# Hospital Privileges for Family Physicians: A Comparative Study Between the New England States and the Intermountain States

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Coincident with the training of increasing numbers of family physicians over the past decade, there has been concern that these new specialists are being limited in utilizing hospital facilities. In 1976, a survey was conducted of hospital administrators throughout eight Rocky Mountain states, and it was determined there were few restrictions placed on family physicians in this area. To determine if there are regional differences this survey was repeated for 242 hospitals in the New England states.

The results showed 80 percent of urban hospitals would very likely extend staff privileges to family physicians (board certified). Specific data on the likelihood of family physicians utilizing surgical, obstetric, intensive care unit, and coronary care unit facilities indicated significant restrictions as compared with the western states surveyed. This study documents presumed regional differences, and raises questions regarding the role of family physicians in hospitals in some parts of the country.

The specialty of family practice is now a decade old, having become the 20th recognized specialty by the American Board of Medical Specialties in 1969. However, in spite of what appears to be dramatic changes in medical education, the role of the family doctor in the modern hospital seems unsettled and in the state of evolution. This is particularly true in urban areas. In fact, reports from various medical news media have indicated that in certain parts of the United States family physicians have indeed been restricted from utilizing certain hospital facilities.

Those involved in family medicine education, both predoctoral and residency training, have been aware that this is a growing concern which may have a negative influence on career choice of prospective primary care physicians. Many medical students interested in pursuing careers as family physicians, and some family practice residents, have expressed fears that they may not be able to obtain hospital privileges. In fact, faculty and

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housestaff in other disciplines seem to advise students accordingly, that they should "at least" become board certified as an internist or pediatrician if they hope to become adequately trained primary care physicians and to be able to utilize hospital facilities. Such concern is not limited only to prospective family physicians, but probably dissuades many students from all primary care specialties. Petersdorf stated in a recent article:

> . . . perhaps the most important determinant that motivates young physicians to a sub-specialty, however, is the apprehension that some accrediting body, and probably the government, will limit the practice privileges of the internist who is not certified in a sub-specialty. For example, the fear that only certified cardiologists will be able to work in a coronary care unit or to interpret electrocardiograms or echocardiograms, that only pulmonary specialists will be able to attend to patients in intensive care units, and that only certified gastroenterologists will be permitted to perform liver biopsies.[1]

Some concern over hospital privileges by the national representatives of the specialty of family practice is evidenced by the American Board of Family Practice (ABFP) assigning a long-range planning committee to study this problem. In March 1976, they took a major stand on hospital privileges by stating,

> . . . a diplomat of the ABFP should be accorded the same basic consideration in regard to hospital privileges as given to diplomats of other specialty boards. The diplomat's hospital privileges should be commensurate with training, experience, and demonstrated abilities. Within the hospital staff, the diplomat should be eligible for full privileges in the Department of Family Practice, in conformity with the department's bi-laws.[2]

The American Academy of Family Physicians has also firmly stated their position—"the Academy's position in brief opposes any arbitrary qualifications for appointment to hospital staff other than those of demonstrated ability and competence and [supports the position] that the final responsibility should rest with the Chairman of the Department of Family Practice and other specialty departments involved."[3]

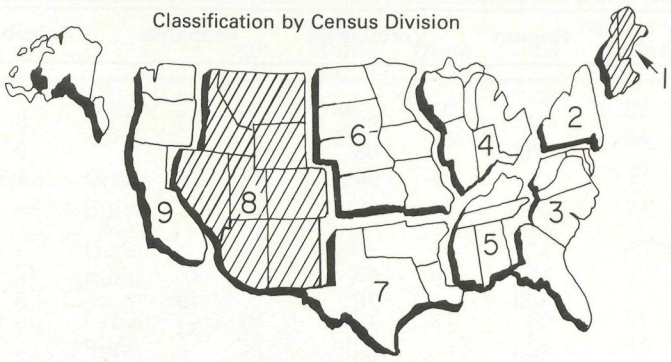
In spite of the efforts of the American Academy of Family Physicians and the American Board of Family Practice to ensure that family physicians have privileges based on their abilities, there has been resistance from other national specialty organizations. In fact, the President of the American College of Surgeons in 1977 expressed categorical opposition to the training of family physicians in surgery, and their subsequent utilization of surgical facilities in hospitals. His comments were made public in the December issue of the *American College of Surgeons Bulletin,* which quoted the surgical leader as follows: "It is obvious that there is a coordinated effort by Family Practice for surgical privileges in hospitals, and for surgical knowledge and competency necessary for the generalist." Furthermore, "it is time for us to drop the unwarranted politeness we have accorded a movement dedicated to lowering the quality of surgical care."[4]

