Hospital Privileges for Family Physicians

David V. Hansen, David N. Sundwall, MD, and Robert L. Kane, MD
Salt Lake City, Utah

Many medical students interested in family medicine as an eventual career, as well as physicians doing residency training in family practice, have expressed concern that they may not be able to obtain hospital privileges. To determine if family physicians are, in fact, restricted in their use of hospital facilities, a survey was conducted of 176 hospitals in the AMA's Region 8. A two-page questionnaire was sent to the hospital administrators; 93 percent responded either by mail or phone. Hospitals were classified as urban or rural and information regarding general staff privileges and specific clinical areas, eg, surgery, obstetrics, intensive care unit, and coronary care unit, was obtained. Criteria for extending staff privileges, consultation requirements, number of family physicians on staff, and recent changes in the number of family physicians applying for privileges was also studied.

The results showed that 88 percent of the urban and 98 percent of the rural hospitals stated it would be very likely that a board certified family physician would obtain full staff privileges. Specific data on the likelihood of a family physician using facilities in the ICU, CCU, surgical, and OB departments indicated some restriction in urban areas, although it was not as much as expected. The results were encouraging and suggest that family physicians, at this time, have access to the majority of hospital facilities in the Intermountain West. It is hoped that this pilot study will be of use in the gathering of similar information from other regions in the United States.

The development of the new specialty of Family Practice is now a matter of history. This resulted from a recognition that the strong emphasis on the "science of medicine," characteristic of medical education in the 1950s and 1960s, led to significant deficits in the number of physicians providing general medical care.[1] McWhinney has suggested that medicine now stands at the end of an era and that the benefits of technology have been reaped without steps having been taken to control its negative effects.[2] In an attempt to return to humanitarian, cost-conscious medicine, much energy and money has been expended to educate specialists in family medicine. This, it is hoped, will produce a generalist capable of providing scientifically sound medical care, yet with special skill in dealing with ambulatory and psychosocial problems. Tangible evidence of this trend is the fact that there are now 310 approved residency programs in family practice, a dramatic increase from the handful of such programs in the late 1960s.

In the face of this redirection in postgraduate training, the precise role of family physicians in the future of health care in the United States remains to be determined. Frequent concern is voiced about the possibility that the family doctor is evolving toward the role of a strictly ambulatory physician, similar to the British and European generalist. Medical students and residents often express their concern that, as family physicians, they may not be able to obtain hospital privileges. And, unfortunately, some medical educators reaffirm this fear, advising students that they should "at least" become board certified as an internist and/or pediatrician if they wish to become adequately trained primary care physicians and fully authorized to use hospital facilities.

This paper attempts to determine the current status of opportunities for family physicians in the hospital setting in a limited geographic area of the United States. In 1969, the American Academy of General Practice conducted an ambitious survey questioning all Academy members regarding their hospital practice and satisfaction with same.[3] The number of questionnaires received and processed was 19,257. Information was obtained regarding number of years in practice, length and type of postgraduate training, and content of practice, ie, adult medicine, pediatrics, surgery, obstetrics, and orthopedics. Also, physicians were queried regarding whether they had active staff privileges at one or more hospitals (89 percent did), and about specific privileges within the hospitals, ie, medicine, pediatrics, surgery (minor and major), ICU, and CCU. Physicians were specifically asked if they were satisfied with their hospital privileges; 96 percent reported they were, only four percent stating they believed they were unduly restricted. These data were remarkable in view of currently voiced concerns that family physicians are being, or will be, severely limited in their opportunities to use hospital facilities.

Methods

In an attempt to obtain current data to either confirm or dispel concerns about hospital privileges for family physicians, a survey of hospital administrators (not physicians) was conducted regarding hospital privileges for family physicians.

From the University of Utah College of Medicine and the Department of Family and Community Medicine, University of Utah College of Medicine, Salt Lake City, Utah. Requests for reprints should be addressed to Dr. David N. Sundwall, Division of Ambulatory and Community Medicine, University of California, San Francisco, CA 94143.

