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ORIGINAL ARTICLE

Providing Obstetric Care: Suggestions From Experienced Family Physicians

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ABSTRACT

Background and Objectives: The number of family physicians who include obstetric care in their scope of practice is declining, resulting in lower access for patients to obstetric care, especially in rural and underserved communities. In our study, we aimed to understand the experiences of mid- to late-career family physicians and capture suggestions regarding how to maintain obstetric deliveries as part of practice throughout their careers.

Methods: We administered a 30-item online survey to mid- to late-career family physicians regarding their obstetrical care practice and their suggestions for family physicians to continue attending deliveries throughout the course of their career. We developed descriptive statistics of individual and practice characteristics and thematically analyzed open-text comments offering suggestions for continuing to provide obstetric care.

Results: About 1,500 family physicians agreed to participate in the online survey, 992 of whom responded to an open-text question asking for suggestions for family physicians hoping to continue providing obstetric care throughout their careers (56% response rate). The primary themes included suggestions regarding interprofessional relationships, call coverage/backup, training and education, practice characteristics, practice setting, work-life balance, job seeking, policy, and compensation.

Conclusions: The findings revealed individual- and structural-level considerations to improve longevity in obstetric scope of practice. Support from multiple levels is necessary to ensure that competent family physicians continue attending deliveries throughout their careers. Practices and hospital systems can have a sizeable impact by directly helping family physicians provide obstetric primary care within their scope of practice, while national organizations can influence health care system-level changes.

INTRODUCTION

The percentage of family physicians (FPs) attending deliveries has declined steeply since 2000 from 25% providing this care to 7%.[1–3] Several factors have contributed to this decline. Though 25% of graduating FPs have reported intention to attend deliveries, they have had a difficult time securing a job that allows them to do so.[3–5] Difficulty acquiring hospital privileges, abiding interprofessional relationship stressors with obstetrician/gynecologists (OB/GYNs), and maintaining adequate volume for competency are additional structural barriers that make practicing the full scope of obstetric care challenging for FPs.[6,7] Personal factors, such as lifestyle limitations and disinterest in obstetric care, also contribute to the overall decline.[4,8]

In rural communities,[9] family physicians provide the bulk of obstetric care, filling a service gap where they often are the only clinicians attending deliveries,[10] including performing cesarean sections.[11] A national shortage of 22,000 OB/GYNs is projected by 2050. This coverage gap is already being felt in rural counties, of which nearly 59% do not have an OB/GYN.[12,13] Additionally, only 18% of rural counties have advanced practice midwives.[13] Closures of rural hospitals, including labor and delivery departments, compound these workforce shortages, exacerbating obstetrical deserts and worsening obstetric and infant health outcomes.[14,15]

Given these declines in provision of and access to obstetric care, FPs have an imperative to continue to provide this care as part of their scope of practice throughout their careers. To build on previously conducted studies with early career FPs,

this study focused on experienced FPs to understand how FPs at any stage of their careers can successfully maintain this scope of practice.

METHODS

We administered a 30-item online survey to mid- to late-career FPs to understand their experiences providing obstetric care over the course of their careers. Note that though we used the term "maternity care" in our data collection instrument, we have substituted "obstetric care" for the purposes of this article. We used the American Board of Family Medicine (ABFM) Continuing Certification Exam Registration Questionnaire (2013-2019) to identify FPs who have been in practice for at least 10 years and answered "yes" to the question, "Do you deliver babies?" This sample included FPs who were currently delivering babies and those who were delivering babies but had stopped since their last board certification. Between October 5 and November 4, 2020, all 4,139 FPs meeting inclusion criteria were emailed up to three invitations to participate in our survey via SurveyMonkey (Momentive). Our study was approved by the Institutional Review Board of the American Academy of Family Physicians (AAFP).

