

Documentation of Resident Exposure to Disease Entities

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The medical privilege application forms of hospitals in 15 southern states were examined for the degree of privilege delineation required. Forty-nine percent of the responding hospitals require extensive delineation of privileges. Residents in the Anderson, South Carolina Family Practice Center have instituted a method of systematically recording exposure to disease entities encountered in the patient population not enrolled in the Family Practice Center. These records can be integrated with existing tabulation of enrolled patients. There are potential benefits for residents' future hospital privilege applications as well as for modification of the curriculum by faculty.

Repeatedly, residents in family practice are exhorted to document their training experiences in residency.^{1,2} The reasons include obtaining hospital privileges at a level commensurate with competence, mitigating liability to suit, and monitoring resident exposure to disease entities and special procedures. This paper presents information gained in a survey of 15 southern states relating to hospital privilege applications and then describes a simple mechanism for tabulating and storing information on resident exposure to diagnostic entities encountered outside an enrolled model fam-

ily practice unit population. The information tabulated is not limited in potential usefulness to hospital-privilege application. It is easily extended to monitoring in-training exposure to specific disease entities and categories, especially as it relates to curriculum modification.

Format of Hospital Privilege Applications

Applications for medical staff privileges were requested of 90 hospitals listed in *Clark's Directory of Southern Hospitals*.³ The hospitals were selected to represent a broad range in size. No

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special hospitals such as mental hospitals, military hospitals, veterans' administration hospitals, hospitals for the mentally retarded, or cancer institutes were included. Hospital size ranged from 34 to 833 beds. Otherwise the selection was without deliberate intent and there was no other particular information available on the hospitals. The response rate to the request for a copy of the privilege application was quite good: 63 hospitals, or 70 percent. These applications were then divided into three groups:

I. Those requiring application for privileges disease category by disease category or procedure by procedure. This group is hereafter referred to as "full delineation."

II. Those requiring application for privileges grouped into only a few broad disease categories (less than 15), or for only a few procedures (less than 15), or in which delineation was only in one specialty (most commonly general surgery). This group is hereafter referred to as "partial delineation."

III. Those requiring application for privileges delineated only by specialty or hospital department, such as surgery, pediatrics, obstetrics. This group is hereafter referred to as "no delineation." The results of this division may be seen in Table 1.

A point-biserial coefficient of correlation revealed no relationship between the size of the hospital and the requirement for full delineation of privileges. The partial delineation category was grouped with the no delineation category for this analysis. Although the number of teaching hospitals responding was only 12 and too small for a statistical comparison, there appeared to be no relationship to the requirement for more specific privilege delineation.

Limitations

It would be naive to assume that the degree of specificity appearing on a hospital's privilege application form accurately reflects a like specificity in the granting or withholding of privileges.

Nevertheless, it is not unreasonable to assume the existence of some underlying reasons for the requirement of applications for "fully delineated" privileges.

The Joint Commission on Accreditation of Hospitals (JCAH) sets only broad guidelines for the delineation of medical staff privileges: "All recommendations to the governing body for staff appointment must include a clear delineation of clinical privileges. Privileges granted shall be commensurate with the training, experience, competence, judgment, character, and current capability of the candidate. When a hospital uses a system involving classification of privileges, the scope of the classifications must be well defined and the standards that must be met by the applicant should be clearly stated for each category."⁴ Forty-nine percent of the hospitals replying to the survey appeared to have adopted the "full delineation" type of application form to partially satisfy this requirement. Several hospitals which did not use such a form included in their reply that a change in the form was imminent. A trend toward such a form may be in progress as indicated by several responding hospitals.

How variously the hospitals responding hew to the requirement of the JCAH for "well defined" classification is suggested by the range from zero to nearly 1,000 in specific disease categories and procedures. Among those hospitals with an application requesting full delineation there was a very marked mode at approximately 550 disease categories and procedures. This reflects the use of form 1028 by Briggs/Will Ross, Inc., of Des Moines, Iowa. Sixteen responding hospitals use this form. Disease categories and procedures were usually grouped according to medical specialty or subspecialty, eg, surgery, orthopedics, medicine, or pediatrics. Only two had a separate grouping for family practice or general practice, a reflection of the identity problem family practice is often said to have. Where the hospital's constitution and by-laws were gratuitously included by the responding hospital it was generally noted that the family physician would be under the oversight of the committee chairman of each department in which he had privileges.

Grouping of diseases and procedures by specialty was diverse, including at times dentistry, podiatry, pathology, and radiology. Even more diverse were the disease categories and procedures

Delineation	Number of Hospitals	Percent	Number of Teaching Hospitals
Full	31	49	4
Partial	6	10	0
None	26	41	8
Total	63	100	12

chosen for inclusion on the forms.

A brief selection of disease categories and procedures gives the flavor of these application formats. Note the range from the picayune to the relatively exotic: premature infant care with/without complications (separating over 4 lbs from under 4 lbs), hemophilia, uncomplicated diabetes, hypertension, mild/moderate/severe preeclampsia, arterial puncture, cardiac catheterization, cardioversion, spinal tap, sigmoidoscopy, small intestinal biopsy with the Crosby capsule, single undisplaced phalangeal fracture, complicated/uncomplicated pneumonia, renal dialysis, and pancreatitis. It is doubtful that many of these hospitals scrutinize the appropriateness of prepara-

tion for privileges checked off by physicians, at least for the present. They may serve only as evidence (with face validity) that the hospital staff and governing body are attempting to meet JCAH requirements. A further potential service would protect staff and governing body members in those malpractice suits which allege that due care was not taken in limiting staff physicians to privileges within their competence. A sociogram of the local medical community might be more predictive of how hospital privileges will actually be granted to new family physicians. Once these forms are created, however, they are convenient vehicles for working toward a more thorough fulfillment of the intent of the JCAH requirements. The more than

1,000 procedures and disease categories these forms collectively list also reinforce the urgency of an objective- and competency-based curriculum and evaluation in family practice residency training.