It is remarkable how little data are available to support these concerns. A review of the literature in this area is most impressive in the paucity of information. Regional studies have shown that there are apparently few restrictions on family physicians in the state of Washington and the Intermountain West.[5,6] A statewide survey of New Jersey hospitals in 1977 revealed that over 90 percent would commonly grant all family physicians general admitting privileges, but significant limitations were imposed on specific clinical areas (eg, routine obstetrics, coronary care unit, etc).[7]

In an attempt to gain current information regarding the status of family physicians in the hospital setting, a survey was conducted in 1976 of hospital administrators (not physicians), throughout the Intermountain West (Census Division Region VIII, Figure 1).[6] The survey included 176 hospitals by mailing a two-page questionnaire to the administrators; 93 percent responded either by mail or by telephone. Hospitals were classified as urban or rural, and information was obtained regarding general staff privileges and specific clinical areas (eg, surgery, obstetrics, intensive care unit, and coronary care unit). All of the urban hospitals were surveyed and a random selection of rural hospitals was included. Criteria for extending staff privileges, consultation requirements, and number of family physicians applying for privileges were also studied. The results showed that 88 percent of urban and 98 percent of rural hospitals stated that 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 utilizing the ICU, CCU, surgical, and obstetrics departments indicated some restriction in urban areas, although it was not as much as expected.

**Region VIII-1976**
**States**
1. Arizona
2. Colorado
3. Idaho
4. Montana
5. Nevada
6. New Mexico
7. Utah
8. Wyoming

SMSAs-13




**Region I-1978**
**States**
1. Connecticut
2. Maine
3. Massachusetts
4. New Hampshire
5. Rhode Island
6. Vermont

SMSA's-26

Figure 1. Area used in research

The results were encouraging, and suggested that family physicians in the Intermountain West have access to the majority of hospital facilities, even in urban areas.

Although the initial study provided data which might help dispel fears of students and resident physicians that they would be limited in utilizing hospitals in the Intermountain West in 1976, it is obvious that these data are not reflective of any other part of the country. As indicated above, isolated reports from various parts of the United States have given publicity to the fact that family physicians have been restricted from hospital facilities. One disturbing example is of a young board certified family physician who was trained in a university based residency program in the West, had documented considerable obstetrical training, and yet was refused obstetrical privileges in a Massachusetts hospital.[8]

Recognizing the initial study of Region VIII states had geographic limitations and represented a relatively small number of the nation's family physicians, the current study of New England states was undertaken to gain further data to document the status of family physicians in the hospital setting.

## Methods

To obtain current data about hospital privileges in the New England area, a survey of hospital administrators was again conducted. The area included Census Division Region I, the states of Connecticut, Rhode Island, Massachusetts, Vermont, New Hampshire, and Maine (Figure 1). Hospitals were divided into urban and rural areas, based on their location within or not within a standard metropolitan statistical area (SMSA).*

The hospitals studied were limited to those classified by the American Hospital Association as follows: (1) control: nongovernmental, not for profit; (2) services: general medical or surgical; and (3) stay: short stay, ie, 50 percent of all patients stay less than 30 days.[9] A total of 242 hospitals have been so classified in this area. Of these, 137 (57 percent) were within an SMSA, and classified as urban, and 105 (43 percent) were not within an SMSA and were classified as rural.

*An SMSA is defined as 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 within the central county or counties.