The full survey (Supplement 1) asked respondents about their personal and professional characteristics, details of their obstetric practice, and barriers to and suggestions for continuing to attend deliveries. The survey contained 26 closed items and four open-text questions that allowed respondents to provide more detailed and nuanced information. The research team was composed of two medical anthropologists working in family medicine research and experienced in qualitative methodology (M.T., A.E.) and three FP researchers who currently deliver babies as part of their practice (T.B., A.D., J.G.). The team used a qualitative approach, immersion-crystallization,[16] to analyze responses to the open-text question, "What suggestions do you have for family physicians hoping to continue to include maternity care in their practice over their career?" The team first established a priori codes derived from other survey items, conducted a review of relevant literature, and ensured that the research team had the required expertise. Next, each team member independently coded an initial sample of 40 random comments and met with the rest of the team regularly to reach consensus on the application of codes, identify the emerging themes, and establish an initial codebook. As the team became immersed in the data, using the a priori codes in the coding process, the team identified and agreed on additional emerging themes. The entire sample then was subdivided with each team member coding 200 comments. The research team held weekly meetings to discuss further emerging codes, verify consistency of the application of codes, and refine code definitions when needed to reach interreader agreement. A single comment that contained multiple themes was assigned more than one code. A priori codes were refined and emerging themes were defined and refined through the iterative coding process, which culminated in a set of nine crystalized themes. Because these qualitative data were collected via a survey instrument, we were able to calculate frequencies of how many respondents commented on each theme.

To characterize the survey respondents, we developed descriptive analyses of the demographic data. We also developed descriptive analyses of one survey item regarding barriers to providing obstetric care to understand how respondent suggestions compared and to provide insight regarding how to address the barriers. The latter survey item asked, "In the course of your career, have you ever encountered any of the following barriers to providing obstetric care?" and the response options (allowing respondents to select all that apply) included "low volume, lack of continuing medical education in maternity care, not available in practice I joined, challenges with privileging, liability/fear of lawsuit, billing hassles, poor reimbursement, malpractice insurance too costly/challenging, lifestyle impact, difficult relationships with OB-GYNs, call structure/coverage, fear of bad outcomes, none of the above, other (please specify)." We calculated the frequency and proportion of each response option to categorize barriers as small (barriers reported by fewer than 20% of respondents), medium (reported by 20%-40%), or large (reported by more than 40%), and mapped the suggestions, also sorted by frequency of comments, that addressed those barriers.

RESULTS

According to SurveyMonkey tracking, of the 4,139 FPs who met the inclusion criteria, 2,705 opened at least one email invitation and 1,512 of those agreed to participate in the survey, giving us a known response rate of 56%. Most respondents were over 40 years old, non-Hispanic, White, and worked in practices with at least six clinicians (see Table 1 for respondent demographic characteristics). Of the 1,512 respondents, 66% (n=992) provided open-text suggestions for continuing to provide obstetric care. We identified nine primary themes (Table 2), which sometimes intersected.

Interprofessional Relationships

The most frequent theme was the importance of interprofessional relationships, particularly with OB/GYNs. Suggestions focused on seeking out a practice that has an established, positive working relationship with OB/GYNs or intentionally establishing a good rapport with OB/GYNs in the practice or hospital system the FP joins.

> In bigger systems there is still plenty of hostility (although often not overt), and that can be wearing. It helps to have a strong department, and some allies in OB
>
> *—female, attended deliveries for 20 years*

> Find a group practice that is supportive of family physicians providing obstetrical care. When your practice is hiring a new OB/GYN, be involved in [the] recruitment process and find someone supportive of FP/OB
>
> *—male, currently attending deliveries for 28 years*

FPs also mentioned the importance of forming collaborative and mutually beneficial relationships with other clinicians potentially providing obstetric care both within the practice setting and the community at-large, including other family physicians, maternal-fetal medicine specialists, labor and delivery nurses, midwives, and doulas. Some FPs noted that support from leadership and administration, especially when securing admitting privileges, helps FPs to sustain obstetric practice.

Call Coverage and Backup

Respondents made suggestions about ensuring a formal call structure and adequate backup. FPs suggested setting clear boundaries with the practice and patients regarding call and availability.

