Profile of Ob-Gyn Practice

The economic environment for providing women's health services continues to challenge obstetrician-gynecologists. Declining reimbursement and rising practice expenses are but two of the challenges confronting obstetrician-gynecologists in 2003. If ob-gyns are to maintain financially viable practices – and thus, continue to care for their patients – they need accurate, up-to-date economic information.

In 1991 the American College of Obstetricians and Gynecologists initiated the Socioeconomic Survey of ACOG Fellows to assess the organizational and financial aspects of ob-gyn practice. The first Socioeconomic Survey gathered baseline data on ACOG members' practice characteristics and workload, as well as individual income, practice revenues, and practice expenses. The College repeated the Socioeconomic Survey in 1994, 1998, and 2003. A minimum of 1100 practicing ob-gyns responded to each round of the survey, providing a rich source of data on financial and organizational trends in ob-gyn practice in the 1990s and early 21st century.

This profile provides an overview of ob-gyn demographics, practice characteristics, and workload in 2003 and presents trends from 1991 through 2003. Future papers will address other topics covered by the 2003 Socioeconomic Survey.

Demographics

Since ACOG initiated the Socioeconomic Survey in 1991, the number of women physicians in obstetrics and gynecology has expanded dramatically. In 1991, 21% of ob-gyns responding to the survey were women. In 2003, women represented 39% of survey respondents. Most of the increase in the proportion of women occurred between 1998 and 2003, as the large numbers of women medical students who chose ob-gyn residencies in the 1990s entered active practice.

Results from the 2003 survey indicate a small, but statistically significant increase in the mean age and experience of respondents. The average 2003 survey respondent was 46.5 years of age and had been in practice 15 years, while the average 1991 participant was 45.7 years old and had been in practice 14 years. In 2003 20% of respondents had been in practice for less than five years, 22% had been in practice between five and ten years, 26% were in practice between 11 and 20 years, and the remaining 31% had been in practice for more than 20 years. The distribution of respondents among these categories did not change significantly

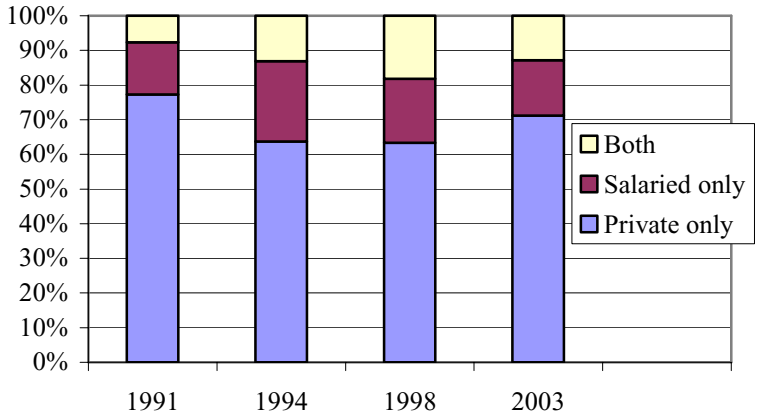
The racial and ethnic composition of ob-gyns has remained fairly consistent since 1991. More than 8 out of 10 ob-gyns participating in the 2003 survey were white. Nine percent identified themselves as Asian or Pacific Islander, 4 percent as African-American, and 3 percent as "other" (including American Indian/Alaska Native). Five percent reported that they were Hispanic.

The vast majority of ob-gyns responding to the survey practiced within metropolitan areas. Only 12 % of those participating in the 2003 survey reported a non-metropolitan practice location. (Respondents whose practice zip codes were located in a metropolitan statistical area were classified as "metropolitan" and those with practice zipcodes located outside of a metropolitan statistical area were classified as "non-metropolitan"). There was no statistically significant change in the percentage of respondents reporting a non-metropolitan practice location from the 1991 survey.

Practice Setting

In 2003 private practice remained the dominant practice setting for ob-gyns, with 70% of respondents to the survey reporting only a private practice position (respondents could report more than one type of practice arrangement). This represents a statistically significant decrease from the 77% of respondents reporting only a private practice position in 1991. The dominance of private practice fluctuated during the period covered by the four ACOG Socioeconomic Surveys (see Figure 1), dropping between 1991 and 1994, remaining stable through the 1998 survey, and then regaining some of its share by 2003.