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

| | Region | Very Likely | Probable | Possible | Unlikely |
|---|---|---|---|---|---|
| **Family Physician** | | | | | |
| Urban | I | 80 | 9 | 8 | 3 |
| | VIII | 88 | 8 | 2 | 2 |
| Rural | I | 94 | 5 | 1 | — |
| | VIII | 98 | 2 | — | — |
| **General Practitioner**** | | | | | |
| Urban | I | 49 | 27 | 17 | 7 |
| | VIII | 76 | 19 | 3 | 2 |
| Rural | I | 59 | 33 | 7 | 1 |
| | VIII | 90 | 8 | 2 | — |

*All figures in percentages
**Differences between Region I and VIII hospitals for the general practitioner significant at $P < .005$

In the summer of 1978, a two-page questionnaire was sent to the administrators of each hospital along with a cover letter from the Division of Primary Care and Family Practice at Harvard Medical School, which supported the need for this survey and requested cooperation from the hospitals.* The hospital administrator was then 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. Forty-one percent of those who provided data mailed the questionnaire within the expected time. Six percent telephoned in the data. When the three-week period from the time the questionnaire was mailed had elapsed, the remaining hospitals were contacted directly by telephone. Another 18 percent mailed the questionnaire and 35 percent provided their data over the telephone. Data was obtained from 200 hospitals, representing 83 percent of all those surveyed.

Questions were asked regarding general staff privileges, use of specific departmental or clinical areas, and changes over the past five years in requests for hospital privileges. Other hospital characteristics considered in the analysis were occupancy rate, presence of a clinical department of general or family practice, and the ratio of general practitioners and/or family physicians to the total active staff. The data obtained in Region I are compared to that of Region VIII which were obtained in the initial study in 1976. Differences were compared by chi-square test with a standard significance level set at $P < .05$.

## Results

The questionnaires sent to the hospital administrators listed a series of questions designed to assess current and future status of hospital privileges for family physicians. The response rate from the urban and rural hospitals was nearly identical. Of the 137 urban hospitals polled, 112

*The authors are indebted to Dr. Anthony Bower (Instructor in Preventive Medicine, Harvard Medical School) for his cooperation and efforts to solicit assistance from the hospital administrators of the New England area.

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

| | | Region I | | | Region VIII | | | |
|---|---|---|---|---|---|---|---|---|
| | | Full | Some | None | Full | Some | None | P Value** |
| General Surgery | Urban | — | 46 | 54 | 7 | 82 | 11 | <.005*** |
| | Rural | — | 65 | 35 | 32 | 64 | 4 | <.005 |
| Nonsurgical Obstetrics | Urban | 14 | 45 | 41 | 24 | 71 | 5 | <.005 |
| | Rural | 30 | 55 | 15 | 76 | 24 | — | <.005 |
| Surgical Obstetrics | Urban | — | 27 | 73 | 11 | 60 | 29 | <.005 |
| | Rural | — | 17 | 83 | 36 | 52 | 12 | <.005 |
| Intensive Care Unit | Urban | 19 | 60 | 21 | 30 | 61 | 9 | NS |
| | Rural | 35 | 60 | 5 | 54 | 45 | 1 | <.03 |
| Coronary Care Unit | Urban | 18 | 59 | 23 | 27 | 59 | 14 | NS |
| | Rural | 35 | 60 | 5 | 54 | 44 | 2 | <.04 |

*All figures in percentages
**Difference between Regions I and VIII
***P value <0.05 is statistically significant
NS=Not Significant

(82 percent) responded; for the rural hospitals, 88 of the 105 hospitals polled responded (84 percent). Total response rate was therefore 83 percent.

As shown in Table 1, the administrators of urban and rural hospitals in both regions stated that board certified family physicians would generally be able to get hospital privileges. However, it was shown that the non-board certified general practitioner would be less likely to get privileges in Region I than in Region VIII.

When questioned concerning how they based their decisions on granting privileges, administrators of rural hospitals in Region VIII relied more heavily on medical experience than did those of rural hospitals in Region I, suggesting that board certification is less important in the rural West. Administrators of urban hospitals in both Region I and Region VIII, 93 percent and 85 percent respectively, indicated that a combination of documented medical experience and board certification was most important.

