Special Article

Rising Malpractice Premiums and Obstetric Practice Patterns

The Impact on Family Physicians in Washington State

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All 853 active members of the Washington Academy of Family Practice were surveyed in the summer of 1985 to determine the impact of rising malpractice premiums on patterns of obstetric practice. Of the 685 physicians who responded, 61% are currently practicing obstetrics. The median number of deliveries per year was 29, with a range of 1 to 130 deliveries per physician. Younger physicians, rural physicians and those in group practice were more likely to practice obstetrics than older, urban physicians in solo practice. Of the 266 respondents not currently practicing obstetrics, 77% had discontinued obstetric practice within the past five years—half because of issues related to professional liability. Of those practicing obstetrics, 50% stated that they would cease obstetric practice if malpractice premiums rose to $12,000.

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The medical malpractice issue has emerged as one of the most powerful forces shaping the practice of medicine in the United States in the 1980s. The impact of the medical malpractice crisis has been most pervasive in the practice of obstetrics.[1] Obstetric practice is provided for the most part by obstetrician-gynecologists and general and family practitioners, and both groups have had to redefine the scope and content of their obstetric practice in the wake of a growing number of suits and large increases in malpractice premiums. The full impact of these changes on the future of obstetric practice is unclear.

Obstetric practice is a discretionary part of a family physician's clinical repertoire. The proportion of family physicians actively practicing obstetrics varies greatly by region of the country, urban or rural location and physician age.[2] Because malpractice premiums are much higher for family physicians who include obstetrics in their practices, the differential cost must be spread over a relatively small number of patients. Thus, rising malpractice premiums may make it economically infeasible for family physicians to continue obstetrics.

This study was designed to assess the extent to which proposed increases in malpractice premiums for family physicians in Washington State were likely to affect their future obstetric practice. Because family physicians represent an important clinical source of obstetric care in this state, the potential loss of a large number of physicians might sharply limit access to care for a large group of patients. In addition, because family physicians are the predominant source of medical manpower in rural areas, patients in these locations might be forced to travel long distances for obstetric care or to forego traditional obstetric care altogether.[3]

Methods

A questionnaire was sent to all 853 members of the Washington Academy of Family Physicians, a group whose membership includes the majority of general and family practitioners in the state. The one-page survey asked questions about the organization of a physician's practice, the amount of effort devoted to obstetric care and a number of specific queries about the impact—past, present and future—of malpractice premiums on the extent of obstetric services offered. The questionnaire was pilot tested before distribution, and two mailings were sent to ensure an adequate response. In all, 685 physicians returned a properly completed survey, yielding a response rate of 80%.

Results

Characteristics of Respondents

Of the 685 respondents, 85% were board certified in family medicine. The median number of years they had been in practice was 13. About 36% of the respondents had completed residency training in family medicine.

As Table 1 shows, 82% of the respondents are in private practice, with group practice the most popular mode. About 14% are in salaried practice, employed either by health maintenance organizations or in hospital settings such as emergency rooms. Of the sample, 26% are in nonmetropolitan

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areas as defined by the US Census, with the largest number of practitioners working in large cities.

A total of 419 of the respondents—61% of the sample—currently are directly involved in providing obstetric care. Younger physicians, rural physicians and those in group practice were significantly more likely to practice obstetrics than older, urban or solo practitioners. Although 71% of female physicians practice obstetrics as compared with 60% of male physicians, this difference is probably due to the fact that the female physicians in this study are younger than their male counterparts.

As shown in Figure 1, there are large differences in the obstetric load of family physicians in Washington State. The median number of deliveries is 29 annually, with a range from 1 per year to 130 per year. These differences in obstetric volume seem to be related more to individual differences among physicians rather than any systematic differences due to practice location, physician age or gender, board certification or residency training or the organization of the practice. No specific subgroup of physicians practicing obstetrics could be identified that had either a very high or a very low volume of deliveries.