Figure 1
Trends in Ob-Gyns' Practice Setting, 1991 - 2003



Approximately 15% of survey respondents reported only a salaried position in 1991. Although the share of ob-gyns reporting only salaried positions grew significantly during the 1990s, by 2003 the proportion of ob-gyns working only in salaried positions had returned to virtually the same level as in 1991.

The remainder of ob-gyns reported holding both a salaried position and being in private practice. In 2003, 13% of survey respondents worked in both a salaried and a private practice position. Among those reporting both a salaried and a private practice position, the most frequent combination was hospital employee and single-specialty group practice. Significant growth in the percentage of ob-gyns reporting hospital employment (from 5% in 1991 to 14% in 1998) could reflect the widespread purchase of physician practices by hospitals in the 1990s.

Perhaps the most striking change in practice setting is the decline in the percentage of ob-gyns in solo practice from 33% in 1991 to 23% in 2003 (see Table 1).

Most of this decline occurred during the 1990s, leveling off between 1998 and 2003. In contrast, ob-gyns in group practices (both single and multi-specialty) comprised 60% of all respondents to the 2003 survey, compared to 52% of respondents in 1991.

Table 1
Practice setting, 1991 - 2003

	Survey Year			
Practice Setting	**1991**	**1994**	**1998**	**2003**
Solo practice	32.7%	27.2%	24.1%[1]	22.6%[2]
Single specialty group	40.3%	40.8%	41.6%	45.2%
Multi-specialty group	11.5%	9.0%	15.7%	14.6%
Salaried employee of private practice	1.0%	2.8%	2.4%	1.3%
HMO	6.1%	6.0%	6.0%	3.9%
Hospital	5.3%	9.7%	13.6%[1]	11.3%
University/medical school	8.9%	11.4%	11.1%	10.0%
State/local government	1.0%	2.1%	1.0%	0.8%
Federal government	0.8%	1.1%	0.8%	0.6%
Active duty military	--	2.8%	1.0%	1.5%
Other	1.2%	4.9%	2.2%	4.3%

[1] *t*-test 1991 – 1998, $p < 0.05$
[2] *t*-test 1991 – 2003, $p < 0.05$

Not only did the importance of group practice for ob-gyns grow, average group size rose, as well. Single specialty group practice ob-gyns reported an average of 6 physicians per group in 2003. In comparison, average single specialty group size was 4 physicians in 1991. Multi-specialty groups have been a less common practice setting for ob-gyns. These groups tend to be larger than single specialty groups, with an average of 12 ob-gyns and 105 physicians of all specialties in 2003.

Practice settings reported by 2003 survey respondents varied by age, geographic location, and gender. Private practice ob-gyns were significantly older than their salaried practice colleagues (47.1 years compared to 43.9 years) and reported more years of experience (15.53 years in practice compared to 12.37 years in practice). Almost 9 out of 10 non-metro ob-gyns were in private practice compared to slightly more than four out of five metro-area ob-gyns. Male ob-gyns were significantly more likely to report private practice positions than women (87% compared to 77%).

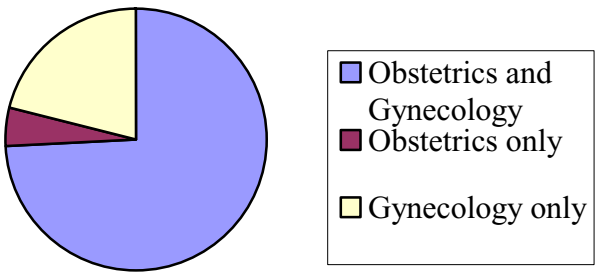
Among private practice respondents, solo practice ob-gyns were significantly older than their group practice colleagues (51.6 years compared to 45.5 years). Solo practitioners reported an average of 19.3 years in practice, while group practice survey respondents had been in practice an average of 14.1 years. Ob-gyns in solo practice were less likely than those in group practice to be located in metropolitan areas: only 83% reported a metropolitan practice location compared to 89% of group practitioners. There were no significant differences by gender.

