

# **The Consequences of Hospitals Denying Obstetric Privileges to Board Certified Obstetric Fellowship Trained Family Physicians:**

## *Obstetric Privileges Based on Training, Experience, Ability & Competence*

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### **Introduction**

Family physicians are an important part of obstetrical care and perform about 800,000 deliveries per year or 20% of all deliveries in the United States (1). A significant challenge for family medicine physicians practicing obstetrics is obtaining hospital privileges (2, 3). The most contended aspect of granting family physicians obstetrics privileges centers on performing cesarean sections. The specialty of family practice was created in 1969 (4). Family practice was recognized by the American Board of Medical Specialties that year as the 20th specialty (5). Documentation of the struggle by family physicians for obstetric privileges dates back to 1977 (6, 7). The American Academy of Family Physicians (AAFP) and the American College of Obstetricians and Gynecologists (ACOG) developed core educational guidelines for training and collaborative practice in obstetrics in 1980 and reaffirmed them in 1988 and 1998 (8, 9). The AAFP and the ACOG Joint Statement recommended competency-based hospital privileges instead of specialty-based privileges (10). The AAFP (11), ACOG (11), American Medical Association (AMA) (11), and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (8) all agree that privileges should be based on documented training, experience, demonstrated ability and current competence (8). Any physician who meets those criteria for privileges should be credentialed for privileges regardless of specialty (11). "The most important objective of the physician is the provision of the highest standards of care, regardless of specialty" (6). Granting privileges is a hospital responsibility and should be based on training, experience and demonstrated competence regardless of specialty (6). Still, ACOG and AAFP conclude that ultimately it is ultimately the decision of the local hospital to grant privileges (7).

Many specialties of medicine share similar areas of practice (8). Both neurosurgeons and orthopedic surgeons operate on backs. General surgeons and orthopedic surgeons both perform trauma surgery. Otorhinolaryngologists and general surgeons perform thyroidectomies. Plastic surgeons and general surgeons augment breasts. Both family medicine physicians and obstetrician/gynecologists deliver babies (8). Unfortunately, obstetrics has been the center of controversy for physicians and hospitals for many years (8). Often family physicians have difficulty obtaining cesarean section privileges (12). The traditional belief that a lack of training in cesarean hysterectomy is sufficient grounds to justify withholding obstetric privileges to family physicians is no longer the case as most graduating OB/GYN residents have never performed a cesarean hysterectomy and a few have never even seen one (13). While OB/GYNs provide a great part of the obstetrical training of family physicians and have a great influence on whether family physicians practice obstetrics, OB/GYNs generally oppose family medicine obstetrics privileges in the hospital setting (14).

Family medicine is the most widely distributed specialty in the United States encompassing metropolitan to rural, underserved areas (15). Therefore, family physicians are in the best demographic position to provide obstetric care. All women deserve timely access to obstetrical care (16). In rural Canada, many family physicians practicing obstetrics perform less than 20 cesarean sections a year, yet there is no reasonable alternative (16). Family medicine residencies produce the largest number of physicians capable of providing obstetrical care but only a small percentage offer obstetrics in their practice (17). Both family

medicine residents and OB/GYN residents are trained to deliver babies. There are three times as many family medicine residents as OB/GYN residents in the United States. *Thereby, three times as many family medicine residents are trained deliver babies as are OB/GYN residents* (17). There is a tremendous need for family physicians to provide obstetric care, especially in rural, underserved areas (18). AAFP maintains that privileges should be based on documented training, experience, ability, and current competence which are a spectrum (19):

Training—acquisition of skills to do something; development of a particular skill; instruction in a group of skills (20)

Experience—having done the procedure; knowledge, skill, practice to put to test (20)

Ability—knowledge of how to do something; being able to; acquired proficiency (20)

Competence—demonstrated ability to do something; demonstrated proficiency; judgment, skill and strength (20)

### **Training**

Obstetrics is a traditional required component of the standard curriculum for family medicine residency programs (21). The quality of training is maintained by the Residency Review Committee (22). The AAFP-ACOG Joint Statement has standard core educational guidelines for obstetrics for family medicine residents (23). Cesarean section is within the scope of Family Medicine (23). Family medicine residencies are responsible for training their residents in obstetrics (21). Adequate training in obstetrics is defined by AAFP-ACOG Joint Statement on curriculum which determines adequate numbers of deliveries, continuity of care patients and time spent on OB/GYN rotations and services (24). Family medicine residencies prepare physicians for obstetrical care using these guidelines (24). If training is inadequate, it must be remedied (50). There are no studies indicating how much training is necessary for family physicians to perform cesarean sections (13). The number of cesarean sections performed by residents in training range from 25 to 100 with the average being 46 (13). The ACOG/AAFP cooperative statement set the minimum standards for training in obstetrics for family medicine residents (25).

