

Why Family Physicians Deliver Babies

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BACKGROUND. Numerous factors have been hypothesized to explain the steady decline of family physicians providing maternity care. Rather than exploring reasons for departure, we sought to learn why many family physicians choose to deliver babies.

METHODS. A previously piloted questionnaire was mailed to 1300 family physicians who had attended continuing education programs related to pregnancy. The respondents were classified as: those who had always delivered babies (group 1: "Always Did"); those who had previously not delivered babies, but had started or planned to start doing deliveries (group 2: "Started Later or Plan"); and those who had never delivered babies or had previously delivered but stopped (group 3: "Will Not Do"). The study focused on the reasons respondents in the first two groups decided to deliver babies and contrasted their views with those of the third group.

RESULTS. Five hundred seventy-five valid responses were returned (421 "Always Did"; 92 "Started Later or Plan"; 62 "Will Not Do"). Response patterns were similar for all geographic regions. Reasons for delivering babies that appeared with statistically significant frequency included personal enjoyment, adequate obstetrical training in residency, desire to care for younger families, and supportive obstetricians during residency. Reasons for not delivering babies included unacceptable lifestyle, a community's saturation of maternity caregivers, fear of lawsuit, and absence of need to build a practice.

CONCLUSIONS. Family physicians who deliver babies appear to be primarily motivated by personal enjoyment, followed by a desire to care for younger patients and adequate training in residency. Those who do not perform deliveries primarily cite the unacceptability of a maternity caregiver's lifestyle. The expectation of the practice and a lack of community need are also important influences on the decision of family physicians to deliver babies.

KEY WORDS. Physicians, family; family practice; maternity care; obstetrics; pregnancy. (*J Fam Pract* 1998; 46:34-40)

The lack of local access to prenatal care significantly increases the risk of adverse outcomes for mother and child.^{1,2} Increased travel time to a pregnancy care provider predicts less adequate prenatal care.³ Family physicians provide a substantial portion of pregnancy care, attending an estimated 500,000 of the 4 million births in the United States each year.⁴ Compared with obstetricians, family doctors are better distributed geographically⁵ and are less likely to have patients with preterm labor who experience epidural anesthesia,

episiotomy, instrument delivery, or cesarean section, even after adjusting for pregnancy risk.^{6,7} The percentage of family physicians who deliver babies has declined steadily from 37% in 1980⁸ to 29% in 1988⁹ to 26% in 1993.¹⁰ This decline has ominous implications for the health of pregnant women and their newborns, especially for the one in four Americans who reside in rural areas, where obstetricians constitute less than 1% of physicians.⁵ Thus, the important role of family physicians in perinatal care is even more dramatic in rural America, where they represent two thirds of maternity caregivers.¹¹

Nearly half of medical students intent on a career in family practice initially express a strong interest in pregnancy care.¹² Their attitudes change, however, such that only one quarter of practicing family physicians provide perinatal care. Various hypotheses have been offered to explain this attrition, including perceptions about malpractice risk,¹³⁻²⁰ attitudes of obstetricians,²⁷ and impact on lifestyle

Submitted, revised, September 3, 1997.

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and income.²⁸⁻³¹ Ironically, perceptions of malpractice risk and income effects are usually incorrect.³²⁻³⁴ Family physicians who discontinue obstetrics because of expressed concerns over liability insurance costs do not return to delivering babies, even after malpractice premiums are reduced by 25%.¹⁶ Recent data suggest that there is no relationship between the level of increase in malpractice insurance premiums and the likelihood of discontinuing obstetric practice.³⁵

Most of the attention on family physicians providing pregnancy care has focused on their reasons for leaving or never offering it, not on their reasons for staying or returning. Our experiences with the American Academy of Family Physicians' (AAFP) annual continuing medical education (CME) program devoted specifically to family-centered perinatal care and with the Advanced Life Support in Obstetrics (ALSO) course³⁶ revealed that there were many family physicians who had been committed to delivering babies throughout their careers, as well as a growing number of family physicians who had decided to return to perinatal care. We sought to explore why these physicians elected to offer maternity care and thereby to provide an empirical basis for targeted efforts to encourage and support more family physicians to do the same.