Practice Characteristics

The survey asked respondents whether they currently practiced obstetrics and gynecology, obstetrics only, or gynecology only. As shown in Figure 2, approximately

three fourths of survey respondents reported practicing both obstetrics and gynecology or obstetrics only. Twenty percent reported practicing only gynecology.

Figure 2
Ob-Gyns' Practice Scope, 2003



Among gynecology only respondents, 16% had never practiced obstetrics, while more than 40% had discontinued practicing obstetrics within the past five years (that is, since 1998). In general, gynecology only respondents cited personal reasons for the decision to stop practicing obstetrics. Half indicated that a desire for more personal time (30%), change in a personal situation (9%), personal health concerns (6%), or age (5%) prompted them to discontinue obstetrics. Another 10% indicated that an interest in changing professional focus was the primary motivation for stopping obstetrics. Relatively few (9%) attributed the decision solely to issues related to professional liability. However, 36% of gynecology only respondents identified fear of litigation, a negative experience with litigation, the inability to afford professional liability insurance, or the inability to obtain professional liability insurance in addition to other factors as reasons for the decision to drop obstetrics.

Previous surveys did not ask respondents to identify themselves as obstetrics and gynecology, obstetrics only, or gynecology only practitioners, so we cannot report trends in this measure. Analyses of the 1991, 1994, and 1998 surveys assessed this issue by classifying respondents as obstetrics and gynecology or gynecology only on the basis of the annual number of deliveries reported. Four fifths of respondents to the 2003 survey (80%) reported performing at least one delivery in 2002. Those respondents who performed deliveries in 2002 were significantly younger (45.1 years compared to 53.7 years) and had been in practice for a shorter time (13.3 years compared to 21.1 years) than those reporting no deliveries. Women and men were equally likely to have performed deliveries in 2002. Non-metro providers were somewhat more likely to report at least one delivery in 2002 (86% compared to 79%), although the difference was not statistically significant at the $p < 0.05$ level.

Results from the 2003 survey show a small, but statistically significant change from the 1998 survey, in which 84% of respondents reported performing at least one delivery in the previous year. In addition, the average age of those reporting deliveries fell from 46 years in the 1998 survey to 45 years for 2002 respondents and the mean number of years in practice for respondents practicing obstetrics dropped from 14 in 1998 to 13 in 2003. It is not clear whether these small changes signal an important shift in ob-gyn practice, or whether they result from factors such as differences in the age and gender profiles of the 1998 and 2003 respondents. An analysis that controls for such factors is beyond the scope of this paper.

The 2003 survey also shows a small, but statistically significant decline in the percentage of ob-gyns with a surgical practice. Approximately 94% of respondents to the 2003 survey reported performing at least one surgical procedure, while 97% of 1998 survey respondents performed some surgery. Those 2003 respondents who did not include surgery in their practices were significantly older (56 years compared to 46 years) and had been in practice significantly longer (24 years compared to 14 years).

More than four out of five survey respondents (82%) identified themselves as ob-gyn generalists, while 18% identified themselves as subspecialists. Maternal fetal medicine and reproductive endocrinology were the most frequently cited subspecialties (5%), followed by urogynecology and gynecologic oncology (3%).

Work Hours

We asked respondents to report the number of hours spent in a variety of patient care and administrative activities during their most recent complete week of practice. In 2003, ob-gyns reported an average of 50 hours per week spent on patient care activities alone. This total does not include hours when the respondent was on call, but not providing direct patient care. Although the total number of weekly patient care hours reported in 2003 did not differ significantly from the level reported in 1991, Table 2 does demonstrate some interesting shifts in how ob-gyns spent their time.

Between 1991 and 2003, our survey results reveal a small, but statistically significant increase in hours spent seeing patients in the office. There was a corresponding decrease in time spent on hospital rounds, possibly reflecting a broader trend toward outpatient treatment and office-based services.