Deutchman's study showed that family physicians have lower rates of cesarean section deliveries, use of forceps, diagnoses of cephalopelvic disproportion, and low birth weight babies (21). The study supported the high quality of outcomes of obstetric care provided by family physicians supporting the evidence for training and privileging of family physicians for obstetrics privileges and their ability to perform their own cesarean sections (21). Research has shown that the maternal and perinatal outcomes of family physicians and obstetrician/gynecologists are equivalent (21). Cesarean section rates for family physicians are 12.9% compared with 20.2% for obstetricians (8). Babies delivered by family physicians were more likely to be delivered vaginally and if instrumental, with vacuum (21). This data supports the training of family medicine residents to practice obstetrics.

Providing adequate training in obstetrics may be difficult in a traditional family medicine residency in which sufficient numbers of deliveries may not be available (18). An enhanced obstetrics track has been developed at the University of California, Davis Medical Center to provide family medicine residents with very similar training in obstetrics as OB/GYN residents in a four year family medicine obstetrics residency (18). There was no difference in cognitive test scores for obstetric knowledge between family medicine obstetrics and OB/GYN residents (18). There is variability in capabilities of residents, so some are ready to practice sooner than others (16). For advanced maternity skills 20 cesarean sections performed by a family

physician and involvement in another 30 are recommended by some Canadian training programs (16). ACOG-AAFP recommends 10 or more cesarean sections in a three month block (16). A U.S. study recommended 46 cesarean sections in training for family physicians (13). The American Board of Physician Specialties verifies training in obstetrics through the Board of Certification in Family Medicine Obstetrics (BCFMO) (24). To sit for the Board, a family medicine obstetrics applicant must have satisfactorily completed 100 vaginal deliveries and 50 cesarean sections (26). The literature does not specify the amount of training necessary to perform cesarean sections (13).

### **Experience**

Documentation of experience is essential in obtaining hospital privileges today (5). If there is low volume or a no volume experience, hospitals should provide a mechanism for assuring competency such as precepting or proctoring (27). This mechanism should be applicable for all staff and all specialties in line with JCAHO standards (27). In order to take the BCFMO exam, an applicant must have performed at least 100 vaginal deliveries and 50 cesarean sections (28). To attest to the value of experience, the BCFMO also allows an experience track to qualify to take the certification examination and applicants must have practiced obstetrics for at least 5 years with at least 100 vaginal deliveries and 50 cesarean sections, presented in a case list for review. Documentation of experience during residency is essential in obtaining hospital privileges (29). Family physicians that practice obstetrics are more likely to perform a wider range of other procedures (18, 30). There is no difference in scores on the CREOG Examination (18) and family medicine obstetricians are able to meet the requirements of American Board of Family Medicine in-service exams on family medicine (18).

### **Ability**

Family medicine physicians trained in obstetrics met and occasionally exceeded the reference standards in all measures (13). Outcome measures were surgical complications, blood transfusion, APGAR scores, postop length of stay (13). This study supports family medicine graduates performing cesarean sections based on a variety of training backgrounds and variable numbers of cesarean sections done during residency (13). Advanced maternity skills can be taught in a family medicine residency (16). So, completing residency training and board certification are important in obtaining privileges (13). Still, OB/GYNs have described family physicians practicing obstetrics as "... less qualified people who have had only a brief obstetrical orientation" (7). In response to society's need for high-quality OB training, family physicians have been trained in many procedures including instrumental delivery and cesarean section (31). Obstetrics fellowships programs have been developed to augment obstetric skills learned in family medicine residencies (32).