> Think carefully about coverage—delivering your own patients (which is very rewarding, but harder lifestyle-wise) vs a set call schedule for deliveries
>
> *—female, attended deliveries for 10 years*

Some suggested that reliable partners incorporated into a larger team-based model of care can help secure a mutually beneficial call structure. According to one respondent,

> If your hospital has an OB hospitalist system or a midwifery program, approach the groups with proposals that may support you (and you support them) for coverage/call.
>
> *—female, attended deliveries for 20 years*

Additional call coverage recommendations included sharing night/weekend call with partners to maintain a healthy work-life balance and ensure adequate sleep schedules, and the importance of trusting one's backup/call partners.

Training and Continuing Medical Education

FPs noted that adequate training is necessary to begin and continue providing obstetric care; for example, training might include residency training within a high-volume obstetrics setting, resident instruction by FPs who provide obstetric care, and fellowship training to supplement residency education.

> Residents need more faculty mentors who show them how to integrate OB in their practices. An academic setting does not adequately portray OB in a usual community FM setting, so residents I know are afraid of the time and liability commitment.
>
> *—female, currently attending deliveries for 19 years*

Some advised regular attendance at conferences on obstetrical care such as AAFP's Family-Centered Pregnancy Care conference, or suggested taking the Advanced Life Support in Obstetrics course every few years to stay current. Others recommended departmental case reviews, staying up-to-date on obstetric peer-reviewed evidence, and affiliating with a residency program to maintain skills and knowledge.

> Stay über-current with the OB literature and use your currency as a way to educate obstetricians about new studies and guidelines. This can help increase confidence in your knowledge/currency if done in a humble way.
>
> *—female, currently attending deliveries for 11 years*

Practice Characteristics

FPs made suggestions regarding practice characteristics, such as building patient panels that include reproductive-age patients and using a team-based model of care that includes other physicians (OB/GYNs, maternal-fetal medicine specialists), nurses, medical assistants, midwives, and doulas. Many noted the importance of working in a practice that has an adequate volume of obstetric patients so that FPs can maintain skills and admitting privileges.

> You do need a significant volume to maintain skill and experience. What I did was join an obstetrical group and bring family medicine there.
>
> *—female, attended deliveries for 35 years*

Practice Setting/Location

FPs suggested that particular geographic areas or rural locations may have higher need for obstetric providers, and thus allow for continued obstetric practice.

> Women need good care in all areas. I practice in a rural area. We have hospitals in our area that are closing their OB units. Try to bring someone with you if you go to a place without OB care. It's easier to do with some help.
>
> *—undisclosed gender identity, currently attending deliveries for 27 years*

Others suggested joining an academic practice, residency program, or federally qualified health center (FQHC) where community support and obstetric opportunities would be higher.

> Go somewhere where maternity care is needed or become faculty at a program where maternity care is needed.
>
> *—female, currently attending deliveries for 18 years*

Work-Life Balance

FPs suggested how to balance the uncertainty of providing obstetric deliveries with home life. These individual-level suggestions included advice about discussions with family members about managing personal time.

> Be realistic with your spouse or significant other regarding the lifestyle impact that obstetrics will have. And remember that you can control the number of deliveries you take each month.
>
> —*male, currently attending deliveries for 32 years*

Respondents often connected work-life balance to adequate call structure.

> Call and coverage are key to keeping some semblance of a life outside of medicine—not missing time to travel, time with your friends, partner anniversaries, date nights, birthdays, school performances, sporting events, family vacations.
>
> —*female, attended deliveries for 20 years*

Job Seeking

Respondents noted that to maintain this scope of practice throughout a career, providing obstetric care immediately after residency is essential. FPs therefore recommended identifying and joining a practice that has a collaborative environment with other clinicians providing obstetric care, is located in an area that needs obstetric clinicians, has FPs already providing obstetric care, and/or has a formalized contract clause that guarantees obstetric privileging.

Policy Suggestions

Respondents mentioned the importance of policy and advocacy efforts at the national level to ensure that FPs maintain hospital privileges, to increase residency obstetric requirements and provide additional residency or fellowship programs, and to support adequate compensation. FPs called for national support through the participation of membership/professional organizations such as AAFP and state chapters, and credentialing organizations such as ABFM.