When the extent to which privileges would be granted in specific areas was probed, differences between Region I and Region VIII became more apparent. Table 2 summarizes the responses of Region I and Region VIII hospital administrators regarding privileges granted to family physicians in the areas of obstetrics, surgery, and the medical intensive care units. In each case, the Region I hospitals were significantly more limiting in their granting of privileges to family physicians in surgery and obstetrics. However, there was remarkably little difference in restrictions in the use of ICU and CCU facilities in the urban hospitals of each region, both areas indicating limitations. The data also show that the rural ICU and CCU in Region I were not as significantly limited as the areas of surgery and obstetrics, in rural as well as urban areas. However, the family physicians currently may utilize the ICU/CCU with proper supervision or use of consultation.

All of these data are clearly illustrated in Figures 2 and 3, indicating differences in the specific clinical areas for Regions I and VIII.

The conditions surrounding the granting of these specialized privileges are further reflected in

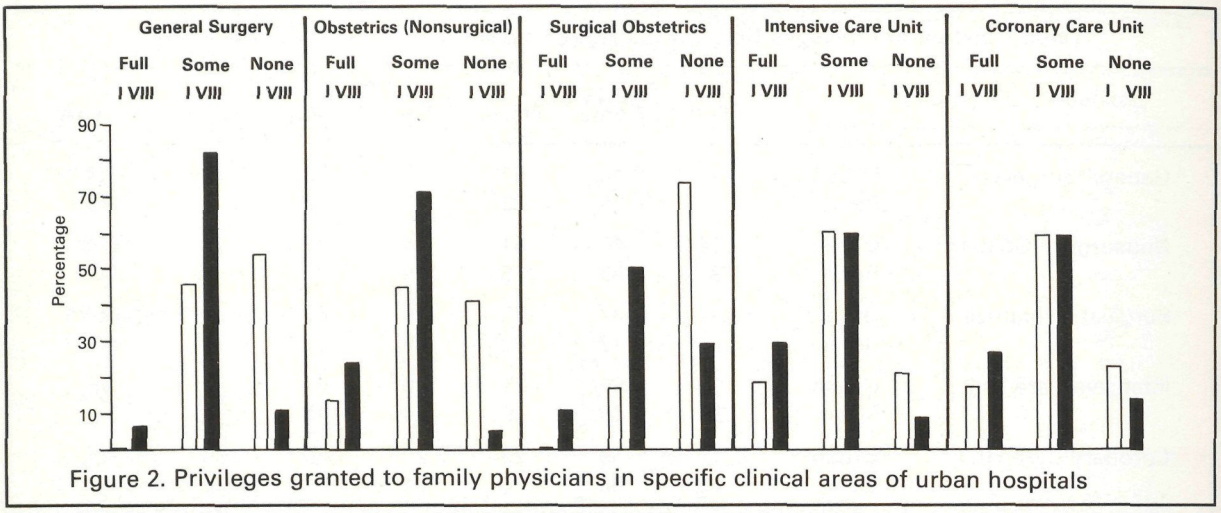



Figure 2. Privileges granted to family physicians in specific clinical areas of urban hospitals

