Hospital Practice of the Family Physician

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In contrast to a number of other countries in the world, general practitioners in the United States, though predominantly involved in ambulatory care, have traditionally maintained an active role in the care of their patients in the hospital. Some are suggesting, however, that in the design of the future health care system for the United States, the primary care physician (ie, the family physician) confine his or her practice principally or exclusively to the ambulatory care setting.[1,2] There are even some within the general/family practice field who view the emphasis placed on ambulatory care in family practice residency programs as potentially limiting the development of a sufficiently broad range of knowledge and skills needed for appropriate levels of inpatient care by future family physicians. It is therefore of interest to assess what information is available concerning the current and projected roles of the family physician in hospital care.

Although most studies of the content of family practice to date have focused chiefly on the ambulatory setting, the last several years have seen some studies of existing patterns of hospital practice and the hospital privileges of family physicians. These studies have helped to clarify the hospital roles of family physicians in this country.

A study of 19 family physicians in a nonmetropolitan area of southern Illinois showed that they devoted approximately one quarter of their time to inpatient care, with an average of 11 patients per physician seen in the hospital each day. Their hospital based care included pediatric, obstetric, general medical, and geriatric care, as well as some surgery and surgical assisting.[3] A one-year study of the hospital admissions of 16 family physicians in a 600-bed community hospital in a Pennsylvania city revealed that 914 inpatients were cared for by physicians in the Department of Family Practice. The leading discharge diagnoses were arteriosclerotic and chronic ischemic heart disease, congestive heart failure, normal delivery, normal newborn, diabetes mellitus, and hypertension. Consultations were requested in approximaely one half of the hospital admissions, with cardiology and general surgery being the most common consultations. In most of these instances the responsibility for hospital care was shared with the consultant.[4] In a third study, a recent graduate of a family practice residency reported in 1978 on the hospital problems he cared for during his first year in practice in an Iowa community of 15,000 with a 100-bed hospital. During that year, primary responsibility was assumed for the care of 235 inpatients, with an average of 20 patients hospitalized each month. The most frequent diagnoses were newborn care, vaginal delivery, congestive heart failure, and chronic lung disease.[5] Still another one-year study was recently reported for the Family Practice Residency Inpatient Service in a 643-bed Army Medical Center in Georgia. Of 631 hospital admissions during the year, 38.1 percent had medical problems, 28.5 percent were admitted to the pediatrics ward, 21.5 percent were admitted to obstetric-gynecology

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wards, and 12 percent to other wards. Two thirds of the total patients were managed without consultation, including over half of the medical patients and over 80 percent of pediatric and obstetric-gynecology inpatients.[6]

Various studies have demonstrated comparable quality of hospital care provided by family physicians and other specialists. Garg and his colleagues, for example, analyzed the care of hospitalized patients by physician specialty in a number of general hospitals in Ohio. Family physicians provided care for 28 percent of these patients. Their performance in the care of patients with congestive heart failure, transient ischemic attack, and recent stroke was compared with internists and cardiologists. Additional comparisons were made with internists and urologists for the care of patients with acute and chronic urinary tract infections. No significant differences were demonstrated in the average physician performance of the various specialty groups (Garg ML, Mulligan JL, Gliebe WA, et al: Physician specialty, quality and cost of inpatient care, unpublished).

Several studies have also shed light on the status of hospital privileges among family physicians. Mechanic's study of over 800 United States general/family physicians during the early 1970s showed that about three quarters of those in group and nongroup practice were "very satisfied" with their hospital privileges (a comparable level was found for pediatricians in the same study).[7] In 1977 a survey of 176 hospitals in the American Medical Association's Region 8 (Arizona, New Mexico, Nevada, Utah, Colorado, Idaho, Wyoming, and Montana) 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. Coronary care unit privileges would be denied categorically in 14 percent and 2 percent of urban and rural hospitals, respectively.[8] In another study in 1978 of 95 acute care, short-stay, general hospitals in New Jersey, it was found that the proportion of general/family physicians maintaining hospital privileges in general medicine was 98 percent, with 72 percent in general pediatrics, 64 percent in ICU, 60 percent in CCU, 45 percent in newborn nursery, and 20 percent in obstetrics (the proportion of general/family physicians including obstetrics in their practice is atypically low in the northeastern United States compared to all other parts of the country).[9]

Most consultations and referrals in family practice are for assistance with treatment rather than for diagnostic opinion. When consultation has been requested for the care of a specific problem, the family physician usually continues to play an active role in the care of the patient.[10] Examples of such involvement include ongoing management of concurrent medical problems, assisting at surgery, pre and postoperative care, and dealing with the patient's family.

The available evidence therefore points to an active role of general/family physicians in hospital care in the United States. The inpatient roles of individual family physicians vary with their training, interest, the availability of other specialties, the needs of the community, and regional patterns of medical care. Family practice residency programs are preparing future family physicians to maintain an active role in hospital care. A growing number of *clinical* departments of family practice are being established in community hospitals throughout the country. They are increasingly involved in the monitoring of the quality of care provided by family physicians and the delineation of their hospital privileges conjointly with other clinical departments. The continued active role of family physicians in hospital practice will result in optimal continuity of care, coordination of care with consultants as needed, and facilitation of continuing medical education of the family physicians so involved.

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