Hospital Privileges of Family Physicians

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The subject of hospital privileges for family physicians has attracted widespread interest and some controversy in recent years. The increasing supply of physicians, together with maldistribution of physicians by specialty and geographic area, has led to increased economic competition among physicians and to more than occasional reports of arbitrary restriction of privileges with little regard to the individual physician's experience, training, and demonstrated competence. It has been uncertain to what extent the spiraling costs of liability insurance would influence hospital privileges, particularly in surgery and obstetrics. Until recently, there has not been sufficient experience by graduates of family practice residencies to provide a clear picture of the role of residency trained family physicians in hospital practice. Fueled by the beliefs of some faculty members in the other specialties, some medical students have expressed concern over the extent of their future hospital privileges should they enter family practice.

There has not been solid information available until now to resolve these questions and concerns. Several statewide and regional studies have been reported during the last several years.[1-7] These were useful in describing patterns of hospital privileges in their areas but could not be generalized across the country. Two large national studies conducted by the American Academy of Family Physicians (AAFP) now fill in the picture and allow the lingering questions about hospital privileges for family physicians to be definitively answered. In this issue, Clinton, Schmittling, Stern, and Black report the results of a national survey carried out in 1980 involving a sample of 5,216 active AAFP members, stratified by regions, representing an 83.7 percent response rate.[8] This excellent study, together with a recently published national study of 3,021 graduates of family practice residencies between 1970 and 1978,[9] rather fully describes current patterns of hospital privileges for family physicians in the United States.

Some interesting findings emerge from these studies, particularly concerning changes in types of hospital privileges over the last ten years. A national survey of 19,257 AAFP members in 1969 (then the American Academy of General Practice) showed, for example, that the proportions of respondents with hospital privileges in obstetrics, surgical assisting, and major surgery were 67, 64, and 40 percent, respectively. By way of comparison, the 1980 AAFP study showed reductions of hospital privileges in all three areas, with obstetrics decreasing to 37 percent, surgical assisting to 55 percent, and major surgery to 14 percent.[8-10] Despite these reductions, however, the proportion of respondents satisfied with their hospital privileges remained constant (95 to 96 percent). It is intriguing also to compare the current hospital privileges of graduates of family practice residency programs in these same categories. Here we find the proportions reporting hospital privileges in obstetrics, surgery assisting, and major surgery to be 64, 62, and 7 percent, respectively.[9] Residency trained family physicians have therefore returned to the 1969 AAGP patterns of hospital privileges in obstetrics and surgery assisting, but have further reduced their role in major surgery. At the same time, however, almost 90 percent of residency trained family physicians hold hospital privileges in intensive care coronary care units, whereas only about 50 percent of their AAGP counterparts in 1969 held such privileges. Residency trained family physicians also compare favorably with the respondents in the 1969 AAGP study for hospital privileges in medicine and in pediatrics: 93.5 and 92.5 percent, respectively,

0094-3509/81/090325-02$00.50

compared with 91 and 77 percent of AAGP members in 1969.[8,10]

Of further interest are the reasons for lack of hospital privileges in specific areas based on the two recent national AAFP studies. The overwhelming majority of family physicians without privileges in certain categories did not request them. Denial of privileges is uncommon. In 1980 only 3.6 percent of active AAFP members felt their privileges were unduly restricted,[8] whereas denial of privileges affected 1 percent or fewer of residency trained family physicians in medicine, pediatrics, and obstetrics, and only 1.8 percent and 3.6 percent of residency graduates requesting privileges in ICU/CCU and complicated obstetrics, respectively.[9] Likewise, prohibitive liability insurance costs are not a major factor. Even in the Pacific region, where these rates are highest, this was a reason for not having privileges in obstetrics and major surgery for only 9 to 14 percent of active AAFP members[8] and less than 4 percent of residency trained family physicians[9] in 1980.

The 1980 AAFP survey of active members makes explicit the actual differences in hospital privileges for family physicians by size of hospital and community and by region. This and other studies have shown that the range of privileges tends to be somewhat greater for family physicians in smaller hospitals and in the western states as compared with larger hospitals and the eastern states, especially in obstetrics and surgery. Despite these differences, however, the principle of gaining hospital privileges on the basis of training, experience, and demonstrated competence is gaining ground throughout the country. The American Medical Association[2] and the Joint Commission on Hospital Accreditation[11] have taken steps to reinforce this process. Board certification in family practice has been demonstrated to affect positively the extent of hospital privileges granted to family physicians.[2,3] The fact that one in five of active AAFP members holds hospital privileges today for routine obstetrics in New England, and that only 1.7 percent of such members in that region have had these privileges denied, shows that some positive change in regional variations is possible and is indeed taking place. The more effective roles of clinical departments of family practice in hospitals,[11,12] together with the support of the AAFP for members needing legal assistance to assure due process in the granting of privileges, can be expected to maintain reasonable opportunity for family physicians to acquire appropriate hospital privileges throughout the country.

These developments are important to the continuity and quality of patient care in the hospital in the context of both definitive care by family physicians and their shared responsibilities for inpatient care with consultants. The active role of family physicians in hospital care provides an unequalled opportunity for frequent interchange with the other specialties and continuing medical education. Although considerable variation is likely to continue in the extent of hospital privileges, especially in rural areas and in smaller hospitals, hospital practice continues to be an integral part of family practice. Board certification and residency training in family practice are generally receiving the recognition they deserve in the granting of hospital privileges. Taken together, these patterns should allay the concerns of those medical students who have been apprehensive of the future roles of family physicians in US hospitals.

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