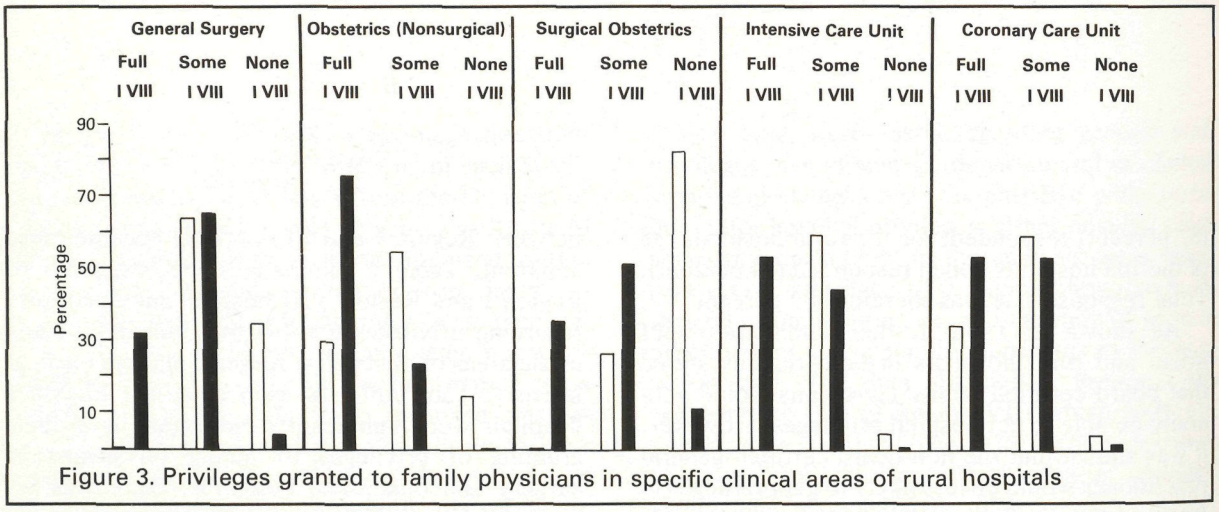



Figure 3. Privileges granted to family physicians in specific clinical areas of rural hospitals

Table 3, which shows the extent to which mandatory consultation is required for family physicians in order that they might be permitted to use hospital facilities in specific clinical areas. There was not as great a difference in required consultations in Region I and Region VIII as might be expected. However, in three of five specific clinical areas, more urban hospitals in Region I did require that family physicians obtain more consultation than in Region VIII. Rural hospitals in Region I also required more consultation in the area of surgical obstetrics.

In an effort to estimate 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. There has been an increase in family physicians applying for

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

| | | Region I | | | Region VIII | | | |
|---|---|---|---|---|---|---|---|---|
| | | All Cases | Some Cases | Not Required | All Cases | Some Cases | Not Required | P Value** |
| General Surgery | Urban | 37 | 61 | 2 | 16 | 59 | 25 | .005*** |
| | Rural | 26 | 49 | 25 | 11 | 59 | 30 | NS |
| Nonsurgical Obstetrics | Urban | 6 | 76 | 18 | 11 | 53 | 36 | NS |
| | Rural | 2 | 41 | 57 | 3 | 41 | 56 | NS |
| Surgical Obstetrics | Urban | 22 | 71 | 7 | 33 | 50 | 17 | NS |
| | Rural | 34 | 52 | 14 | 11 | 63 | 26 | .03 |
| Intensive Care Unit | Urban | 35 | 51 | 14 | 20 | 48 | 32 | .03 |
| | Rural | 20 | 47 | 33 | 10 | 54 | 36 | NS |
| Coronary Care Unit | Urban | 42 | 43 | 15 | 24 | 43 | 33 | .03 |
| | Rural | 28 | 41 | 31 | 15 | 52 | 33 | NS |

*All figures in percentages
**Difference between Regions I and VIII
***P value <0.05 is statistically significant
NS=Not Significant

privileges in the urban area of both regions. In the rural area of Region I, there has been a significantly greater increase in application for privileges as compared to Region VIII (however, "rural" for New England is not the same as "rural" in the West) (Table 4).

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, nonsurgical and surgical obstetrics, intensive care unit, and coronary care unit. (When 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. With the average privilege score, differences between Regions I and VIII were highly significant for the majority of hospital characteristics studied. Region I hospitals generally gave fewer privileges.

It is interesting to note that in those hospitals in both regions which had greater than a 25 percent proportion of family physicians on the staff, the regions were not statistically different when compared to their average privilege score. This suggests that in a hospital in either region with a large proportion of family physicians on the staff, differences in privileges granted between regions are not great. Also, if a hospital in either region had a clinical department of family or general practice, there was again no significant difference between regions, and *fewer* privileges were available to family physicians. However, a clinical department of family or general practice probably indicated a larger hospital with more specialists available in every category, and therefore more competition with family physicians.

## Discussion

There are obvious limitations to this study design in that even with a geographic comparison adding a dimension to the initial study, this information cannot be extrapolated to reflect all parts of the United States. Areas of marked contrast were intentionally chosen, ie, the relatively rural Mountain states vs the much more densely popu-

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

| | Region | Increase | Same | Decrease |
|---|---|---|---|---|
| Urban | I | 45 | 39 | 16 |
| | VIII | 57 | 30 | 13 |
| Rural** | I | 64 | 26 | 10 |
| | VIII | 37 | 50 | 13 |

*All figures in percentages
**Difference between Region I and VIII rural hospitals significant at $P < .002$

lated New England states, with the understanding that differences between these areas are likely to be the greatest. The status of family physicians in other parts of the country probably falls between what has been reflected in this study.