METHODS

In the summer of 1995, we conducted the first phase of this study by mailing a pilot questionnaire to 224 physicians who had participated in the 1995 annual AAFP perinatal care CME program. This group was selected in order to target family physicians who had a high likelihood of providing, or being interested in providing, pregnancy care and who might be willing to reflect on the reasons behind their own decisions about delivering babies.

One hundred forty-four (64.3%) of the pilot questionnaires were returned, supplying an expected return rate for calculating stratified sample sizes in the second, larger phase of the study. The respondents ranged in age from 28 to 63 years with a mean of 37.7. The gender distribution was 43% female, 57% male. Seventy-one percent reported delivering babies throughout their practice careers (study classification group 1: "Always Did"); 23% delivered babies at some point in their careers or expected to do so in the future (group 2: "Started Later or Plan");

3% never delivered babies or did so at one time but quit permanently (group 3: "Will Not Do"); and 3% could not be accurately classified. Physicians in group 2 (those who delivered babies previously but not continuously since entry into practice) were asked to disclose the reasons for deciding both for and against doing obstetrics at different times in their careers. Respondents selected applicable statements from lists supplied in the questionnaire and had the option of writing in any other reasons that influenced their decisions. The responses obtained in this phase of the study were used to make revisions and additions to the lists. A copy of the final questionnaire is available on written request to the corresponding author.

The same sample selection rationale applied to the second phase of the study: to target family physicians with a high likelihood of including, or wanting to include, the delivery of babies in their practices. The total pool of persons eligible for the main study was defined as individuals with MD or DO degrees appearing in the participant lists from the 1991 to 1995 AAFP perinatal care CME programs and from the 1993 to 1995 ALSO courses. Participants residing outside the United States were removed from the pool to prevent potential confounding due to structural differences in national health care systems. The eligible pool included 152 who attended an AAFP program on maternity care, 3637 physicians who attended ALSO courses, and 65 who attended both.

Based on the assumption that family physicians' opinions about providing maternity care might differ by geographic region, the country was divided into Northeast, Southeast, Central, and Western regions for stratified sampling. Further assuming that the response rate and respondent classifications in this sample would parallel those in the phase 1 sample, it was determined that a mailing to 325 individuals would be required for each region. That number was expected to yield a sufficient number of respondents for detecting a 20 percentage point difference (at two-tailed $\alpha=.05$) in agreement with a given questionnaire item between two geographic regions for physicians in classification group 2, which was the smaller of the two subgroups containing physicians committed to delivering babies.

The survey questionnaire with a cover letter explaining the purpose of the study was sent to a geographically stratified random sample of 1300 physicians on January 19, 1996. Subjects were asked

to respond by February 9, 1996. A stamped return envelope was enclosed bearing a unique subject identification number so that the questionnaire could be associated with the respondent's geographic region and originating address list (AAFP CME or ALSO) while disassociating personal identification from the dataset used for analysis. Because of financial constraints, potential subjects received only a single mailing; no follow-up solicitations occurred.

RESULTS

Five hundred eighty-eight (45%) of the delivered surveys were returned. Thirteen were returned with incomplete responses and have been excluded from analysis. Thirty-seven surveys were returned by the postal service as undeliverable. Five were returned without identification but were otherwise valid; they have been excluded only from the demographic analyses. The rate of valid response for delivered surveys was 50% (160/321) for the Northeast region, 36% (117/322) for the Southeast, 45% (143/319) for the Central, and 52% (155/301) for the Western. The response rate was 52% for AAFP-only participants, 45% for ALSO-only participants, and 65% for participants in both programs.

SEX, AGE, GEOGRAPHIC DISTRIBUTION

Of the 568 respondents who answered questions regarding sex and age, 208 (37%) were female and 360 (63%) were male. There was no significant difference in the gender distribution by region ($\chi^2=4.72$, $P > .1$). The men's average age of 39.7 years was significantly older than the women's average age of 36.4 years ($F=29.65$, $P < .001$). There was a significant difference in age between regions as well ($F=2.62$, $P < .05$), with the Northeasterners being younger (37.8) than the Westerners (39.9). Nearly three quarters (73%) of the respondents had always delivered babies (group 1), 16% at one time did not deliver babies but had started later or planned to do so (group 2), and 11% had either never delivered babies or had stopped and did not intend to start again (group 3). The distribution of these three respondent groups showed no significant regional variation ($\chi^2=7.0$, $P > .3$). No significant differences attributable to geographic region were found in any of the analyses reported below.