Table 2

Hours per week in professional activities, 1991 - 2003

	Survey year			
	1991	**1994**	**1998**	**2003**
In the office seeing patients	24.37[1,2]	24.79[3,4]	26.53	26.62
In the OR, labor and delivery	14.19[1,5]	15.69[4]	15.23[6]	14.28
Making hospital rounds	4.67[1,2,5]	4.00[3,4]	3.67	3.50
Seeing patients in OP clinic or ER	1.76[1,5]	2.60[3,4]	2.18	2.03
House calls or seeing patients in nursing home	0.13[1]	0.12[3]	0.21	0.14
Telephone calls, interpreting tests, etc.	4.26[2]	4.23[3,4]	4.00[6]	3.56
All patient care activities	49.22[1,5]	51.31[4]	51.76[6]	50.11
Administrative activities	--	15.05[3,4]	13.82[6]	13.05
Total professional activities	--	66.13[4]	65.54[6]	62.45

[1] *t*-test 1991 – 1998, $p < 0.05$
[2] *t*-test 1991 – 2003, $p < 0.05$
[3] *t*-test 1994 – 1998, $p < 0.05$
[4] *t*-test 1994 – 2003, $p < 0.05$
[5] *t*-test 1991 – 1994, $p < 0.05$
[6] *t*-test, 1998 – 2003, $p < 0.05$

Respondents to the 2003 survey reported an average of 13 hours per week spent on administrative activities. Practice management and administrative duties accounted for 4 hours of this time, while continuing medical education activities consumed another 3 hours, with the remainder divided among other non-patient care activities including hospital committee responsibilities, travel between practice sites, professional society activities,

and teaching/research. The 2003 data show a small, but statistically significant drop in hours spent on administrative activities since 1994 when the question was first included in the survey.

Reported weekly work hours varied significantly by practice setting and demographic characteristics (see Table 3).

Table 3
Variation in weekly professional hours, 2003

	Hours per week		
	Patient care	Admini-strative	Total
All			
Salaried practice	47.78 [1]	18.07 [1]	64.98 [1]
Private practice	50.56	12.08	61.96
Group practice	51.08 [1]	12.97	62.05
Solo practice	49.17	13.31	61.73
Male	50.77 [1]	13.48	63.41 [1]
Female	48.97	12.47	60.89
Non-metro	52.21 [1]	11.12	62.64 [1]
Metro	49.82	13.32	62.41
Years in practice			
Less than 5 years	53.99	14.03	67.03
5 to 10 years	50.85 [2]	12.84	62.72 [2]
11 to 20 years	51.01	13.05	63.53
More than 20 years	46.29	12.43	58.24

[1] *t*-test, $p < 0.05$
[2] ANOVA, $p < 0.05$

Private practitioners worked significantly fewer hours overall, but reported more patient care hours than ob-gyns in salaried practice. Ob-gyns in salaried practice reported 50% more administrative hours. This suggests that many respondents in salaried practice hold positions with significant non-patient care responsibilities. Among private practitioners, those in group practice spent significantly more time in patient care than their colleagues in solo practice, although administrative burdens did not vary significantly between group and solo practice. Men responding to the survey reported more patient care hours and total professional hours. In addition, respondents with less than five years in practice reported more patient care hours and more total hours.

Patient Visits

Since 1994 the Socioeconomic Survey has asked respondents to report the number of patient encounters in a variety of settings during the most recent complete week of practice. In 2003, ob-gyns reported an average of 92 patient visits per week in all settings, a small, but statistically significant increase compared to the 90 visits per week reported in 1994 (see Table 4).

As shown above in Table 3, average weekly patient care hours decreased slightly over the same time period. Ob-gyns achieved the increase in patient visits by increasing productivity from 1.8 patient encounters per hour in 1994 to 1.95 visits per hour in 2003.

