Family Practice Forum

Membership in Family Practice Departments: An Urban Hospital Model

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In the past dozen years, family medicine has come a long way as a specialty. In resident training it has made remarkable strides both in numbers of physicians trained and in the academic quality of the residency programs. The American Academy of Family Physicians has made significant contributions on the national scene representing the interest of its membership on reimbursement and hospital privilege issues. This journal reflects evidence of the specialty's coming of age in scholarly contributions to the literature.

On the local level in hospital medical staff organizations, progress has not been so spectacular. The resurgence of family practice has caught medical staffs unprepared for responding to the needs of family physicians. Departmental status has been recommended and achieved in some hospitals, but the issues of granting of admitting and procedural privileges can become sources of conflict among departments.

Some in medical leadership positions have suggested that family practice is for communities lacking services of other specialties and that certain hospitals should be designated as primary care facilities with family practice attending staffs. It is the opinion of the Family Practice Department of The Swedish Hospital Medical Center (SHMC), Seattle, Washington, that every family needs a family physician and that there is a legitimate role for the family physician in an urban tertiary care medical center.

Swedish Hospital Medical Center is a 653-bed hospital, internationally known, especially for its oncology services and its clinical advances in orthopedic surgery. Prior to merging with Doctors and Seattle General hospitals in 1980, Swedish had a relatively small Department of General Practice. Doctors and Seattle General hospitals brought with them many experienced family physicians plus the well-established Family Practice Residency Program. In the past year, there has been a harmonious affiliation of the primary and tertiary care interests of the medical staff. The Department of General Practice was replaced by the Department of Family Practice. The Family Practice Residency has expanded and taken its place among the medical center's other educational programs. The residency provides a highly visible identity for the specialty by serving as an interface for introducing other specialties to family practice.

The problems the Department of Family Practice has encountered in the first year of integrated staffs at SHMC include (1) having to evaluate credentials and determine privileges for practitioners who do not practice family medicine and who do not fit easily into any other departmental category,

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(2) attracting new family physicians to the department, and (3) assuring that department members maintain their qualifications in the specialty.

Beyond concerns arising from the merger of medical staffs on the SHMC campus are issues of a broader scope. In 1981 the expectation of the medical profession and the public is that all physicians will complete residency training as a requirement for practice. On the part of family practice residency graduates, there is a feeling that it is unfair to allow residency trained family physicians to be categorized with those who have chosen to enter practice without benefit of rigorous postgraduate training in the specialty. It is important to note that recent graduates do not express negative sentiments about those family physicians who have been trained prior to the advent of the American Board of Family Practice or of residency programs. These "old-timers" are held in esteem for their efforts in securing a place for the specialty and establishing the foundation for its practice.

In July 1981, to deal with its concerns, the Department of Family Practice at SHMC established new guidelines for its membership. The criteria for entry into the Department of Family Practice now are as follows:

1. Board qualification, certification, or recertification by the American Board of Family Practice
2. Current membership in the American Academy of Family Physicians
3. Current membership in the department of those ("revered grandparents") whose practice and continuing medical education (CME) efforts reflect their interest in maintaining skills of the specialty of family practice

It was further resolved that all other practitioners who seek hospital privileges of a general nature, but who do not satisfy the previously stated criteria, be categorized separately and not be considered members of the Department of Family Practice.

The guidelines were designed to achieve a cohesive specialty department with strict criteria for qualification and a visible dedication to quality performance. In the largest medical center in the State of Washington, such criteria would be expected of the department to maintain an equal status with those of medicine, surgery, and obstetrics. To have jurisdiction over its members' hospital privileges, the department must have influence over their credentials and scope of practice.

Family physicians are proud of the achievements of their specialty since its inception in February 1969. It is a young and innovative specialty and has learned from the successes and mistakes of other specialty organizations. It has the first board to require a periodic *recertification* examination, and the AAFP is the first academy to insist on CME for continuing membership. It is now time to bring these standards to the medical staff organization and show that family physicians are leading the way once again in demonstrating the dedication of the specialty to quality performance.

The issue of departmental assignment of undifferentiated or nonspecialty practitioners must be addressed. The SHMC Department of Family Practice recommended that requests for privileges coming from these physicians be referred to the credentials committee to screen their qualifications annually and that specific privilege issues be granted with the consent of the department involved.

The Department of Family Practice defends the right of a practitioner who can demonstrate competency for performing a procedure or exercising a clinical privilege, but this issue has to be separated from the problem of assigning undifferentiated practitioners to the Family Practice Department. It is important to avoid turning the Department of Family Practice into a catchall for practitioners who may have excellent but limited skills in one field. A physician whose surgical practice is limited to assisting, or whose training includes a single year of internship or two years of a surgical residency, should not come under the jurisdiction of the Department of Family Practice or be assigned membership there. Other departments may have to develop subcategories or detailed policies that will recognize the rights of these practitioners.

At SHMC, our identity and pride in our specialty were considered sufficiently important that strict criteria for departmental membership were established, and a mechanism of medical staff membership was recommended for those who have undifferentiated or nonspecialty status. This approach to dealing with the cluster of problems that surround medical staff identity for family physicians in a major urban hospital may serve other departments of family practice in their attempt to resolve local conflicts.