There is uncertainty about exactly what obstetrical procedures should be taught in a family medicine residencies and most residency directors have requested the creation of national standards (33). AAFP recommends that residents during their training program should strive to learn all procedures that are within the scope of family medicine as a specialty (33). The Residency Review Committee in family medicine requires procedural skills to be completed by all residents (33). A Society of Teachers in Family Medicine (STFM) task force met and developed core procedures for family medicine (33). They recommended three categories of procedures for family medicine residents: (A) procedures that all residents should learn, (B) optional procedures that a resident may learn; and (C) procedures that require additional training in a fourth year of residency or a fellowship (33). Subsets of "A" included spontaneous vaginal delivery (SVD), vacuum-assisted delivery, basic prenatal ultrasound, circumcision and repair of third- and fourth-degree lacerations (33). Subsets of "B" include cesarean section (33).

## **Competence**

Competency is usually tested by direct observation while in training or proctoring by an experienced physician after training (23). Components that determine the level of competence include experience and feedback, direct observation by supervisor and discussion with other staff, knowledge, experience and self-assessment of learner (34). Board certification is a means of documenting competency in which skills are observed as part of the certification process (23). Candidates for Certification in Family Medicine Obstetrics are evaluated through observation of their surgical skills by a board approved-proctor in obstetrics to test competency (28). Research shows that family physicians trained in obstetrics can maintain their skills with relatively few cesarean sections (16). Many Canadian family physicians only perform 15 cesarean sections per year but maintain competency by lifelong learning, audit, review and continuing education (16). Many of these physicians are in remote locations and their service is essential in providing local obstetric care. Most respondents in this study recommended that physicians needed 11 to 30 deliveries a year to remain competent (35).

## **Outcomes**

Studies comparing obstetrical outcomes among family physicians practicing obstetrics with obstetrician/gynecologists are scant (12). There are only three recent studies in the literature comparing outcomes of family physicians practicing obstetrics with obstetrician/gynecologists (12). A recent study in 2013 compared 250 cesarean sections performed by family physicians and OB/GYNs (12). There were no differences in intraoperative or infectious complications; however, there were fewer complications in the cesarean sections performed by family physicians including fewer blood transfusions and readmissions (12). Neonatal outcomes were the same (12). Two recent studies compared delivery procedures and delivery complications of OB/GYNs versus family physicians practicing obstetrics (36, 37). A study on the delivery procedure rates showed that family physicians practicing obstetrics had lower cesarean section rates than OB/GYNs because they did more vaginal births after cesarean sections (VBAC) (36). The delivery complications study showed that the complications of family physicians were similar to OB/GYNs when caring for high-risk pregnancies (37). Study results show similar cesarean sections outcomes regardless of delivery by family physicians or OB/GYNs (12).

Patients are not at an increased risk when a cesarean section is performed by a family physician (12). In addition, decision making was similar with the two groups (12), as were cesarean section rates (12). Specialty of the physician does not appear to affect patient risk (12). Franks and Eisinger, in a 1986 retrospective study of 6,856 deliveries by family physicians and obstetrician/gynecologists found that there is no difference in adverse perinatal outcomes between the two groups of physicians (38). Black, in a large study in England also found that there was no difference in perinatal morbidity between 1970 and 1979 among the two groups of physicians (38). So, there is no increased risk in care by family physicians as compared to obstetrician/gynecologists (38). "Specialty is not a risk factor for adverse perinatal outcomes." (38). OB/GYNs, however, do not believe that family physicians should deliver babies because OB/GYNs believe that all deliveries are all potentially "high risk" (4). Still, studies show that family physicians deliver babies as safely as OB/GYNs (4, 21) and that family physicians do not provide poorer obstetric care (4).

## **Difficulty Obtaining Hospital Privileges**

Obstetric fellowship-trained family physicians to have difficulty obtaining obstetrics privileges, especially in The American Academy of Family Physicians (AAFP) (11), American College of Obstetricians and

Gynecologists (ACOG) (11), American Medical Association (AMA) (11), and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (8) all agree that privileges should be based on documented training, experience, demonstrated ability and current competence and not necessarily on specialty certification (8). The final decision about privileges, however, rests with a hospital board based on a recommendation by the executive or credentials committees. "The most important objective of the physician is the provision of the highest standards of care, regardless of specialty." (6). The majority of OB/GYNs, however, are opposed to family physicians delivering babies (32). OB/GYNs become, over time, more supportive of family physicians doing deliveries; most support comes from older obstetrician/gynecologists (39). Overall, though, OB/GYNs feel that family physicians are inadequately trained for obstetrics (39). Less than 50% of OB/GYNs believe that family physicians should practice obstetrics (41). OB/GYNs believe that family doctors should have few obstetric privileges (39). Some residents are denied obstetrics privileges after residency training (40). Obstetric privileges do not correlate with size of hospital (25).