PHYSICIANS' REASONS FOR NOT DELIVERING BABIES

Physicians who at one time did not deliver babies but had started later or planned to do so (group 2, $n=92$) and physicians who had never delivered or who had stopped and did not plan to start again (group 3, $n=62$) were asked to indicate which if any of 15 reasons (14 specific and one or more "other" reasons) contributed to their decision not to deliver babies. One hundred forty-one of the 154 physicians in these two groups answered this item, selecting an average of 3.16 reasons.

Reasons for not delivering babies given by all respondents who reported one or more reasons for not delivering babies appear in the first column of Table 1. The most frequently selected reasons were: unacceptable lifestyle (50%, with 18% considering it their most important reason), joining a practice that did not expect or allow the physician to deliver babies (44%), and obstetricians in the practice community who were unsupportive of family doctors delivering babies (28%). Twenty-four percent of respondents also stated other reasons for not delivering babies that were mostly slight variations on those listed in the questionnaire, but a lack of local facilities was also mentioned ($n=11$) as an additional reason.

The second and third columns of Table 1 display the distributions of reasons for not delivering babies given by physicians who never delivered babies or who stopped and did not intend to start again ($n=61$) compared with physicians who at one time did not deliver babies but had started later or planned to do so ($n=80$). Those physicians who did not intend to deliver babies were most differentiated from those who did not deliver babies at one time but had started or intended to start delivering babies by the following: lifestyle issues (77% vs 30%), the community's lack of need for more maternity caregivers (36% vs 11%), fear of lawsuit (25% vs 9%), and the absence of need to build a practice (28% vs 13%).

PHYSICIANS' REASONS FOR DELIVERING BABIES

Physicians who always delivered babies (group 1, $n=421$) and physicians who at one time did not deliver babies but had started later or planned to do so (group 2, $n=92$) were requested to select which if any of 16 reasons (15 specific and one or more "other" reasons) contributed to their decision to deliver or

plan to deliver babies. Five hundred two of the 513 physicians in these two groups answered this item, selecting an average of 7.82 reasons.

The distribution of reasons for delivering babies for the 502 respondents appears in the first column of Table 2. The most frequently selected reasons for delivering babies were: personal enjoyment (92%, with 45% considering it their most important reason), a desire to care for younger patients (78%), and adequate obstetrical training in residency (77%). Sixteen percent of respondents also stated other reasons they had for delivering babies. These other reasons included three concepts that were not listed in

the questionnaire, but appeared with notable frequency in the narrative responses: delivering babies should be considered an integral part of family medicine's mission to provide comprehensive and continuous care (n=39); family physicians who were family practice residency faculty and who had served as positive role models (n=19); and practicing obstetrics was a prerequisite for joining a family practice residency faculty (n=11).

The second and third columns of Table 2 show the distribution of reasons for delivering babies by those physicians who had always delivered babies (418/421 respondents in group 1) com-

TABLE 1

Reasons Given by Family Physicians for Not Delivering Babies, by Group

Reason	All Responding n = 141*			Will Not Do n = 61*			Started Later or Plan n = 80*			P
	Reason† Selected, %	Rank of Reason	Identified‡ as "Most Important," %	Reason† Selected, %	Rank of Reason	Identified‡ as "Most Important," %	Reason† Selected, %	Rank of Reason	Identified‡ as "Most Important," %	
Unacceptable lifestyle	50	(1.0)	18	77	(1.0)	39	30	(2.0)	3	<.001
Practice does not expect me to deliver babies	44	(2.0)	17	36	(2.5)	7	50	(1.0)	25	
Community obstetricians unsupportive	28	(3.0)	4	26	(6.5)	29	(3.0)	6		
Excessively costly malpractice insurance	25	(4.0)	5	30	(4.0)	2	21	(4.0)	8	
Community does not need more obstetricians	22	(5.0)	1	36	(2.5)	2	11	(9.0)		<.001
Do not need to build my practice	19	(6.5)		28	(5.0)		13	(8.0)		<.05
Unsupportive practice environment	19	(6.5)	3	21	(9.5)		18	(5.0)	5	
Unsupportive obstetricians in residency	18	(8.0)	2	23	(8.0)		14	(7.0)	4	
Significant fear of lawsuit	16	(9.0)	1	26	(6.5)		9	(11.0)	3	<.01
Inadequate obstetrical training in residency	15	(10.0)	4	21	(9.5)	5	10	(10.0)	4	
Unable to obtain obstetrical privileges	14	(11.0)	1	11	(11.0)		16	(6.0)	3	
Do not like delivering babies	9	(12.0)	4	10	(12.0)	7	8	(12.0)	1	
Inadequate reimbursement for obstetrics	6	(13.0)		7	(13.5)		5	(13.0)		
Inadequate CME in obstetrical skills	4	(14.0)		7	(13.5)		1	(14.0)		