Impact of Malpractice Premiums on Obstetric Practice

In all, 198 of the respondents reported that they had stopped practicing obstetrics during the past five years, representing 29% of all respondents and 74% of the 266 respondents not currently practicing obstetrics. An additional 126 physicians—18% of the respondents—reported a decrease in obstetric volume during the same period. About half of those who had stopped or decreased their obstetric practice cited professional liability issues as the primary cause—both the reality of increased premiums and the fear of future malpractice suits. The balance of those with curtailed obstetric involvement gave a variety of reasons for the change in practice patterns, with the leading factor being the personal inconvenience and practice disruption caused by obstetric practice. Table 2 contrasts the characteristics of physicians who have maintained their obstetric practice at past levels during the past five-year period with those groups who had either curtailed practice or ceased obstetrics entirely. As noted earlier, a cluster of interrelated characteristics is associated with the decision to continue practicing obstetrics: relative youth—as measured by the amount of time in practice; residency training and board certification, and group practice.

Future Trends in Obstetric Practice

The 419 respondents who were currently practicing obstetrics were asked to predict how a rise in malpractice premiums would affect their practices. Exactly half responded that they would probably cease practicing obstetrics in response to further premium rises. To quantify that expressed intention, we specified specific premium levels ranging from $8,000 per year to $32,000 per year and asked the respondents to indicate the level at which they would seriously consider not offering obstetric care. As can be seen in Figure 2, the effect is linear, with most respondents willing to tolerate premiums of $8,000 and virtually none willing to continue obstetrics if premiums rose to $32,000, the level for obstetrician-gynecologists prevailing at the time of the survey. At $12,000 per year for occurrence malpractice insurance, about half of the respondents predict they would cease obstetric practice.

Discussion

The rapid increase in malpractice premiums is being driven by two major factors: an increase in the number of claims filed and an increase in the size of malpractice awards. In Washington State, 6 claims were filed per 100 practicing physicians in 1971. The incidence of new claims had increased to 15 per 100 physicians in 1981 and to 21 by 1984 ("Medical Malpractice," *Seattle Post-Intelligencer,* September 1, 1985, p F-4). During the ten-year period from 1975 to 1984, the size of the average award has nearly quadrupled, rising from $50,000 in 1975 to nearly $200,000 in 1984. Not

TABLE 1.—*Characteristics of Survey Respondents (N=685)*

Practice Characteristics	*Number*	*Percent of Total*
Currently practicing obstetrics	419	61
Private group practice	317	46
Private solo practice	243	36
Health maintenance organization	69	10
Hospital-based	28	4
Other	28	4
Totals	685	100
≤15 years in practice	406	59
>15 years in practice	279	41
Totals	685	100
Practice Location		
Large metropolitan area	396	58
Small metropolitan area	112	16
Rural	177	26
Totals	685	100

TABLE 2.—*Differences Among Physicians Who Have Maintained, Decreased or Stopped Obstetric Practice During the Past 5 Years (N=605)**

	Maintained (N=281)	*Decreased (N=126)*	*Stopped (N=198)*
Percent women	16	9	8
Average years in practice	12	18	23
Percent in solo practice	25	38	50
Percent board certified	96	84	70
Percent finished family practice residency	63	30	19
Percent in rural areas	29	42	20

*80 questionnaires were deleted because of incomplete or inconsistent responses to this question.

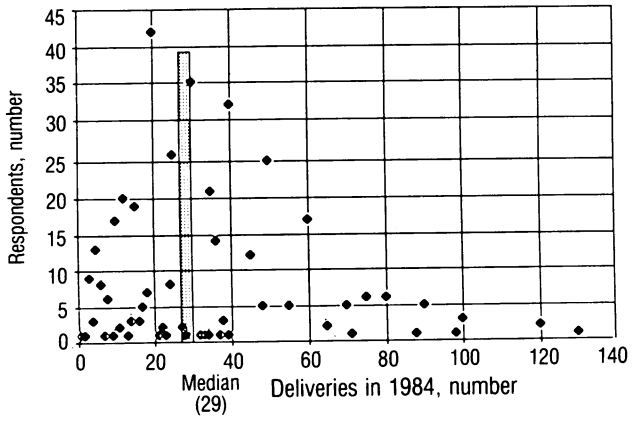

Figure 1.—Number of deliveries in past year by family physicians in Washington State who practice obstetrics (N = 419).

surprisingly, the cost of malpractice insurance has increased commensurately.

