do increased obstetrical, pediatric, or procedural practice activities, with their inherent positive outcomes or increased reimbursement or both, lead to increased levels of satisfaction?

Since it is generally recognized that of all third-party payers, Medicare involves the highest "hassle factor,"[32,33] it is not surprising that 70% of the non-OB group, with its significantly higher percentage of Medicare patients, lists "government and other third-party interventions, red tape, and hassles" as the greatest dissatisfaction of their

career. Only 43% of the OB group had a similar response. The non-OB group's percentage (29%) of Medicare patients is less than that reported for family physicians in the state of Florida (36%),[4] which is the highest in the nation and 11% more than the national average of 25%.[20]

Even though the hours worked by both groups were similar (Table 1), "stress and lack of time" was the second most important dissatisfaction listed for the OB group as a whole, and the greatest dissatisfaction among physicians in the OB group who have been in practice fewer than 5 years. This finding suggests that physicians who deliver babies might benefit from developing strategies for dealing with these perceived stressors. Although this dissatisfaction diminished with time in practice, educating younger physicians about strategies to avoid or reduce the dissatisfactions reported by the OB group may be one useful approach to prevent attrition.[14,32]

Practice Economics

Although the mean income for the non-OB group ($104,000) was 12% greater than the 1991 national average ($93,000),[8] the OB group's mean income ($164,000) and the difference in mean income between the OB group and the non-OB group ($60,000) is, to our knowledge, the largest reported. There are several possible reasons for this difference. First, the increased number of procedures performed by the OB group could explain the increased income reported in these data, as procedural services are usually reimbursed for physicians at a higher rate per unit of time than are nonprocedural or cognitive services. Second, the significantly lower percentage of Medicare patients seen by the OB group may explain, at least in part, the income differential between the two groups, as it has been shown that Medicare reimbursements result in serious underpayment for Medicare services,[34] particularly in Florida.[35] Third, Medicaid obstetrical services are reimbursed at reasonably high levels in Florida ($50 per prenatal visit and $800 per routine delivery)[36] and Medicaid qualification in Florida in 1992 was set at 185% of the poverty level.[36]; both of these reimbursement criteria are greater than in many other states.[6] Fourth, Florida historically has had higher charges and reimbursements (particularly for procedures) as compared with many other states. Finally, the exclusion of academic, part-time, public health, student health, staff model HMO physicians, and military family physicians from these data may have increased the reported incomes. These physicians may earn less take-home income than their private practice colleagues.

Malpractice Cost and Risk

The family physicians in the non-OB group who delivered babies before 1991 reported reasons for discontinuing maternity care that were similar to the reasons reported in other studies.[15,17,21,26–28,37–40] The cost of malpractice insurance was reported as the primary reason for discontinuing obstetrics. Mean PLI costs in Florida are nearly two times the national average.[5] Because of this, we were surprised to find a very low reported incidence of obstetrical malpractice claims and suits, and a lower percentage of reported non-OB claims and lawsuits in the OB group as compared with the non-OB group. The rate of 2.9 OB malpractice claims per 100 physician years for the OB group, which translates to one OB malpractice claim per 35 years of practice, is nearly as low as the lowest rate reported in the literature (2.7).[37] When the family physicians from the non-OB group who had delivered babies prior to 1991 were included, the rate decreased to 0.3 OB malpractice claims per 100 physician years, or one per 325 physician practice years. To the authors' knowledge, this is the lowest rate reported in the literature.

Although it has been reported that only one OB malpractice claim in eight will result in a lawsuit,[41] these data indicate that the ratio for family physicians in Florida is 1:4. Even so, this means that there is only one lawsuit per 139 years of practice in the OB group. When the non-OB group members who delivered babies prior to 1991 were factored in, the rate was one OB malpractice suit per 1488 years of physician practice. For the OB group, the risk of a non-OB malpractice claim, 6.5 per 100 physician years of practice, was more than twice their risk for an OB claim. Rosenblatt reported that the risk of a non-OB malpractice claim for family physicians delivering babies in Washington State was about three times as high as the risk for an OB claim.[37] Even so, family practice residents in Florida predict that the malpractice risk for the OB portion of their future practices will exceed the non-OB malpractice risk.[13,18] These data should be reassuring to those concerned about the malpractice risk of obstetrics in family practice, a conclusion that has also been expressed by others.[14,21,26,27]

This study has a number of limitations. First, the questionnaire had only a 49.5% response rate. Although responders and nonresponders were demographically similar, they were not necessarily similar in income or malpractice experience. Therefore, a potential reporting bias exists. In addition to the moderately low response rate, the very low number of physicians in the OB group makes generalization of these data problematic. Second, it is not known whether happier, more satisfied, higher income earning, or procedurally oriented family physicians persist in delivering babies, even when most of their

colleagues have stopped doing so. If so, the significance of the reported data may be limited by selection bias. The locale studied is a third potential bias in the data. Florida's charges and payments for physician services, particularly procedural services, are generally higher than those of most states.[6] Therefore, there may be a greater reported income differential between the OB and non-OB groups. The disproportionate percentage of Medicare patients cared for by Florida's family physicians who did not deliver babies also may have resulted in differences that would not have been reported in other states or regions. Fourth, interpretation of physicians' self-reported data may have rendered the results less accurate than objective data.[24]

Conclusions

It appears from these data that the few family physicians in Florida who deliver babies, as compared with family physicians who do not deliver babies, are more likely to (1) receive greater compensation financially and psychologically for similar work effort; (2) derive more satisfaction from medicine and family practice; (3) perform a wider range of procedures; (4) have younger practice populations with more complete families and fewer Medicare patients; (5) have a more diverse and comprehensive hospital and office practice; and, despite paying significantly higher malpractice insurance premiums, (6) rarely experience OB malpractice claims and (7) report fewer non-OB malpractice claims as compared with the non-OB group.

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