Family physicians have difficulty obtaining privileges due to 1) arbitrary wide-sweeping hospital administrative decisions 2) economic considerations in which privileges are denied to enhance earning potential of existing hospital staff 3) an increasing supply of physicians 4) difficulty of family physicians demonstrating training and competence; and 5) inaccurate and conflicting perceptions of the skills of family physicians (39). However, even adequately trained family physicians have difficulty obtaining cesarean section privileges (12). OB/GYNs often sell family physicians short in regard to providing high-quality obstetric services (31). It is critical that family physicians meeting these criteria--training, experience and competence-- be granted obstetric privileges (31). Credentials are granted by OB/GYN or Family Medicine Departments.

Family physicians are unable to obtain hospital privileges for a variety of other reasons, such as their office is too far from the hospital, competency, economics and supply of certain specialty physicians (3). AAFP states that physicians' privileges should not be withheld based on number of specialists (10).

It is harder to get obstetrics privileges at university hospitals than community hospitals (3). Teaching hospitals typically restrict family physicians more than other hospitals (17). Hospital privileges are crucial to physicians and often are granted based on economic and social interests of individual physicians, hospitals and the public (42). It has been suggested that hospital privileges should have judicial oversight (42). The hospital board ultimately makes the decision about hospital privileges (42). Customary exclusion standards include inadequate malpractice insurance, failure to maintain hospital records, and disruptive conduct (42).

Rural physicians are less restricted than urban physicians (2). Smaller hospitals grant privileges more readily than do larger hospitals (2). This paper supports more favorable privileges for family medicine physicians in rural and smaller hospitals (2). Both family physicians and OB/GYNs agree that rural obstetric care would decline if family physicians quit doing deliveries (39).

### **Improving Opportunity to Get Privileges**

Hospitals should have a credentialing process that considers training, experience, ability and competence of family physicians when granting privileges, which supports the recommendations of JCAHO (44). Specialty training itself should not be sufficient for granting or denying privileges. Family physicians should be credentialed in family medicine which requires a full clinical department (44). Recommendations for privileges are (44):

- 1) Have adequate training and experience
- 2) Put together all documents needed
- 3) Read Family Practice in Health Care Organizations
- 4) Read the legal opinion obtained by the AAFP
- 5) Know hospital rules and regulations
- 6) Insist on written explanation of denial of privileges
- 7) Solicit local support including FM department, FPs and other physicians
- 8) Exhaust all avenues of appeal
- 9) Seek support from local AAFP chapter
- 10) Seek support from national AAFP organization
- 11) Meet the AAFP conditions for financial support
- 12) Seek ABFM board approval (44).

Family physicians in rural areas and those that finish a family medicine residency are more likely to obtain obstetrics privileges and practice obstetrics (45). In Dr. Rodney's study, 96% of family medicine obstetrics fellowship graduates attained privileges for cesarean section (32). Residency training increases the likelihood that a graduating resident will provide obstetrical care (19). Family physicians are most likely to practice obstetrics if they worked in a nonmetropolitan area (19) and if they completed a family medicine residency (19). There is a high correlation of completing an obstetrics fellowship and getting OB privileges (46). Most hospitals require family physicians to have completed an obstetrics fellowship in order to apply for obstetrics privileges. Some 66% of family medicine obstetrics fellowship graduates obtained cesarean section privileges (10). Performing more than 50 cesarean sections during fellowship, geographical location in the United States and practicing in rural, underserved areas all associated with obtaining cesarean section privileges (10).

Family medicine faculty supervision of obstetric care by family medicine residents increases the likelihood that residents will practice obstetrics (40). Good training with content documentation, seeking appropriate level of privileges commensurate with experience, skills and competence and demonstration of skills is important in obtaining privileges (47). Requiring applicants to provide references to attest to their competence is reasonable (42). AAFP recommends that all hospitals have a Department of Family Medicine (46). That department would then have the responsibility of recommending privileges to the credentialing committee. Ultimately the governing body of the hospital (the foundation board, the hospital board, the board of directors, the board of trustees) grants privileges (46). Privileges should be based on licensure, demonstrated abilities and current competence (46). When OB/GYNs work closely with family physicians, they appreciate their skills and believe that family physicians can provide obstetrical care and take care of most complications of pregnancy (41).