Compensation

Most of the comments about compensation focused on larger systemic issues such as poor reimbursement rates, payment models that do not factor in time spent in labor and delivery, and inadequately reimbursed call structures that ultimately incentivize cesarean sections and other interventions. To help mitigate some of these factors, respondents suggested negotiating an equitable compensation plan before accepting a position.

Aligning Reported Barriers With Suggestion Themes

Twelve barriers to providing obstetric care were identified by the 1,483 respondents who provided a response to that survey item (Table 3). The largest barriers (ie, the most commonly reported) were lifestyle impact, low volume, difficult relationships with OB/GYNs, and call structure/coverage. The suggestion themes that we identified here have directly or indirectly addressed most of the barriers FPs reported encountering while providing obstetric care. Respondents offered fewer suggestions to address some larger barriers such as low volume, while they offered a larger number of suggestions for smaller barriers such as lack of continuing medical education (CME).

DISCUSSION

Our study demonstrated that adequate support is needed for FPs to maintain obstetrical care throughout the course of their careers, an idea that underlaid the open-text suggestion themes. Most of these themes directly addressed overlapping barriers to continuing to provide this care (Table 3) that aligned with previous research.[4–7,17]

Lifestyle impact was the barrier reported most frequently on the survey and is highly related to the call structure and coverage barrier because it contributes to work-life balance. Many open-text suggestions directly and indirectly addressed lifestyle impact, at structural (call structure, backup), organizational (team-based models), and individual (work-life balance efforts) levels. In particular, creating fair and balanced call schedules with partners and colleagues, as well as ensuring adequate obstetric backup structures that rely on strong relationships with OB/GYNs, influenced the ability of FPs to balance work and life, and thus play a large role in addressing lifestyle-related barriers. Scheduling issues can be addressed by establishing a mutually beneficial coverage schedule that works for individual physicians, the practice, and the hospital system to meet the needs of patients without overtaking the personal lives of those who attend deliveries.[17–19] Reorganizing call schedules to be mutually beneficial also can help foster a collaborative model of team-based care for patients.

As previous research has shown, difficult relationships with OB/GYNs is a large barrier. Many respondents suggested that this issue can be addressed on an individual level by intentionally building and maintaining positive interprofessional relationships with OB/GYNs and other obstetric providers. Such positive relationships can mitigate privileging challenges, create strong backup groups, and enhance administrative support. Additionally, national organizations and advocacy groups can help shift hospital policies to base privileging decisions on skills and competencies rather than on provider type—a change that could strengthen interpersonal working relationships.[5,20] National organizations such as AAFP and the American Council of Gynecologists have helped foster supportive relationships between OB/GYNs and FPs in rural areas,[21] and AAFP has advocated for admitting privileges for FPs.[22] More systematic attention to these issues would better support all FPs in continuing to provide obstetric care throughout their careers.

Low delivery volume and challenges with privileging were selected as significant barriers in our survey, and a small proportion of respondents addressed these in their comments. The variability in defining what counts as low volume, however, depends on practice location and internal policies for maintaining skills, making identifying a singular solution

difficult. Many comments were unclear about whether they were talking about hospital policies for delivery volumes or their own personal discomfort with maintaining competency with low obstetric volume. This ambiguity may speak to a larger issue using volume as the primary measure for obstetric training, maintaining competency, and privileging. Respondents did mention the importance of building a practice that supports an obstetric scope, including attracting a diverse and young patient population, which may help maintain adequate obstetric volume. Suggestions that identified practice setting/location, job seeking, adequate training, and strong CME in obstetrics indirectly targeted volume and privileging issues. Interestingly, while many respondents offered suggestions related to training and CME, lack of CME in obstetric care, by itself, was not a barrier reported by most respondents.

Fear of bad outcomes, liability and fear of lawsuits, poor reimbursement, and malpractice were identified by a fair number of FPs as barriers to providing obstetric care. Because these are difficult barriers to address, few respondents provided suggestions to address them. More research, policy, and advocacy work should focus on the interconnectedness of these four barriers and how in combination they may drive FPs out of obstetric practice.

