Hospital Privileges of Family Physicians in North Carolina

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Ninety-eight percent of the North Carolina hospitals studied grant some or all of their family physician staff general medicine privileges, while 80 percent grant some or all family physician staff coronary care unit privileges. Sixty-eight percent of the hospitals grant some or all family physicians general pediatrics privileges, while 72 percent grant newborn nursery privileges. Routine obstetrics privileges are present in 67 percent of the hospitals. Only 24 percent of the hospitals grant some or all the family physicians operative surgical privileges. There is a significant difference between urban and rural hospitals in first assistant surgery privileges. Of the 38 hospitals granting first assistant privileges, 35 are rural. Family physicians in smaller hospitals, especially those having fewer than 100 beds, are less likely to be required to seek consultations.

Hospitals were asked to note what privileges a new board certified family physician staff member might expect to receive. There was little change from the current pattern. This study suggests that the opportunity for extensive hospital practice by family physicians currently exists in North Carolina.

Hospital admitting privileges represent one of the most emotional and controversial issues in family practice. Only recently has an attempt been made to gain current information on the status of family physician hospital privileges.[1-3] To date, there have been regional or statewide studies in Washington (1969),[4] New Jersey (1977),[2] Health and Human Services Region VIII (Intermountain West) (1976),[1] Health and Human Services Region I (New England) (1978),[3] and an unpublished study by the Ohio Academy of Family Physicians in January 1979 (according to Tennyson Williams, MD, Chairman, February 1979).

These studies suggest several factors that affect privileges. Family physicians in the western United States have more hospital privileges than do their eastern counterparts. Rural physicians are less restricted than are urbanites. Smaller hospital grant privileges more readily than do larger hospitals, and privileges in medical and general pediatric areas are more common than in obstetrics or newborn nursery.

This study was undertaken to describe the ex-

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Table 1. Description of North Carolina Hospitals by Geography and Bed Number

SMSA* Classification	Number of Beds				
	<100	100-199	200-400	>400	Total
Urban	0	3	4	13	20
Rural	43	29	10	5	87
Total	43	32	14	18	107

*SMSA—Standard metropolitan statistical area

tent to which family physicians are granted hospital privileges in North Carolina and to investigate whether determinants suggested by earlier studies affect privileges in this southeastern state. The study was initiated by the Health Care Services Committee of the North Carolina Academy of Family Physicians, with the support of the North Carolina Hospital Association.

Methods

The family physician privileges questionnaire used in New Jersey by the New Jersey Academy of Family Physicians was selected as this study's data gathering instrument.[2] The questionnaire defined "privilege" as the ability of a physician to admit and treat patients in a given area of a hospital, and "family physician" as board certified or board eligible family physicians and general practitioners.

The questionnaire was distributed to hospital administrators in each of the 126 acute care, short stay, general (nongovernmental) hospitals in North Carolina. Administrators were asked to report the following information: (1) total number of physicians and family physicians on the staff, (2) number of family physicians with privileges in specified areas, and (3) hospital policy regarding privileges for new family physicians joining the staff. Administrators were also asked to have the completed form reviewed by the chief of the department, section, or division of family practice, by a knowledgeable family physician, or by the president of the medical staff. The initial questionnaire mailing was followed by a second mailing and by a telephoned request to each nonresponding hospital. A total of 107 (85 percent) questionnaires were received by March 1, 1980, the response deadline.

In addition to the questionnaire responses, each hospital was classified as either rural or urban. A hospital was considered urban if it was located in an area meeting the United States Office of Management and Budget definition of a standard metropolitan statistical area (SMSA). North Carolina has seven SMSA's, including Asheville, Charlotte, Durham, Fayetteville, Greensboro/High Point/Winston-Salem, Raleigh, and Wilmington.

The data were coded, keypunched, and analyzed using Statistical Analysis System (SAS) computer programs at Duke University. Analyses involved frequency distributions and cross-tabulations. Associations in tables were examined with the chi-square significance test. Other statistical tests, such as tests of difference between means and proportions, were also performed.