*The n for each group is the number of respondents selecting one or more of the specified reasons for not delivering babies.

†Percentages selecting issues sum to more than 100% since respondents could select any number of issues.

‡"Most Important" percentages do not sum to 100% since not all respondents identified a most important issue.

P value determined using the chi-square test.

pared with those who at one time did not deliver babies but who had started later or planned to start to do so (84/92 respondents in group 2). Those physicians who always delivered babies were most differentiated from those who at one time did not deliver babies but had started or planned to start delivering babies by the following: personal enjoyment (95% vs 76%), adequate obstetrical training in residency (83% vs 51%), a desire to care for younger patients (82% vs 62%), and obstetricians in their residency who were

supportive of family doctors delivering babies (45% vs 36%).

DISCUSSION

A search of the literature revealed that the number of respondents in this study represents the third largest sample of US family physicians ever surveyed on their attitudes toward obstetrics. The absence of statistically significant differences in responses across the four geographic regions sug-

TABLE 2

Respondents Indicating Reasons For Delivering Babies by Group

Reason	All Responding n = 502*			Will Not Do n = 418*			Started Later or Plan n = 84*			P
	Reason† Selected, %	Rank of Reason	Identified‡ as "Most Important," %	Reason† Selected, %	Rank of Reason	Identified‡ as "Most Important," %	Reason† Selected, %	Rank of Reason	Identified‡ as "Most Important," %	
Belief I would enjoy delivering babies	92	(1.0)	45	95	(1.0)	49	76	(1.0)	24	<.001
Desire to care for younger patients	78	(2.0)	15	82	(3.0)	17	62	(2.5)	7	<.001
Adequate obstetrical training in residency	77	(3.0)	2	83	(2.0)	2	51	(7.0)	1	<.001
Able to obtain obstetrical privileges	67	(4.0)	1	68	(4.0)	<1	62	(2.5)	2	
Supportive practice environment	63	(5.0)	3	65	(5.0)	4	56	(5.0)	2	
Adequate CME in obstetrical skills	56	(6.0)	<1	56	(6.0)	<1	56	(5.0)		
Acceptable lifestyle	51	(7.0)	2	52	(7.0)	1	48	(8.0)	2	
Practice expected me to deliver babies	50	(8.0)	9	49	(8.0)	7	56	(5.0)	15	
Obstetricians in residency supportive	43	(9.0)	<1	45	(9.0)	<1	36	(11.0)		<.05
Community obstetricians supportive	42	(10.0)	<1	43	(10.0)	<1	39	(9.0)		
Community needed more obstetrics	34	(11.0)	2	33	(11.5)	2	38	(10.0)	4	
Need to build my practice	31	(13.0)	2	33	(11.5)	2	24	(14.0)	2	
Affordable malpractice insurance	31	(13.0)	1	31	(13.5)	<1	30	(12.5)	2	
Adequate reimbursement for obstetrics	31	(13.0)		31	(13.5)		30	(12.5)		
Minimal fear of lawsuit	17	(15.0)		17	(15.0)		17	(15.0)		

* The n for each group is the number of respondents selecting one or more of the specified reasons for not delivering babies.

† Percents selecting issues sum to more than 100% since respondents could select any number of issues.

‡ "Most Important" percents do not sum to 100% since not all respondents identified a most important issue.

