

Is There a Sea Change Ahead for Obstetrics and Gynecology?

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A number of beneficial sociocultural reforms have occurred throughout our society, including a new work/family balance. This change, and a number of others, are challenging the dynamic balance within our specialty. We must advocate for appropriate social, political, and economic interventions that will realistically mesh with the health care needs of our nation, while preserving that which is best about the culture of American medicine. (Obstet Gynecol 2002;100:1342-3. © 2002 by The American College of Obstetricians and Gynecologists.)

In late October 1991, an unusual combination of climatic conditions produced a tremendous, unexpected storm off the north coast of Massachusetts. Originally referred to as the "No Name Storm," it was dramatized by Sebastian Junger in a book and subsequent movie entitled *The Perfect Storm*. Analogously, a combination of lifestyle changes, change in provider gender distribution, rising malpractice costs, inadequate reimbursements, and market forces may be converging to create our specialty's perfect storm.

During the 1960s, 10% or less of graduating medical students were women. Today half of our medical school graduates are women. These young women have found the discipline of obstetrics and gynecology attractive, and now more than 75% of our residents are female, as many as in any other discipline. Many benefits have accrued with this change. Patients have been pleased that their preferences for female obstetrics-gynecology care providers are being met. The discipline has developed a heightened sensitivity to "women's issues," such as the need to balance the demands of work and raising a family.

The new work/family balance has benefited both genders and undoubtedly made patient care safer by decreasing inhumanely long work shifts and work weeks. Certainly an overworked, exhausted physician cannot be at his or her best. It took the Libby Zion case in New York City to elicit a public outcry to limit the number of work hours for trainees. This mandate has survived and

today permeates the clinical practice model even after training. Controlling the hours of the work week may have been one of the factors that enhanced the desirability of our discipline to women. These residents have joined staff model HMOs, faculties at teaching hospitals, and community group practices and, less often, started solo private practices.

With all the benefits that have accrued, a number of dilemmas have emerged for both the individuals involved and the entities that employ them. In many instances our female colleagues have postponed motherhood to complete their training. As providers of women's health care, we recognize the need for new mothers to be with their infants. But maternity leaves place a significant burden on the remaining practitioners in the group who must do additional coverage and call. They have less time with their own families, and with each subsequent pregnancy leave, tension and resentment can grow. When the new mother returns to work, she may well be expected to work 60 or more hours per week, too much for a mother with a young family. Many of these women desire part-time status and will accept less salary for less time, but that is not an attractive solution. The expenses of child care make it a challenge to make ends meet, to say nothing of the internal turmoil they experience from being away from their families, often at odd hours. For those in an academic setting, the part of the time that they work is inevitably their patient care service commitment at the expense of time for academic endeavors that lead to career advancement.

From the employer's perspective, malpractice insurance becomes even more burdensome because it remains payable at the full rate, whereas the practitioner is generating part-time revenue. In an academic setting, part-time status seriously diminishes time available for the other missions of the department, including teaching and research. In all practice settings it interrupts continuity of patient care and may adversely impact patient satisfaction. As with maternity leave, this increases the workload of those working full time, has a significantly adverse impact on finances, and serves over time to engender resentment.

The general malpractice scene appears to be worsening and has reached crisis proportions in many states. Annual malpractice insurance premiums in some states have reached amounts that have forced practitioners to stop providing obstetric care. A recent article in the *Washington Post*¹ pointed out that many counties in Mississippi no longer have any physicians providing obstetric care. The main malpractice insurance carrier in Nevada² withdrew from the market, leaving 60% of that state's obstetricians without coverage. The *Miami Herald*³ recently reported that many obstetricians in some Flor-

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ida counties are “going bare” without any insurance rather than pay annual malpractice insurance premiums in excess of \$120,000 for inadequate coverage. Our young colleagues in training are increasingly discouraged and intimidated by the apparent harassment of the malpractice situation in our discipline.

Nationwide, obstetricians-gynecologists’ median take home income rose by 1% from 1999 to 2000 despite a 19% rise in their median gross income.⁴ The discrepancy is due to the squeeze of adverse market forces. Expenses such as rent and staffing costs are increasing, whereas reimbursements per unit of service are flat or decreasing. This requires practitioners to work significantly longer hours to generate the increased revenues necessary to meet their expenses. Our students and residents observe these tensions among professional life, family life, and the growing financial pressures from inadequate revenue, an adverse marketplace, and rising malpractice costs. Many of them carry substantial educational debt burdens, and these factors inevitably influence their career choices. We have seen a steady decrease in the number of medical students interested in obstetrics-gynecology during the past 3 years as they increasingly choose less demanding fields that require shorter training periods and shorter work weeks in practice.

Are medical students’ perceptions of the undesirable nature of our specialty in general and community practice settings paralleled by their observations of their clinical faculties in major academic medical centers? On their clinical rotations they see faculty who are busy clinicians, required to provide ever more direct patient care including relatively frequent call to earn their salaries from clinical revenues, while having little time for academic endeavors and limited opportunity for academic advancement. The majority of academic medical centers care for a high percentage of indigent patients for whom public assistance reimbursement is sorely inadequate. Obstetrics and general gynecology are much like primary care from a revenue perspective, and almost all primary care departments in academic medical centers require institutional subsidies. We have consistently lagged behind some of the other major clinical disciplines in scholarly pursuits and accomplishments. In the recent past, more than 80% of the articles in one of our prestigious journals were observational studies with no power and of little consequence. The present model with heavy

emphasis on direct patient care in most academic medical centers will aggravate this trend, further depreciating our academic discipline and, ultimately, clinical care.

It would be presumptuous for us to attempt to propose a comprehensive solution for all of these problems. One suggestion, however, is to create a system of “hospitalists” and office practitioners. Physicians who confined their practices to the office would probably obtain substantially lower malpractice insurance rates with defined working hours and no risk to be called in to the hospital unexpectedly. Hospitalists would have defined shifts and work weeks of reasonable length. A hospitalist could choose to work evenings or weekends when a spouse, working a standard 5-day work week, would be available to provide child care. Practitioners could choose one option or the other at different times in their lives and careers to match their needs and interests. The flexibility of different working arrangements and lifestyles might be more attractive to medical students considering their specialty choices.

Will the coming together simultaneously of the several factors that we have outlined be more powerful than each issue alone? Is our perfect storm in the making? If the answer is yes, then we need to become active now rather than reactive later. To the extent that we can address these issues from within our discipline, we must. Many of these problems are societal, however, and can not be solved exclusively from within. To address those, we must advocate for appropriate social, political, and economic interventions that will realistically mesh with the health care needs of our nation, while preserving that which is best about the culture of American medicine.

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