### **Need for Privileges**

Women with less access to obstetric care have more complicated deliveries, more preterm deliveries and a higher cost of neonatal care (17). Women who have to travel for obstetrical care often have a greater

number of complicated deliveries, increased rates of prematurity, and higher costs (47). Family medicine residencies produce the largest number of physicians capable of providing obstetric care but only a small percentage of family medicine residency graduates offer this care in their practice (17). Sometimes they do not offer obstetric care because they feel that they are inadequately trained or there may be quality of life issues. Factors that influence family physicians' decisions to practice obstetrics include: difficulty in obtaining privileges, scarcity of OB/GYNs, professional liability coverage, and clinical exposure during medical school (9). Barriers need to be removed so that family physicians can obtain hospital privileges and continue to deliver babies, particularly in rural areas, where rural practice is associated with obstetric care (48, 49). Privileges can be granted by family medicine, OB/GYN or both jointly (50). Loss of obstetrics services in rural areas has had deleterious neonatal results (49). Women in rural areas of the United States and Canada have better outcomes if they deliver locally (51). Maternity services that do not have cesarean section capability are at risk of not surviving (51). Being able to perform a cesarean section is the key to providing local obstetrical care (51). When cesarean section privileges are present, 85% of women deliver locally in Canada (51).

Family physicians typically care for socially vulnerable populations and geographically isolated populations, such as rural, underserved America (52). Access to obstetric care is a public health concern (53). A shortage of family physicians practicing obstetrics translates into poorer neonatal outcomes (53). The United States predicts a drastic reduction in OB/GYN physicians in the next few years due to low career satisfaction, increased liability and fewer U.S. students matriculating into OB/GYN residencies (54). More than 75% of graduating OB/GYN residents are female and many want reduced workloads, job sharing and part time professions (59). More than 50% of OB/GYNs are more than 50 years old (24). There has been a decrease in OB/GYN residency programs from 272 in 1995 to 252 in 2005 (24). Most OB/GYN residency graduates sub-specialize. Most family physicians who stop practicing obstetrics never return to it (55). Denial of hospital privileges accounts for a loss of family physicians practicing obstetrics (49).

### **Conclusion**

Obstetrics is a core component of family medicine residency training (8). The American Academy of Family Physicians and the American College of Obstetricians and Gynecologists developed core educational guidelines for training and collaborative practice (8). AAFP, ACOG, AMA and JCAHO recommend that hospital privileging be based on documented training, experience, demonstrated abilities and current competence (8, 11). However, the real world experience for most family physicians practicing obstetrics has not been that simple. The majority of obstetrician/gynecologists do not believe that family physicians should practice obstetrics even though outcomes of OB/GYNs and family medicine OB physicians are comparable (8). A physician who meets the criteria for privileges should be credentialed for privileges regardless of specialty according to AAFP, ACOG and AMA (11). Family physicians are often the only provider in rural areas, without an OB/GYN or general surgeon to assist them, so, they must be able to perform cesarean sections independently (13).

Delivery of healthcare in rural, underserved areas is a national concern (41). One of the great questions in medicine is which type of provider is qualified to deliver babies (4). There is no evidence that family physicians provide less optimal care than OB/GYNs (4). The standard of obstetrical care today mandates that a provider be able to perform a cesarean section (13). The literature shows that family physicians provide good care (13, 16). Family medicine obstetricians can be given the same obstetric privileges as OB/GYNs (36, 37). Despite the reluctance of hospitals and in particular obstetrician/gynecologists, to grant family physicians cesarean section privileges, the performance by family physicians in our study of nearly

15,000 deliveries over nine-year period is impressive (36, 37). The overall cesarean section rate, the primary cesarean section rate and the repeat cesarean section rate of family physicians practicing obstetrics are considerably lower than rates for obstetrician/gynecologists (36). The lower cesarean section rates are mitigated by the much higher vaginal birth after cesarean section rate (VBAC) by family physicians. VBAC is recommended by ACOG. How we label physicians is not important. What *is important* is what physicians can do based on training, experience, ability and competence.



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