Another limitation acknowledged in this paper is that the respondents, ie, the hospital administrators or their delegated personnel, were left to determine precisely what constituted full, some, or no privileges. These interpretations could differ considerably from hospital to hospital. For this reason, in determining the "average privilege score," the system was weighted in favor of giving emphasis to full privileges. A further problem is that information being derived from an administrative organization of the hospital may simply reflect by-laws rather than actual practice. Nonetheless, the significant difference in data obtained suggests some candor on the part of the respondents.

The information obtained raises several issues regarding the role of contemporary family physicians in hospitals. Perhaps most importantly, it documents that there are significant regional differences in the United States. One frequently hears that family medicine varies considerably from one location to another, and whether this is a strength or weakness is left to individual interpretation. Rather than having a homogeneous mode of practice, the variation may reflect response to local needs and be a healthy difference.

The following issues are also raised by this study, although the data do not specifically address them.

1. *Physician satisfaction.* This had not been determined in the present study, in that physicians themselves were not contacted. In 1969, the American Academy of General Practice (just prior to becoming the American Academy of Family Physicians) conducted an ambitious survey questioning all Academy members regarding their hospital practice and satisfaction with same.[10] The Academy received questionnaires from almost 20,000 physicians, and it determined that 89 percent had active staff privileges at one or more hospitals. Physicians were specifically asked if they were satisfied with their hospital privileges and 96 percent reported that they were, with only 4 percent stating that they were unduly restricted. These data are remarkable in view of the currently voiced concerns that family physicians are being severely limited in their opportunities to use hospital facilities.

It is interesting to speculate how many family physicians might be completely satisfied with their role even in the New England states where there are limitations. It may be that many physicians have voluntarily limited their hospital work in preference for ambulatory medicine, and that young physicians selecting careers as family physicians prefer not to care for or manage seriously ill patients in the hospital. At the conclusion of the initial survey of Region VIII, it was recommended that another study similar to the 1969 survey be conducted by the American Academy of Family Physicians. This study is presently being done; the results will reportedly be available within the coming year.

2. *Role of malpractice and malpractice insurance on limiting hospital work.* Many family physicians who previously had done obstetrics and surgery have reportedly limited their practice

**Table 5. Average Privilege Score According to Hospital Characteristics***

| | Region I | | | Region VIII | | | |
|---|---|---|---|---|---|---|---|
| | Low (0-1.00) | Medium (1.01-2.00) | High (2.01-3.00) | Low (0-1.00) | Medium (1.01-2.00) | High (2.01-3.00) | P Value** |
| Hospital Location | | | | | | | |
| Urban | 78 | 19 | 3 | 66 | 20 | 14 | <.03*** |
| Rural | 58 | 32 | 10 | 23 | 30 | 47 | <.005 |
| Number of Beds | | | | | | | |
| ≤99 | 60 | 30 | 10 | 20 | 26 | 54 | <.005 |
| ≥100 | 74 | 23 | 3 | 53 | 27 | 20 | <.005 |
| Occupancy Rate | | | | | | | |
| 0-49% | 60 | 30 | 10 | 24 | 28 | 48 | NS |
| 50-74% | 67 | 26 | 7 | 36 | 24 | 40 | <.005 |
| 75+% | 73 | 24 | 3 | 54 | 29 | 17 | <.005 |
| Clinical Department of Family Practice or General Practice | | | | | | | |
| Yes | 64 | 31 | 5 | 55 | 27 | 18 | NS |
| No | 72 | 22 | 6 | 30 | 26 | 44 | <.005 |
| Proportion of family physicians on staff $\left[\frac{FP + GP}{\text{active staff}}\right]$ | | | | | | | |
| 0-24 | 73 | 23 | 4 | 56 | 27 | 17 | <.005 |
| 25-49 | 67 | 25 | 8 | 48 | 22 | 30 | NS |
| 50-74 | 44 | 37 | 19 | 18 | 41 | 41 | NS |
| 75+ | 29 | 57 | 14 | 29 | 23 | 48 | NS |