The data presented here are from a pilot study of the Bureau of the Census, Region 8 (Arizona, New Mexico, Nevada, Utah, Colorado, Idaho, Wyoming, and Montana). Each hospital was classified as being either within or not within a Standard Metropolitan Statistical Area (SMSA).* There are 13 SMSAs within Region 8 (Figure 1).

The hospitals studied were limited to those classified by the American Hospital Association as follows: *Control* – nongovernmental, not for profit; *Service* – general medical or surgical; and *Stay* – short stay, ie, 50 percent of all patients stay less than 30 days.[4] A total of 327 hospitals met these qualifications. All hospitals with greater than 100 beds (a total of 101 hospitals) were surveyed. From the 226 hospitals with less than 100 beds, 75 were selected by means of random sampling. Therefore, a total of 176 hospitals were included, 38 percent within an SMSA (classified as urban) and 62 percent classified as rural.

In the summer of 1976 a two-page questionnaire was sent to the administrator of each hospital selected; he/she was requested either to return the completed questionnaire by mail or to provide the information via a toll-free telephone call. If no response was received within three weeks, the administrator was contacted by telephone. In all, 67 administrators returned the mailed questionnaire, of whom 18 had to be sent a second copy because they had either not received or had misplaced the first; 97 administrators (59 percent) were interviewed by telephone either to gather initial data or to clarify items on the mailed questionnaire.

Questions included information about general staff privileges, use of specific departmental or clinical areas, and changes over the past five years in requests for such privileges. Other hospital characteristics considered in the analysis were occupancy rate, presence of a clinical department of general practice or family medicine, and the ratio of general practitioners and/or family physicians to the total active staff. Differences were compared by chi square, with a statistical significance level set at $P < 0.05$.

*An SMSA is defined as a county or group of counties containing at least one city with a population of 50,000 or more, plus any adjacent counties which are metropolitan in character and economically and socially integrated with the central county or counties.

Results

The questionnaires sent to the hospital administrators listed a series of questions designed to assess the current and future status of hospital privileges for family physicians. The response rate from both urban and rural hospitals was encouraging. Of the 67 urban hospitals polled, 59 (88 percent) responded; for the rural hospitals, 105 of the 108 hospitals polled responded, a response rate of 97 percent. Two hospitals had the same administrator and therefore responded as a single unit.

As shown in Table 1, the administrators of both rural and urban hospitals indicated that both board and nonboard certified physicians practicing family medicine would generally be able to get hospital privileges. Those with board certification were more likely to get the privileges than those without. Even among the urban hospitals, 95 percent of the physicians with or without board certification could probably or very likely obtain hospital privileges.

The administrators of the majority of hospitals in both rural and urban areas, 80 and 85 percent respectively, indicated that a combination of documented medical experience and board certification formed the basis of their decisions about granting privileges. This underlines the importance of a family physician's maintaining accurate records about the content of his/her practice and the procedures he/she has performed.

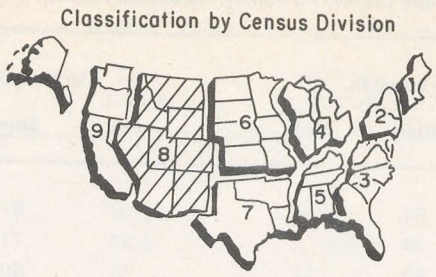
When the extent to which privileges would be granted in specific areas was probed, differences between urban and rural hospitals became more defined. Table 2 summarizes the responses of urban and rural hospital administrators with regard to privileges granted to family physicians in various areas of surgery and in the medical intensive care units. In each case the urban hospitals were significantly more limiting in their granting of privileges to family physicians. Nonetheless, even in the most restricted case, that of surgical obstetrics, 71 percent of the urban hospitals and 88 percent of the rural hospitals indicated that family physicians would be granted at least some privileges. With regard to general surgery and nonsurgical obstetrics, ie, vaginal deliveries, the situation is even more optimistic. None of the rural hospitals and only five percent of the urban hospitals refused privileges to family physicians in the area of nonsurgical obstetrics. Despite fears that family physicians are being severely limited in obtaining surgical privileges, only 11 percent of the urban hospitals and four percent of the rural hospitals granted no surgical privileges to family physicians.