Limitations

This study has limitations. Online surveys limit the type and quality of qualitative data that can be captured in an open-text box format and allow for unpredictable variability in the length and substance of responses. In addition, respondents who chose to complete the survey may have been motivated to provide responses due to positive experiences providing obstetric care and may not have faced the same challenges as nonresponders or those who have had negative experiences. Given the evolving practice environment, this study captured only the experiences and opinions of mid- to late-career FPs and may not be applicable to recent graduates or early career FPs in practice less than 10 years. Finally, the sample was majority White FPs, in urban practice locations, in the Midwest region, which may have masked additional nuances for practicing obstetrics.

CONCLUSION

Data collected from mid- to late-career FPs who provided obstetric care suggests that career longevity is integrally tied to a work structure that tangibly supports a work-life balance that alleviates negative lifestyle impacts.

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TABLE 1. **Demographics of Survey Respondents (n=1,512[a])**

Demographic variable	n (%)
Age (in years)	
<40	215 (14.22)
40-49	663 (43.85)
50-59	476 (31.48)
>60	158 (10.45)
Gender[b]	
Female	784 (51.85)
Male	728 (48.15)
Race	
Asian	74 (4.89)
Black or African American	30 (1.98)
Other	27 (1.79)
White	1,381 (91.34)
Ethnicity	
Non-Hispanic	1441 (95.30)
Hispanic	71 (4.70)
Graduation year, mean (SD)	1998 (7.66)
Degree type	
MD	1,412 (93)
DO	100 (7)
OB years, mean (SD)	20.65 (8.25)
Practice size	
Solo	62 (4.15)
2 to 5	297 (19.87)
6 to 20	645 (43.14)
>20	491 (32.84)
Rurality[c]	
Small rural	32 (2.61)
Large rural	246 (20.07)
Micropolitan	109 (8.89)
Urban	839 (68.43)
Practice region[d]	
Northeast	143 (9.66)
Midwest	594 (50.14)
South	242 (16.35)
West	501 (33.85)
Main practice site	
Hospital/health system owned	281 (18.78)
Independently owned	416 (27.81)
Government[e]	354 (23.66)
Academic	364 (24.33)
Other/HMO/workplace clinic	81 (5.41)

[a] Due to missing data, some variables may not equal 100%. [b] The ABFM questionnaire uses "female" and "male" for gender category choices. [c] Rural data was not available for 2013. [d] The practice region is categorized by US Census Regions. [e] The government category includes FQHCs, rural health clinics, Indian health services, veterans affairs, military sites, or affiliations.

Abbreviations: OB, obstetrician; SD, standard deviation; ABFM, American Board of Family Medicine; FQHC, federally qualified health center; HMO, health maintenance organization