*All figures in percentages
**Difference between Regions I and VIII
***P value <0.05 is statistically significant
NS=Not Significant

in these areas because of the great expense of malpractice insurance if these areas are included, and/or fear of a costly malpractice suit. This was a much publicized problem in the mid 1970s and, subsequent changes in the spectrum of family physicians' clinical work may now be reflected in the hospital privileges data obtained. If so, the stimulus for the "restrictions" would not have come solely from specialty colleagues forcing the generalist out of the hospital, but would represent considerably more complex issues. It is likely that both cost of malpractice insurance and fear of legal reprisals have had a significant impact on limiting the spectrum of a family physician's clinical work throughout the country over the past decade.

3. *Resistance from colleagues.* Hospital privileges are, in fact, determined by physicians, not administrators. There has certainly been marked resistance on the part of some of the specialty colleagues, as indicated above in the statement by the President of the American College of Surgeons in 1977. Other professional organizations have been very supportive and, in fact, have determined guidelines to assist in training family practice residents and in determining their future role. The best example of this is the jointly approved guidelines of the American Academy of Family Physicians and the American College of Obstetrics and Gynecology which addressed training of residents and appropriate hospital practice privileges in obstetrics and gynecology.[11] However, when family physicians are restricted from hospital facilities, either as a group or individually, one can certainly question the motivation of these actions. They are frequently couched in terms of "quality of care" for patients, while equally stringent documentation for competence and experience may not be required of other

specialists to use the same facilities. Hence, the American Academy of Family Physicians has insisted that this be the sole basis for the granting of privileges. In fact, the Academy has provided free legal assistance to physicians who deem themselves unduly restricted and has provided considerable help for individuals with such problems. Such restrictions may come more from economic motivation, that is, concern for the consultant physician's income, than from genuine concern over patient care. Such factors influencing access to hospitals by family physicians must be considered highly unethical and illegal.

4. *Obstruction in addressing problems of health manpower and maldistribution.* The mandate is clear, from the public first, and secondarily from the government, for an increasing number of primary care physicians and for improved access to quality health care. In spite of the efforts of the Bureau of Health Manpower in providing considerable funds to train primary care physicians, a great many students make career choices favoring subspecialty medicine. The extent to which this is influenced by fear of restricting the generalist in the hospital setting would be difficult to ascertain. But it is likely that regulations to ensure equitable granting of hospital privileges will have to be instituted nationwide if concerns over these problems are to be eliminated.

5. *Responsibility of the family physician.* Unfortunately, many of the current problems within the hospital, and some of the restrictions imposed, are the result of inappropriate use of hospital facilities by family physicians. As a specialist in breadth, the family physician must recognize his or her limitations and obtain consultation and referral when appropriate. When this has not been the case, criticism by colleagues in other specialties has been severe and warranted. This is particularly important regarding surgical and obstetrical procedures. If an individual's practice evolves so that he is not performing certain procedures frequently, and there are other specialists doing such procedures more frequently, limitation of one's clinical practice should be voluntary. Family physicians must have the intellectual honesty to periodically reevaluate their knowledge and skills. The spectrum and content of a family physician's practice is certain to evolve over time and his hospital work should reflect this accordingly.

## Summary

The following conclusions can be drawn from this study: (1) Board certification of a family physician is more important in obtaining hospital privileges in New England; however, in the two areas studied, both a combination of documented medical experience and board certification have significant impact on likelihood of obtaining privileges; (2) there is significant restriction of family physicians in use of surgical and obstetrical facilities in the hospitals of New England, both in urban and rural settings; (3) there is remarkably little difference in access to intensive care units and coronary care units between family physicians in the urban Intermountain West and in New England; (4) the family physicians are required to have consultation more frequently in the New England States, both in urban and rural areas, than in the Intermountain West; (5) there has been a greater number of family physicians seeking privileges in rural hospitals in New England than in rural hospitals in the Intermountain West.

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