Access to the intensive care units was also generally available in virtually all of the rural hospitals. Family physicians could use both the intensive care unit and the coronary care unit. In the urban hospitals, 86 percent offered the family physician at least some access to the coronary care unit and 91 percent to the intensive care unit.

The conditions surrounding the granting of these specialized privileges are further explored in Table 3, which describes the extent to which mandatory consultation is required for family physicians in order that they be permitted to use hospital facilities in specific clinical areas. Rural hospitals tended to require consultation universally in only about ten percent of the cases, while urban hospitals required it in approximately 20 percent. In only two instances, however, were these differences statistically significant. Although the urban hospitals were more stringent in their requirements for consultation than the rural hospitals, these differences were not so great as one might have anticipated.

In an effort to estimate the trends for the future of family physicians in hospital practice, the administrators were asked to estimate the changes in the number of family physicians applying for hospital privileges over the past five years. Based on this survey, the growth was greater in urban hospitals than in rural ones. This is demonstrated in Table 4. It probably reflects the growing interest in family practice in urban areas. It is interesting that the same proportion of rural and urban hospital administrators reported a decrease in the number of applications. However, it should be noted that the American Academy of Family Physicians has figures for 1975 and 1976, indicating that there has been a slight preponderance of graduates in family practice residencies settling in rural areas. Specifically, 54 percent of the graduates in 1975 and

States
1. Arizona
2. Colorado
3. Idaho
4. Montana
5. Nevada
6. New Mexico
7. Utah
8. Wyoming



SMSAs
-Phoenix
-Tucson
-Colorado Springs
-Denver
-Pueblo
-Boise
-Billings
-Great Falls
-Las Vegas
-Reno
-Albuquerque
-Provo-Orem
-Salt Lake City-Ogden

Figure 1. Area Used for Study

Table 1. Likelihood That a Family Physician/General Practitioner Would Be Able to Obtain Hospital Privileges

		Rural Hospitals	Urban Hospitals
Family physician (board certified)	Very likely	98%	88%*
	Probable	2%	8%
	Possible	—	2%
	Unlikely	—	2%
General practitioner (non board certified)	Very likely	90%	76%*
	Probable	8%	19%
	Possible	2%	3%
	Unlikely	—	2%

*Differences between rural and urban hospitals not statistically significant

57 percent of the graduates in 1976 have established practices in areas with populations less than 30,000.

In order to relate the degree to which privileges were made available to family physicians, an *average privilege score* was created by weighting the degree of privileges (full privileges = 3, some = 1, none = 0) and averaging across several clinical areas: general surgery, intensive care unit, coronary care unit, and surgical and nonsurgical obstetrics. (Where a service was not available in a hospital, it was omitted.) The score deliberately gives a higher weight to full privileges. The range of scores was then divided into thirds.

Table 5 summarizes the differences in average privilege score according to various hospital characteristics. In each case these differences were highly significant. Urban hospitals gave fewer privileges than rural hospitals; correspondingly, larger hospitals gave fewer than small hospitals. Those with lower occupancy rates (probably also the rural hospitals) gave more privileges.

Interestingly, those hospitals with clinical departments of family or general practice gave fewer privileges than those without, but this again reflects the urban-rural differences. Hospitals in which family physicians form the majority of the medical staff were more likely to allow greater privileges. Thus, relative representation rather than the existence of a formal department appears to be most important in determining the scope of privileges allowed. As might be expected, when there are other specialists available, the family physician is less likely to obtain as many privileges.