P value determined using the chi-square test.

gests that the findings are national in scope. However, the sample was selected from a group of family physicians with a high probability of delivering obstetrical care in order to meet the study's heuristic purpose: the exploration of why individuals choose to deliver babies. This limitation applies particularly to the subgroup not intending to deliver babies (group 3), since the sampling strategy did not target such physicians. Thus the findings are informative but not immediately generalizable to the entire population of US family physicians, and the conclusions discussed here must be viewed in light of this limitation. Replication of this study with a more broadly representative sample and with follow-up mailing to pursue a higher response rate would be necessary to depict the opinion profiles of US family physicians in general.

The lifestyle constraints imposed by delivering babies are clearly the primary reason surveyed family physicians stated that they chose not to deliver babies, whereas those family physicians who always delivered babies or who planned to do so viewed the lifestyle demands as acceptable. The lack of an expectation on the part of the practice that the family doctor deliver babies played a role in the decisions of many family physicians to not provide pregnancy care. Family physicians were also less likely to deliver babies if their communities were seen to have adequate obstetrical services available, if they had no need to build their practices, if they considered malpractice insurance costs as too expensive for obstetrical coverage, if they feared lawsuits, or if they experienced a lack of support from obstetricians. Reasons that appear to be less important included a sense of inadequate training, problems obtaining obstetrical privileges, a dislike for delivering babies, inadequate reimbursement, or inadequate continuing education opportunities. These findings are consistent with those obtained in earlier studies targeted at family physicians who have decided not to deliver babies.^{13, 16, 22, 25, 27, 28-30}

The group of family physicians surveyed who at one time did not deliver babies but later started or planned to deliver babies were more likely to be in a practice that expected them to deliver babies when compared with those who did not intend to deliver babies. They were also less likely to practice in a community with sufficient obstetrical services, to believe that they did not need to build their practices, or to be as fearful of lawsuits. Compared with

those family doctors who always delivered babies, this group was somewhat less likely to believe that they would enjoy delivering babies, to feel adequately trained in residency, to desire to care for younger patients, or to have experienced supportive obstetricians during residency.

Finding enjoyment in the delivery of babies is clearly the most compelling reason why the family physicians in this study decided to deliver babies. Adequate training during residency and a desire to care for younger patients were also important reasons for delivering babies. While a supportive practice environment and the ability to obtain obstetrical privileges were frequently cited as positive influences, less than half were delivering babies because their practices or communities needed or expected them to do deliveries. Malpractice insurance, lawsuit fears, and reimbursement were less important concerns for these physicians.

There are several lessons suggested by this survey. While a number of external factors were important determinants in the decision to deliver babies (support of community obstetricians, supportive practice environment, malpractice premiums, the expectation of the practice), the most frequently cited reasons were personal: personal enjoyment for those deciding to deliver babies and lifestyle concerns for those deciding against delivering babies. Those who delivered babies offered more reasons for doing so (average=7.82) than those who did not deliver babies (average=3.16). This difference suggests that family physicians may be motivated by numerous key positive factors in their decision to deliver babies, while only a few pivotal negative reasons cause them to decide against delivering babies.

Our findings raise the question of whether family practice residents could or should be selected based on their interest in or enjoyment of participation in childbirth. Our study suggests that family physicians who encounter supportive obstetricians during training and in practice are more likely to choose to deliver babies. Thus, residencies and family practice groups should consider affiliations only with obstetricians who are supportive of family physicians delivering babies. Most important, family practice residencies and practice environments should be structured in ways that foster the family physician's enjoyment with participation in the birthing process.

Our findings suggest that family physicians are

most likely to abandon maternity care if the demands on their lives are too great, if the expectation for them to deliver babies diminishes, or if the enjoyment of attending pregnant women decreases. These factors should be considered when shaping the practice environment. Practices that cater to patients from younger groups or communities that readily accept the role of family physicians in pregnancy care will be more attractive to family physicians who wish to do obstetrics. It is tempting to speculate that improved communication and coverage in the care of maternity patients, new models of practice such as collaboration with midwives,³⁷ and other lifestyle improvements will induce increased numbers of family physicians to care for pregnant women.

ACKNOWLEDGMENTS

The authors would like to thank Pam Williams and Diana Winslow, RN, of the American Academy of Family Physicians for their help in identifying family physicians who attended educational programs on perinatal care. We would especially like to express our appreciation to Marla Foseid, without whom the conception of this survey would have ended in stillbirth.

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