What "standards...must be met by the applicant" in ticking off the privileges he/she desires to be granted are, for the present, left to the local hospital staff. On staff privilege applications a resume of premedical, medical, and postgraduate medical education is almost uniformly included as are experiences in continuing medical education, membership in professional societies, and personal references. Academic appointments, publications, and a description of one's medical practice are often included. As necessary as these pieces of information are, they scarcely constitute an objective basis for judging competency in such specific medical skills as are listed on the same form. Completing medical school and residency is no longer always acceptable as *prima facie* evidence of competency to perform all the tasks customarily allotted to a particular medical specialty. Peterson, for example, found no relationship between measures of competency in the daily delivery of health care in general practice (albeit *outside of* hospitals) and traditional measures of success in preparation for medical practice including internship.⁵ It appears that this is being belatedly recognized.

Exposure Index

Residents in the Anderson (South Carolina) Family Practice Center have begun to implement a simple procedure after the fashion of the E-book for monitoring disease exposure. Motivation for following the procedure varies with the resident but is not generally felt to be wholly a defensive posture against a future hospital privilege "freeze-out." It rather involves the desire to see the gaps in exposure as well as possible surfeits of

exposure. A succinct record of disease entities encountered by the end of a three-year residency is produced, incorporating diseases in patients seen outside the Family Practice Center as well as within it. Since most of the hospitalized patients and the procedures and diseases more prevalent in them are not from among the center's enrolled patient population, the residents would have been missing a record of a significant portion of their exposure if they relied solely on the already computerized record devoted to the enrolled patients. The program faculty have encouraged the procedure. An overall picture of resident exposure, particularly during the first one-and-a-half years, is available. This is useful for planning elective rotations or spotting deficiencies in the primarily hospital-based portion of the residency.

For each hospitalized patient cared for by a resident, a document is nearly always produced which comes into his possession. This is usually in the form of a copy of a patient discharge summary dictated by him. Other documents include history and physical examination dictation, death summaries, autopsy or other pathology reports, x-ray reports. Some documents are produced outside of the hospital, such as in outpatient clinics. A copy of these is also occasionally returned to the resident. The resident's task is twofold: first, he/she keeps a personal copy of these documents on non-family practice patients and culls out or collates those that duplicate a single exposure. At intervals the resident consults the ICHPPC code book⁶ and writes at the top of his copy of the document the code(s) corresponding to the disease(s) encountered in that experience. Only those codes are entered which, *in his opinion*, involved a significant experience. Sometimes the resident will not have been involved in the primary problem for which the patient was being treated, in which case the corresponding code should not be entered. Depending on the resident's diligence, a more or less complete record is created representing at least his/her minimum exposure. The coded documents are given to a family practice departmental secretary who enters the patient's name and date of hospitalization under the code in a booklet kept for each resident. She then returns the document to the resident. Since the ICHPPC code has 371 codes, each resident's book could potentially have 371 pages with a varying number of names and dates on each.

As more residents have chosen to keep such a record the recording and storing of the data threaten to become an unmanageable burden in the foreseeable future. Help was sought from the "mother" family practice program in Charleston, South Carolina, with which the Anderson Family Practice Center is affiliated. A simple computer program was designed there to store the data in essentially the same form, and its use has begun.

Shortcomings

The ICHPPC code has certain shortcomings for hospitalized patients in that it is oriented to outpatient care. It was chosen, nevertheless, in order to be able to compile the data from the non-family practice patient population (predominantly hospitalized) with that from the enrolled patients (predominantly outpatients). The ICHPPC code was already in use and seems more appropriate for the enrolled patients. The total exposure of any resident is thus available for examination at any time.

Of 1,427 diagnoses presently stored in the computer, approximately ten percent are coded into relatively nonspecific or residual categories. Two factors in the residency are skewing the coding toward residual categories. The first is resident unfamiliarity with the coding. Secondly, due to rapid growth there is a disproportionate number of first- and early second-year residents, who tend to be the residents caring for patients with the more exotic diseases. With time, the number of diagnoses coded into residual categories can be expected to fall slightly from ten percent.

The requirement that the resident encode his/her own documents is at once a strength and a weakness. The time required is sometimes begrudged, though the task amounts to only a few minutes a month. One benefit of this requirement is the resident's familiarity with the ICHPPC code

itself. Furthermore, no one is in a better position than the resident to judge whether his involvement with the patient and his/her disease resulted in a learning benefit, though the opportunity for "padding" the exposure list is certainly there.

Characteristics of each resident, such as efficiency, interviewing and physical diagnostic skill, and problem-solving ability, are lacking in this tally. The resident's relationship to the patient as a person rather than as an organism with a disease is also not addressed. Other means of evaluating these important aspects of patient care must be found. On the other hand, the tally has a degree of objectivity that is difficult to achieve in resident evaluation. With the patient's name and the date of encounter logged it is possible to refer back to the more complete hospital record to check on the outcome of the encounters. The outcome of these real patient encounters is the kind of output analysis not often possible in a resident evaluation.

Sheer numbers of patients encountered or diseases observed is no guarantee of either expertise or future hospital privilege. It seems prudent, however, for the resident to be in possession of as much hard data as possible regarding his/her training when seeking hospital privileges.

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