The Ob-Gyn Shortage Is Real—And It Might Impact Your Care

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On a typical day Heather Bartos, M.D., sees about 30 patients; in an average month she delivers 20 to 25 babies. An ob-gyn practicing about 45 minutes outside Dallas and chief of obstetrics and gynecology at Texas Health Presbyterian Hospital in Denton, she also spends a day a week in surgery and another tackling administrative tasks. She works through lunch every day so she can attempt to get home at a reasonable hour to see her kids, but the fact that a woman can go into labor at any time makes her days and nights pretty unpredictable. Sometimes the pace is overwhelming. “I know I can’t keep it up forever,” says Dr. Bartos.

There’s another reason Dr. Bartos’ schedule is so hectic: She’s one of only a handful of obstetricians in Denton. A few years from now, when she’s in her early fifties (she’s 47), she

plans to scale back her patient load and handle only five or six deliveries each month. She doesn't know who, if anyone, will step in to take her place. "There's a really high rate of burnout among ob-gyns," she says, and there aren't many young doctors clamoring to start their careers in areas like hers. The potential fallout? Denton could have a shortage of ob-gyns even greater than it already has.

A lack of ob-gyns is increasingly a national problem. Right now half—half—of all counties in the U.S. do not have a single obstetrician, says Hal Lawrence III, M.D., executive vice president and CEO of the American College of Obstetricians and Gynecologists (ACOG). A recent ACOG report concluded that women in Arizona, Washington, Utah, and Idaho face the greatest risk of a severe ob-gyn shortage; Florida, Texas, North Carolina, and Nevada could soon be next, because the female population in those areas is growing without new ob-gyns flooding in. The problem could reach major cities too, according to Doximity, a network for physicians and clinicians. After polling its members and cross-referencing those results with things like birth records and population data, Doximity found that cities including Las Vegas, Orlando, Los Angeles, Miami, Detroit, Memphis, Salt Lake City, and St. Louis, could soon be without enough ob-gyns.

Where the ob-gyns are

A few key factors are driving the decline: first, burnout. "About a third of providers stop obstetrics within the first 10 to 12 years of practicing," says Dr. Lawrence. While some of them transition to only routine gynecological care, which tends to be less stressful and allows for more regular work hours, others turn to subspecialties like urogynecology or gynecological oncology that don't entail delivering babies. "It's a demanding field, and there's a lot of nighttime work," says Dr. Lawrence. "You have to really love what you do." Even ob-gyns who stick it out retire earlier—at age 59 on average, according to Doximity—than primary care physicians, who tend to practice until their mid-sixties.

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Another reason: compensation. Sometimes the cash coming home isn't enough to make up for the intense workload and erratic hours (especially true for providers who accept Medicaid, which generally reimburses doctors at rates much lower than private insurance companies). But the bigger money issue is insurance. Obstetricians face one of the highest rates of malpractice cases. As a result, malpractice insurance is often incredibly expensive. In some areas, says Dr. Bartos, "you could spend almost a third of your salary on insurance."

Valerie Jones, M.D., an ob-gyn in the Maryland suburbs who retired early from clinical care, was warned about the insurance burden before starting her career. "I remember hearing that when you leave residency, you should expect to be sued at least twice in your career," she says. But she was dismayed by how health care in the U.S. can sometimes emphasize productivity and cost-effectiveness over quality of patient care. Disillusioned, she left the field last year when she was only 37, after a health scare of her own led her to reevaluate her priorities and motivated her to spend more time with her three children.

While Dr. Jones admits that it's unusual to stop practicing entirely in your late thirties, she understands why young physicians drop the obstetrics part of the job and just stick with gynecology. "The highs you get from delivering a healthy baby are like no other, but the lows are very low too," she says. Even when a doctor has done nothing wrong, she says, "If there's a bad outcome during childbirth, it's devastating for everyone involved."

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One thing is for sure: A lack of interest in the profession isn't the problem. ACOG has thousands of student members at med schools across the country. "Residency slots [for obstetrics and gynecology] fill up on match day," says Dr. Lawrence. Creating more of those slots would help, but someone needs to pay for it. "Right now residencies in all specialties are funded by the government," he says, though a few hospitals are experimenting with private funding.

How a shortage could impact your care

If you live in a major metropolitan area, you may not feel the hit of fewer providers, says William Rayburn, M.D., emeritus chair of obstetrics and gynecology at the University of New Mexico and author of the ACOG report. Elsewhere the shortage will likely mean longer drives to find a provider, longer wait times, or even rushed or poor care. Those frustrations led Amanda Baker, 45, who lives in rural Virginia, to start seeing a nurse practitioner (NP), even though she has a family history of ovarian cancer. "I have no problem seeing an NP," she says. "For women here, if you can afford to leave the area for care, you leave; if not, you accept the status quo."

Relying on other medical professionals, including NPs, physicians assistants (PAs), and midwives, is one way women can get care in the face of a physician shortage. Laws vary by state, but in many places NPs, PAs, and midwives can prescribe medication, diagnose infections, and perform checkups. While they don't have the same level of training as M.D.s, Dr. Lawrence says they help build very effective care "teams": Picture a practice with a handful of midwives, NPs, and PAs and one or two obstetricians who can step in when necessary. "This [team approach] expands access to care in areas that might have only one or two ob-gyns," he explains.

Telehealth, using technology to consult a doctor virtually, could also become an increasingly essential tool. Web or mobile services can help you "see" a doctor; for example, nurx.com has providers licensed in many states who consult via chat and write prescriptions for birth control that the service delivers. At amwell.com you can consult a virtual gynecologist for help with a urinary tract infection, STI, and more. (While you may be accustomed to having a pelvic exam as part of a checkup, guidelines from the American College of Physicians say that's no longer necessary for most healthy women who aren't pregnant.)

While these are all creative solutions, Dr. Jones is concerned about relying too heavily on them. “Women, especially those with high-risk pregnancies or who find themselves in an emergency situation, should still have access to the skills and expertise of an obstetrician,” she says. “There’s no replacement.”

To get or maintain access to real-life ob-gyns, rural communities may have to figure out incentives to lure physicians away from major metropolitan areas, such as offering to pay off medical school loans, suggests Dr. Lawrence. Malpractice reform would also help, says Dr. Jones, to weed out frivolous but expensive lawsuits.

Expanding government funding for medical residency programs so that more ob-gyns could start training each year would also make a huge difference. But public funds for these programs have been frozen since the Clinton administration; they weren’t increased under President Obama, and it seems unlikely that they’d be unfrozen under President Trump. “Access to women’s health care waxes and wanes with each election,” says Dr. Bartos. “It should always be a priority.”