# Hospital Privileges for Family Physicians: Rights, Rationale, and Resources

Perry A. Pugno, MD
Farmington, Connecticut

This review discusses the factors responsible for problems incurred by family physicians in the process of applying for hospital privileges. They include issues such as local unfamiliarity with family practice as a specialty, regional needs for primary care providers, reluctance to "make waves," and the breadth of privileges sought. Major areas of contention center on the utilization of obstetrical, surgical, and critical care facilities.

If a request for privileges is denied, the applicant does, however, possess the right of due process. This right is substantiated in law and includes appeal procedures consisting of an enumeration of specific justifications for denial, adequate notice of a hearing, and the opportunity to be present, rebut the evidence, and present a defense. When dealing with such conflicts, the family physician will recognize the importance of training-content documentation, a willingness to demonstrate competence, and resources for professional assistance through both local and regional offices of the American Academy of Family Physicians.

In 1976, a young family physician applied for obstetrical privileges at a large New England community hospital. Residency trained and board certified, he presented a request based on demonstrated skills and experience. His request was denied.[1] Thus began a landmark legal action involving a board-certified specialist who was denied privileges within his scope of practice simply because the hospital staff had no experience with board-certified family physicians. In 1978, with the support of the American Academy of Family Physicians (AAFP), the suit was settled out of court in favor of the young physician.

Since that time the AAFP has received increas-

From the Department of Family Medicine, University of Connecticut, Farmington, Connecticut. Requests for reprints should be addressed to Dr. Perry A. Pugno, Department of Family Medicine, Family Medicine Center, The University of Connecticut Health Center, Farmington, CT 06032.

ing inquiries for assistance in obtaining hospital privileges for residency graduates, especially in the fields of obstetrical, surgical, and critical care.[2] The purpose of this review is to discuss some of the factors responsible for the problem of applying for hospital privileges, outline the rights of the applicant, and offer some suggestions for dealing with conflict.

## Background

In the United States today there are about 400,000 active physicians, including administrators, teachers, and researchers. Of these, about 47,000 are practicing, office-based family physicians.[3] In 1979 the AAFP conducted a nationwide survey regarding hospital privileges, and some of their observations were noteworthy.[4-6]

Approximately 96 percent of family physicians have hospital privileges, but one out of ten felt that the privileges granted were unduly restrictive. Regional differences varied across the nation by factors of as much as 125 in the percentages of physicians performing obstetrics and surgery.[7,8] Variables responsible for these differences included rural necessities vs urban oversupply, training program attitudes, regional familiarity with family practice as a specialty, and malpractice costs.

In 1977 the Joint Commission on Accreditation of Hospitals (JCAH) attempted to resolve the problem through the adoption of guidelines for privilege granting by hospitals. Standard 3 of the medical staff section, *Accreditation Manual for Hospitals*,[9] states:

> All recommendations to the governing body for staff appointment must include a clear delineation of clinical privileges. Privileges granted shall be commensurate with the training, experience, competence, judgement, character, and current capability of the candidate. When a hospital uses a system involving classification of privileges, the scope of the classifications must be well defined, and the standards that must be met by the applicant should be clearly stated for each category.

The guidelines for measuring compliance with this standard state that surveyors should look for evidence that the medical staff has devised a reasonable method of delineating clinical privileges that indicate:

(1) adequate documentation of previous training and experience, (2) request forms for clinical privileges that identify at least the specialty areas of practice that have been identified by specialty boards, and (3) an effort has been made to match expertise with clinical privileges to the extent that is practical for the individual hospital, considering its complexity, location, and available medical manpower.

However, a major stumbling block to widespread compliance with the guidelines is that since family practice is a specialty in breadth, the family physician-applicant seeks privileges that are in the traditional domain of more than a single specialty or hospital department. Assistance with this problem has been gained in recent years by the joint ad hoc committees of the AAFP along with the American College of Cardiology and the American College of Obstetricians and Gynecologists.[10] With the support of these and other similar groups, there exists today not a single instance in which a court decision has been required to successfully resolve a conflict of family practice privileges. Yet, this record must be viewed from the perspective that, to avoid conflicts, the majority of family physicians who felt that their clinical privileges were restrictive never even requested privileges for higher-level care.[4] In addition, a recent study of board-certified residency graduates[11] seems to indicate decreased expectations of hospital privileges as a result of pressure from training faculty in narrow-based specialties.[12]

What then are reasonable expectations of clinical privileges for the family physician? To answer this question, in March 1979 the AAFP published a suggested method for the categorization and assignment of privileges based on the content requirements of approved residency training in family practice[13]:

*Category I.* Uncomplicated medical and surgical care as initial privileges that would require peer review or reports of competence for advancement to the next category

*Category II.* More serious medical and surgical problems including some complex obstetrics and surgery. Graduation from an approved three-year residency would be a benchmark indicating appropriate training

*Category III.* Advanced medical and surgical care. This level would usually require additional postgraduate or residency training in a specific field of practice

## Rights of the Applicant

If an appropriately trained family physician is denied clinical privileges commensurate with his experience and competence, what rights exist for redress? This question falls within the realm of jurisprudence—an unfamiliar and nearly always threatening area, but one based on the principles of reason and fair play.

In law, due process is the term applied to those principles of fairness on which the rights of an individual are based and preserved. With reference to hospital staff privileges, the Judicial Council of the American Medical Association in 1981 published an opinion based on civil law to serve as guidelines for appeal.[14] It states in part:

> 9.04 DUE PROCESS. The basic principles of a fair and objective hearing should always be accorded to the physician whose professional conduct is being reviewed. The fundamental aspects of a fair hearing are: a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut the evidence, and the opportunity to present a defense. These principles apply when the hearing body is a medical society tribunal of a hospital committee composed of physicians.
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> These principles of fair play apply in all disciplinary hearings and in any other type of hearing in which the physician may be deprived of valuable property rights. Whenever physicians sit in judgement on physicians and whenever that judgement affects a physician's reputation, professional status, or livelihood, these principles of fair play must be observed.