Table 2. Percentages of North Carolina Hospitals Granting Family Physicians Privileges in Specified Areas (N=107)

Area of Privilege	Family Physician Staff with Privileges			
	All	Some	None	Not Applicable
General medicine	91	7	0	2
Cardiac care unit	72	8	3	17
Intensive care unit	67	8	2	23
Nonoperative surgery	63	7	7	23
General pediatrics	54	14	1	31
Newborn nursery	51	21	7	21
Routine obstetrics	33	34	13	20
First assistant surgery	29	7	31	33
Operative surgery	8	16	51	25
Newborn intensive care unit	4	5	12	79
Operative obstetrics	0	12	56	32

Results

Table 1 describes the responding North Carolina hospitals by geography and bed size. Smaller, rural hospitals predominate. The hospitals were analyzed by geography and percent of family physicians on the medical staff. Only one hospital, a tertiary care medical center, had no family physicians on its staff. The mean percentage of staff family physicians in rural hospitals was 34 percent compared with 14 percent in urban hospitals ($F=14.06$, $P<.0003$).

Larger hospitals, even in rural communities, had significantly lower percentages of staff family physicians. Hospitals with over 400 beds averaged 9 percent staff family physicians; 200 to 400 beds, 19 percent; 100 to 199 beds, 29 percent; and less than 100 beds, 44 percent ($F=16.35$, $P<.0001$).

Table 2 displays the percentage of North Carolina hospitals granting privileges in specific areas to all, some, or none of the family physician staff. The "not applicable" category includes hospitals that do not offer services in an area, eg, no newborn intensive care unit, and those that did not indicate the current status of family physicians in that area. North Carolina family physicians are more likely to receive privileges in medical, nonoperative surgical, and general pediatric areas than in more technical areas, such as obstetrics and first assistant surgery, a pattern consistent with what has been found in other geographic regions.

Current privilege patterns were examined using SMSA classification and bed number as predictors. A significant difference between hospitals was observed only in first assistant surgery by geographic location. Of the 38 hospitals granting first assistant privileges, 35 were rural ($\chi^2=7.22$, $P<.008$).

Hospital policies regarding consultations, eg, for obstetrics-gynecology complications or intensive care unit admissions, were also examined. As illustrated in Table 3, family physicians in smaller hospitals are significantly less likely to be required to seek consultations ($\chi^2=19.03$, $P<.0008$). SMSA classification did not relate significantly to consultation policy.

Finally, hospitals were asked to delineate what privileges a new family physician staff member might expect to receive. Comparison of the projected policies with the current patterns shown in Table 2 did not show any statistically significant changes. Thus, it appears that current privilege policies will continue at least into the near future.

Table 3. Percentages of North Carolina Hospitals of Various Bed Numbers Requiring Family Physicians to Obtain Consultations

	Consultation Policy (%)		
Number of Beds	Required	Not Required	Unknown
<100	19	81	0
100-199	59	38	3
200+	56	41	3

Discussion

This study supports the findings of earlier works showing more favorable privilege policies for family physicians in rural and smaller hospitals. When compared with the New Jersey study, which used the same data gathering procedures, the data show that North Carolina family physicians receive more privileges for higher risk hospital practice (intensive care, cardiac care, newborn nursery, normal obstetrics) and have more freedom from mandatory consultation rules. These findings are consistent with the fact that smaller, rural communities predominate in North Carolina.

The relationship of geography and hospital size to privileges, seen consistently in studies of this nature, shows that the practice of family medicine can differ according to setting. Some may view these differences as the natural adaptation of the specialty to community economics and politics and to the diverse interests of family physicians themselves. Others may view with alarm the restrictions placed on family physicians in larger and urban hospitals, perceiving these limitations as the harbinger of an office bound family physician.[5]

Looking at the immediate future from the standpoint of a family physician seeking hospital privileges, this study suggests that opportunity for extensive hospital practice will continue in smaller, rural hospitals such as those which predominate in North Carolina. Documentation of specific experience, encouraged by professional associations such as the American Academy of Family Physicians and the North Carolina Academy of Family Physicians, can provide the basis for establishing a physician's competence in a desired area of hospital privilege.

Looking at the immediate future from the standpoint of hospital policies, this study suggests that significant changes are unlikely. However, certain factors could have an impact on policies, such as physician surpluses, changes in attitudes of other specialists toward family physicians, as well as changing expectations of family physicians themselves. Because such variables have not yet been studied in depth, long-range predictions about the future of hospital privileges for family physicians remain uncertain.

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