TABLE 2. **Open-Text Suggestion Analysis: Themes and Subthemes (N=992)**

Theme/subtheme	n	Definition
Interprofessional r elationships	269	The importance of interprofessional relationships, connecting with other colleagues including OBs and midwives
OB/GYNs	192	Suggestions regarding establishing and maintaining positive relationships with OB/GYNs
Supportive FM group/partners	150	Comments about how other FPs providing obstetric care are important as partners in practice and/or training, including the importance of having supportive colleagues and peers
Other obstetric professionals	34	Comments about collaborative care from MFM, midwives, pediatricians, doulas
Support of leadership	24	Comments about the importance of building support from administration and leadership, including engaging in administrative aspects of the practice or hospital
Call coverage and backup	268	Suggestions for better systems of call structure or scheduling or the ability to obtain backup when necessary
Training and continuing education	261	Advice on what training or CME to do during residency and fellowship and long-term, including how to keep up with skills
Initial training advice	99	Advice on residency and fellowship training and options
Conferences	66	Continuing medical education conferences or courses
Current evidence-based practices	61	Advice on staying up-to-date on skills and literature
Residency requirements	29	Comments on how residency programs can best support residents who want to learn OB skills
Practice characteristics	166	Specific practice level characteristics that support FPs providing obstetric care
Support	66	General advice on the importance of practice support at all levels
Team-based models of care	53	Recommendations regarding team-based care, practice configurations, or staffing
Building own practice	34	Advice on making an extra effort to build a practice with patient panels that require obstetric care
Volume	28	Any mention of the ways that delivery volume may impact the ability to continue providing obstetric care
Malpractice	20	Advice or comments on liability or lawsuits
Practice setting/location	120	Advice on what location or type of setting sustains obstetric practice
Rural locations	58	Suggestions that rural areas are more likely to need FPs who provide obstetric care
Location with community support	34	Advice to find communities to practice in that are supportive of obstetrics
Academic/residency	21	Suggestions that academic settings foster OB practice
CHC/FQHCs	14	Suggestions that CHC/FQHCs often need clinicians who provide OB care
Go where needed	14	Idea that FPs who want to provide obstetric care may need to go where the need is greatest
Work-life balance	100	Advice on solutions to minimize the impact of OB practice on lifestyle and family
Job seeking	78	Finding and keeping jobs; advice around things to look for to be able to include obstetric care
Policy suggestions	61	Suggestions of policies at any levels
AAFP/ABFM/credentialing support	26	Any mention of national organizations
Political engagement and advocacy	18	Any mention of advocacy, lobbying at state or national levels
Workforce concerns	14	Comments on stopping the decreasing numbers of family physicians providing maternity care
Compensation	41	Suggestions about how FPs are reimbursed for deliveries or desirable compensation structures

Abbreviations: CHC, community health center; FQHC, federally qualified health center; FP, family physician; MFM, maternal-fetal medicine; AAFP, American Academy of Family Physicians; ABFM, American Board of Family Medicine; FM, family medicine; OB/GYN, obstetrician/gynecologist; OB, obstetrician; CME, continuing medical education

TABLE 3. **Alignment of Barriers to Practicing Obstetrics With Mitigating Suggestion Themes**

Barrier (N=1,483)	n (%)	Suggestion (n=992)	n (%)	Comparison*
Lifestyle impact	924 (62)	Call coverage/backup Interprofessional relationships Work-life balance Team-based models	268 (27) 269 (27) 100 (10) 53 (5)	Largest barrier; addressed in many suggestion categories
Low volume	662 (45)	Practice characteristics—volume Practice characteristics—building own practice	28 (3) 42 (4)	Large barrier; few suggestions
Difficult OB/GYN relationships	662 (45)	Interprofessional relationships (With OB/GYNs)	269 (27) 192 (19)	Large barrier; lots of suggestions (and addressed lifestyle issues)
Call structure/coverage	622 (42)	Call coverage	268 (27)	Large barrier; lots of suggestions (and addressed lifestyle issues)
Fear of bad outcomes	479 (32)	Interprofessional relationships Backup Training and CME	269 (27) 268 (27) 261 (26)	Medium barrier; no direct, but lots of indirect suggestions
Liability/fear of lawsuits	332 (22)	Malpractice	20 (2)	Medium barrier; very few suggestions
Privileging challenges	317 (21)	Policy suggestions Practice setting/location	61 (6) 120 (12)	Medium barrier; some suggestions (mostly indirect)
Poor reimbursement	295 (20)	Compensation	41 (4)	Medium barrier; some suggestions
Malpractice insurance	220 (15)	Malpractice	20 (2)	Small barrier; few suggestions
Billing hassles	160 (11)		0	Small barrier; no suggestions
Not available in practice	145 (10)	Practice setting/location Job seeking	120 (12) 78 (8)	Small barrier; some suggestions
Lack of CME	74 (5)	Training and CME	261 (26)	Small barrier; lots of suggestions (may have addressed other barriers)

*Small barriers were reported by fewer than 20% of respondents; medium barriers were reported by 20%-40% of respondents, and large barriers were reported by over 40% of respondents.
Abbreviations: OB/GYN, obstetrician/gynecologist; CME, continuing medical education

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