As in the case of any legal proceeding, a right to counsel and the impartiality of review are elements likewise to include as assumed content of a fair hearing. Each individual element listed, however, is essential to safeguard the fairness of the process.

A listing of specific charges or reasons for denial must be set forth in writing and provided to the physician.[15] This statement of charges defines the issue to be resolved in the hearing process. The ultimate decision of approval or denial must be based on evidence relevant to those facts listed. Similarly, the listing of charges must be provided to the physician with adequate notice of an appeal hearing so that relevant documents may be reviewed and a reasonable time allowed for preparation of a defense. The physician also has a right to be present at the appeal hearing and have an opportunity to present his defense before a hearing body capable of rendering a decision.

Current law states that hospital bylaws must include these appeal procedures.[16] The standards by which a physician is measured, although they need not be minutely codified,[17] must be general standards within the discretionary purview of the applicant-physician's peers and not vague statements.[18,19] With due process and substantial evidence, any hospital may deny privileges,[20] and private hospitals may do so without judicial review.[21,22] The hospital's right of denial serves to protect the public interest and upholds the hospital's responsibility to exclude incompetent or disruptive physicians from its staff.[23,24]

The physician, on the other hand, bears the responsibility for preparing a true and accurate application,[25] proving qualification under reasonable requirements,[26] and agreeing to abide by the rules and bylaws of the hospital.[27] Failure in any of these three elements is justification for privilege denial.

## Approach to the Application Process

With the aforementioned issues in mind, how then should the new family practice residency graduate proceed when planning to apply for hospital privileges?

First, the physician must seek to document the content of his or her residency training.[13] Continued accreditation of the residency program and successful completion is not enough. More and more, residency graduates are being called upon to document the specific content of the training period as it relates to them as individuals. This documentation is particularly important when seeking privileges for specific procedures (such as cesarean sections or appendectomies) or for the care of certain high-risk disorders such as unstable myocardial infarctions. Keeping track of every patient encounter may seem tedious, but it serves as a record of documentation that is very difficult to dispute. Some ways this can be accomplished include the following:

1. Keep a card file of every patient treated during the training period. The system may be 3×5 cards with handwritten notes, a commercially prepared product (INDECKS), or the system offered

by the AAFP, which automatically sorts patients into clinical disciplines.

2. Keep a copy of all dictated procedure, delivery, and surgical notes. In addition to documenting what procedures were performed, the content of the dictation will also serve to demonstrate to a reviewer how it was done. If this is not a matter of routine, arrangements can usually be made with the departments of medical records and medical transcription.

3. Just prior to graduation from the residency program, request a letter from the clinical supervisor of each major service, preferably a letter that lists the special skills and procedures for which that individual is felt to be competent.

Documentation will help demonstrate competence in areas for which hospital privileges are sought, but that is not its only benefit. Documentation also helps the resident monitor and evaluate the educational experience of residency training and provides a demonstration that the competency-based objectives of family practice are being fulfilled throughout the discipline's broadly based training period.[13]

In addition to documenting the content of training, it is essential that the physician seeking privileges strive to be as informed as possible.[2] He should be familiar with the rules, bylaws, organization, and application process of the hospital in which privileges are being requested. It is also helpful to know the current AMA, AAFP, and JCAH policies and recommendations as they refer to clinical privileges in family practice. These recommendations can serve as guidelines for both the scope and the process of requesting hospital privileges.

A final element is to solicit support of the application by physicians currently on staff at that hospital. Family physicians, be they colleagues or not, can be of significant assistance. In addition, specialists looking for referrals from a primary care practice can also be of assistance in obtaining appropriate privileges for the family physician within their scope of practice.

In the event that hospital privileges are denied, it is important that the family physician, or any physician for that matter, carefully and comprehensively follow all of the local rules in taking a timely appeal action. Many times hospital committees neglect to follow their own rules and bylaws correctly, and for the applicant-physician to likewise fail can become a detrimental oversight.

Once an application is formally denied at the highest level of appeal (usually such a group as the hospital trustees or governing board), the physician must carefully review the appropriateness of the application with his or her local support group. If the opinion remains that unfair treatment or capricious judgment has taken place, all documents, correspondence, and chronological facts should be submitted to the state academy of family physicians.[28] An ad hoc committee will review the case, and, if it is deemed meritorious, can elicit the support of both the AAFP Health Care Services Commission and the academy board of directors. As in the case of the young family physician who was arbitrarily denied obstetrical privileges at a New England hospital, support from the second largest medical organization in the country can be coupled with judicious legal action to yield a successful outcome.

In conclusion, for the family physician seeking hospital privileges, especially for the new residency graduate, only a few principles need to be recalled for a successful application: get good training and document its content; seek an appropriate level of privileges commensurate with experience, skills, and competence; have enough confidence in the training received to be willing to demonstrate those skills before securing independent privileges; be patient—the wheels of bureaucracy grind slowly and few organizations rival the bureaucracy of the modern hospital; be informed on the rights, rules, guidelines, and policies that affect the application process; and when efforts are unsuccessful, seek the support and assistance of professional counsel and the other resources available.

If a request for hospital privileges is prepared thoroughly and conscientiously and submitted with adherence to these principles, the family physician applicant can confidently expect an affirmative response.

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