Table 4
Patient visits per week, 1994 – 2003

	1994	1998	2003
Patient visits – Office	72.04[1,2]	78.09	77.71
Patient visits - Hospital, not ER	11.66[1,2]	10.85[3]	10.13
Patient visits - Clinic or ER	4.70[2]	4.87[3]	3.47
Patient visits - Patient's home, nursing home, convalescent facility	0.05	0.05	0.26
Patient visits – Other	0.45[1]	0.93[3]	0.56
Total patient visits per week	89.67	94.79	91.80
Office visits per hour	3.03	3.03	3.11
Total visits per hour	1.81[1,2]	1.92	1.95

[1] *t*-test 1994 – 1998, $p < 0.05$
[2] *t*-test 1994 – 2003, $p < 0.05$
[3] *t*-test 1998 – 2003, $p < 0.05$

Consistent with the 2003 survey findings on work hours, the 2003 patient visit data reveal growth in office-based services. Compared to 1994, respondents reported a higher volume of office encounters and lower volume of hospital visits and outpatient clinic/ER visits. Moreover, in 1994 office visits accounted for 78% of all patient encounters, while in 2003, that percentage rose to 83%.

Variation in patient visits and productivity was similar to variation in work hours (see Table 5).

Table 5
Variation in patient visits, 2003

	Visits per week		Office visits per hour		Total visits per hour	
All						
Salaried practice	72.26	1	2.72	1	1.59	1
Private practice	95.48		3.18		2.02	
Group practice	98.46	1	3.16		1.97	
Solo practice	87.61		2.94		1.88	
Male	96.80	1	3.17		2.05	1
Female	83.79		3.02		1.80	
Non-metro	95.24		2.92	1	1.92	1
Metro	91.21		3.13		1.95	
Years in practice						
Less than 5 years	88.84		2.85		1.71	
5 to 10 years	95.30	2	3.21	2	2.01	2
11 to 20 years	97.17		3.33		2.03	
More than 20 years	86.71		3.02		1.99	

[1] *t*-test, $p < 0.05$
[2] ANOVA, $p < 0.05$

Private practice respondents reported 32% more patient visits, as well as more office visits per hour and total visits per hour. Among private practitioners, group practice ob-gyns reported significantly more visits, but had no significant advantage in visits per hour. Male ob-gyns reported more visits and more total visits per hour than their female counterparts. The volume of visits and visits per hour increased with greater experience through 20 years, but fell off among those in practice more than 20 years.

Procedures

Table 6 shows trends in the annual number of deliveries, hysterectomies, and total surgical procedures performed by ob-gyns responding to the Socioeconomic Survey. Among respondents reporting at least one delivery in 2002, the mean number of annual deliveries was 138, virtually identical to the average number reported in the 1991 survey. In contrast to the stability in the number of deliveries reported, the average volume of hysterectomies declined by 11 percent from 1991 to 2003. Surgical volume appears to be on an upward trend since the mid-1990s, with both the number of hysterectomies and number of total surgical procedures increasing significantly since 1994.

Table 6
Annual procedures, 1991 – 2003

	Survey year			
	1991	**1994**	**1998**	**2003**
Deliveries	137.52	146.85[1]	141.44	138.42
Hysterectomies	29.52[2,3,4]	24.17[1]	23.90[5]	26.17
All surgical procedures	--	88.69[1]	87.33[5]	95.54

[1] *t*-test 1994 – 2003, $p < 0.05$
[2] *t*-test 1991 – 1994, $p < 0.05$
[3] *t*-test 1991 – 1998, $p < 0.05$
[4] *t*-test 1998 – 2003, $p < 0.05$

In 2003, male survey respondents consistently reported more procedures than did female respondents: 25% more deliveries, 33% more hysterectomies, and 51% more total surgical procedures (see Table 7). The number of deliveries did not vary by practice setting, but private practitioners did report 52% more hysterectomies and 38% more total surgical procedures. Solo and group practitioners reported a similar volume of deliveries, hysterectomies, and total surgeries. Deliveries did not vary by metropolitan or non-metropolitan location. However, non-metro ob-gyns performed significantly more hysterectomies and total surgical procedures. The volume of deliveries followed a pattern similar to work hours and patient visits with respect to years of experience, increasing through the first 20 years of practice, and then falling off. However, the volume of hysterectomies and total surgical procedures increased through 20 years of practice and remained steady thereafter.