Obstetric care represents a segment of medical practice that is extremely sensitive to changing patterns of professional liability. More than 3 million births occur annually in the United States. Despite rapid advances in perinatal medicine, not every pregnancy results in a healthy baby. About 1 in every 100 babies will die during the perinatal period and an even larger number will experience significant morbidity, some of which will entail lifelong sequelae. Obstetrics will never be a risk-free endeavor, for either a mother, child or physician.

Because injuries to infants tend to be severe and of long duration, the awards in malpractice cases have been very large. In one study, the average award in cases involving injuries to infants was more than $1,400,000, whereas the average award for all other categories was less than $200,000.[4] As a consequence, malpractice premiums have risen particularly rapidly for physicians practicing in this area.

Obstetrics is a discretionary part of the clinical repertoire of family physicians. In this study, the average respondent with an active obstetric practice delivered 29 babies last year. In 1986 the malpractice premiums for family physicians who practiced obstetrics and were insured by the largest carrier in the state was $13,511; by comparison, the premium for family physicians without obstetrics was $4,324. Thus, the incremental insurance amounted to $317 per child delivered for a typical practitioner. Adding to the fiscal burden for physicians is the shift in most cases from occurrence to claims-made insurance, which requires physicians to remain in practice for at least ten years or purchase costly "tails" when they retire or move to another practice setting.

This study shows that the rapid increase in premiums has had, and will continue to have, a significant impact on practice patterns. If physicians' behavior mirrors their intentions, more than half of all family physicians in the state of Washington will cease practicing obstetrics during this coming year. This has significant ramifications not only for the future of family medicine as a clinical discipline, but will inevitably make it more difficult for important segments of the population to obtain obstetric care near where they live.

As this study shows, about 25% of family physicians practice in rural locations, settings in which they are frequently the only physicians providing obstetric care. Because it is very difficult for a physician to maintain an obstetric practice without some sort of coverage arrangement with colleagues, the loss of one or two physicians in many small communities may make future obstetric practice untenable even for those who wish to continue with this activity. As family physicians forego obstetric practice, patients will be forced to travel to other towns to receive their care. Provocative evidence is beginning to emerge that providing technologically intensive obstetric practice to a low-risk population may actually lead to poorer perinatal outcome, to say nothing of the increased cost and inconvenience shouldered by the women and families who can no longer obtain care in their communities.[5]

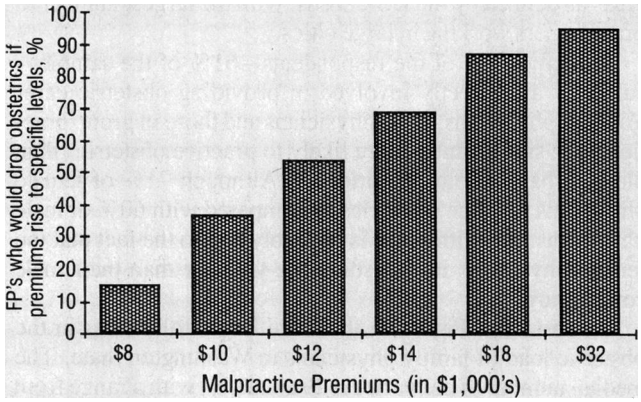

Figure 2.—Impact of specific malpractice premiums on obstetric practice of family physicians (FPs).

There is no simple solution to this problem. It is clear from this survey that obstetric practice has remained an important part of family practice to date. It appears, however, that rising malpractice premiums will have a profound impact on the practice patterns of family physicians. If premiums rise as predicted, obstetrics will be practiced by a minority of family physicians. Perhaps more important, this change is likely to make it more difficult and more expensive for women to obtain obstetric care, and women living in small communities may be forced to travel to other towns for what has been considered a rather fundamental component of primary medical care.

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