Discussion

It should be emphasized that this was a pilot study done in a limited area of the country. In many ways the area studied cannot be considered typical of the rest of the country. Family practice has been more enthusiastically received by both the practicing and academic communities in the predominantly rural areas of

Table 2. Extent of Privileges Granted to Family Physicians in Specific Clinical Areas*

	Rural hospitals			Urban hospitals			
	Full	Some	None	Full	Some	None	P value**
General surgery	32	64	4	7	82	11	< .005
Nonsurgical obstetrics	76	24	-	24	71	5	< .005
Surgical obstetrics	36	52	12	11	60	29	< .005
Intensive care unit	54	45	1	30	61	9	< .005
Coronary care unit	54	44	2	27	59	14	< .005

*All figures are in percentages **Difference between urban and rural hospitals

Table 3. Extent of Mandatory Consultation for Family Physicians in Specific Clinical Areas*

	Rural hospitals			Urban hospitals			
	All cases	Some cases	Not required	All cases	Some cases	Not required	P value**
General surgery	11	59	30	16	59	25	NS
Coronary care unit	15	52	33	24	43	33	NS
Intensive care unit	10	54	36	20	48	32	NS
Nonsurgical obstetrics	3	41	56	11	53	36	< .05
Surgical obstetrics	11	63	26	33	50	17	< .05

*All figures are in percentages **Difference between urban and rural hospitals NS = not significant

Table 4. Change in the Number of Family Physicians Applying for Hospital Privileges in the Past Five Years

	Rural hospitals	Urban hospitals
Increase	37%*	57%*
Same	50%	30%
Decrease	13%	13%

*Difference between urban and rural hospitals significant at P<.05

Table 5. Average Privilege Score According to Hospital Characteristics

	Low (0-1.00)	Medium (1.01-2.00)	High (2.01-3.00)	N*
Hospital location*				
Urban	66%	20%	14%	59 (100%)
Rural	23%	30%	47%	105 (100%)
Number of beds*				
⩽ 99	20%	26%	54%	75 (100%)
⩾ 100	53%	27%	20%	89 (100%)
Occupancy rate*				
0-49%	24%	28%	48%	32 (100%)
50-74%	36%	24%	40%	75 (100%)
75+%	54%	29%	17%	52 (100%)
Clinical Department of FP or GP*				
Yes	55%	27%	18%	58 (100%)
No	30%	26%	44%	106 (100%)
Proportion of family physicians on staff* $\left[\frac{\text{FP + GP}}{\text{active staff}}\right]$				
0-24%	56%	27%	17%	53 (100%)
25-49%	48%	22%	30%	24 (100%)
50-74%	18%	41%	41%	22 (100%)
75+%	29%	23%	48%	62 (100%)

*Differences significant at $P<.005$ N = number of hospitals

Region 8 than has been the case in the more populous areas of the eastern United States. Thus, the positive attitudes reflected by hospital administrators in this region cannot be immediately extrapolated to all hospitals in the country.

Certain limitations to the data must be acknowledged. Some of the questions left respondents to determine precisely what constituted full privileges or "some" privileges, and these interpretations could differ considerably from hospital to hospital. For this reason the weighting system which gave extra emphasis to full privileges was used. Nonetheless, if one focuses simply on the dichotomous response, some or all vs none, the responses still provide much cause for optimism and stand in striking contrast to some of the discouraging opinions about hospital privileges for family physicians that have been bandied about.

This information was derived from hospital administrators and may, therefore, reflect hospital bylaws rather than actual practice. The issue of physician satisfaction has not been addressed. Although no severe limitations in any area of hospital privileges were uncovered, it cannot be concluded that family physicians are completely satisfied with the privileges they have. Perhaps a repeat of the American Academy of General Practitioner's study is needed to address this issue.

The present study was undertaken as a pilot effort to test the feasibility of acquiring this type of data. The results have been gratifying. What is needed now is a national study to ascertain whether the situation prevalent in Region 8 is typical of the nation as a whole.

References

1. Physician Manpower and Distribution: The Primary Care Physician. A Report of the Coordinating Counsel on Medical Education. Chicago, American Medical Association, 1975
2. McWhinney IR: Family medicine in perspective. N Engl J Med 293:176, 1975
3. American Academy of General Practice: Summary of Members Practice Survey. Kansas City, Missouri, American Academy of Family Physicians, 1969
4. American Hospital Association Guide to the Health Care Field, annual edition. Chicago, American Hospital Association, 1975