Table 7
Variation in procedures, 2003

	2002 Deliveries	**2002 Hysterectomies**	**2002 Total Surgical Procedures**
All			
Salaried practice	140.08	18.22 [1]	72.26 [1]
Private practice	138.13	27.65	99.86
Group practice	139.14	26.49	94.41
Solo practice	135.74	25.16	99.18
Male	150.23 [1]	30.20 [1]	109.78 [1]
Female	119.55	19.46	72.63
Non-metro	131.55	34.02 [1]	118.11 [1]
Metro	139.66	25.21	92.77
Years in practice			
Less than 5 years	133.52	22.87	74.97
5 to 10 years	143.26 [2]	24.86 [2]	93.59 [2]
11 to 20 years	149.04	27.75	102.78
More than 20 years	127.89	27.81	104.78

[1] *t*-test, $p < 0.05$
[2] ANOVA, $p < 0.05$

Methods and Data Sources

The data reported here are from four mail surveys of ACOG member physicians in the 50 states and the District of Columbia conducted in 1991, 1994, 1998, and 2003. All four surveys used a similar questionnaire, designed by staff of ACOG's Department of Health Economics, in collaboration with Princeton Survey Research Associates (PSR) of Princeton, New Jersey. PSR managed and supervised questionnaire design, pretesting, sampling, data collection, and data entry for each of the surveys.

Results from each survey are weighted to be representative of the ACOG membership in terms of geographic location, sex, Fellowship status, and age in that year. ACOG staff analyzed the data using SPSS for Windows, Release 11.5. Differences between sample means were tested with *t* tests and adjusted for each survey's design effect and finite population correction factor. Differences between sample proportions were tested with *Z* tests and adjusted for each survey's design effect and finite population correction factor. All comparisons and trends discussed in the text are statistically significant at $p < 0.05$ unless otherwise noted.

A detailed explanation of the survey sample for each year follows:

1991

The 1991 survey is based on self-administered mail questionnaires completed by a representative sample of 1,286 ACOG member physicians living in the U.S. and involved with patient care. The questionnaires were initially mailed out on July 23, 1991 to 2,000 randomly selected ACOG Fellows and Junior Fellows in practice. Residents were excluded from the sample. Questionnaires returned by October 24 were tabulated. The final response rate was 67%. For results based on the total sample, one can say with 95% confidence that the error attributable to sampling and other random effects is plus or minus 3 percentage points.

1994

The 1994 survey is based on self-administered mail questionnaires completed by a representative sample of 1,146 ACOG member physicians living in the U.S. The questionnaires were initially mailed out on September 12, 1994 to a proportionate stratified random sample of 2,100 ACOG Fellows and Junior Fellows in practice. Residents were excluded from the sample. Questionnaires returned by December 9 were tabulated. The final response rate was 55%. For results based on the total sample, one can say with 95% confidence that the error attributable to sampling and other random effects is plus or minus 3 percentage points.

1998

The 1998 survey is based on self-administered mail questionnaires completed by a representative sample of 1,230 ACOG member physicians living in the U.S. The questionnaires were initially mailed out on October 12, 1998 to a proportionate stratified random sample of 3,100 ACOG Fellows and Junior Fellows in practice. Residents were excluded from the sample. Questionnaires returned by February 15, 1999 were tabulated. The final response rate was 42%. For results based on the total sample, one can say with 95% confidence that the error attributable to sampling and other random effects is plus or minus 3 percentage points.

2003

This survey is based on self-administered mail questionnaires completed by a representative sample of 1,492 ACOG member physicians who live in the United States. The questionnaires were initially mailed out on January 21, 2003 to a proportionate stratified random sample of 3,100 ACOG Fellows and Junior Fellows in practice. Residents were excluded from the sample. Questionnaires returned by May 6, 2003 were tabulated. The final response rate was 49%, accounting for ineligible respondents and undeliverable questionnaires. For results based on the total sample, one can say with 95% confidence that the error attributable to sampling is plus or minus 2 percentage points.

For more information contact:

Rebecca Kelly
Director, Health Economics
(202) 863-2456
rkelly@acog.org