Family Physicians in University Hospital Intensive Care Units

Barry D. Weiss, MD
Tucson, Arizona

Although physicians in most family practice residency programs hospitalize their patients at community hospitals, those in 21 programs in the United States hospitalize patients exclusively at university hospitals. Through a questionnaire mailed to directors of each of these programs, it was learned that family practice residency faculty have medical intensive care (ICU) privileges at 38 percent of these university hospitals. No family physicians had ever been denied ICU privileges at any of these hospitals. Mandatory consultations were reported by only a minority of programs.

At 62 percent of these university hospitals, family physicians do not have ICU privileges. However, no family physician had ever made a formal application for them. Intensive care patients at these hospitals were generally cared for by specialists and house staff in internal medicine or critical care.

In recent years the specialty of family practice has undergone tremendous growth and development. The comprehensive training provided by family practice residency programs has led family physicians to care for patients whose problems also fall into the spheres of other medical specialties. Occasionally there have been problems with granting hospital privileges to family physicians; obstetrics and surgery are frequently cited as problem areas.[1-4]

Conflicts also arise in the area of intensive care. Family physicians spend up to 30 hours per week in the hospital, and much of that time involves caring for patients with general medical problems.[5,6] Nonetheless, although nearly all family physicians have hospital privileges for general internal medicine, medical intensive care privileges are not universal.[7,8]

At university medical centers, intensive care privileges for family physicians have special significance. University hospitals establish trends in medical care, and there is a growing movement at university centers toward ultraspecialization in intensive care. This movement is manifested by the creation of special critical care physician teams and residency training programs in critical care medicine.[9] Although 75 to 95 percent of American hospitals grant intensive care unit privileges to family practitioners,[7,8] the growth of critical care medicine may create difficulties for family physicians who request intensive care privileges at university hospitals.

From the Department of Family and Community Medicine, Arizona Health Sciences Center, Tucson, Arizona. Requests for reprints should be addressed to Dr. Barry Weiss, 1450 N. Cherry Avenue, Tucson, AZ 85719.

© 1983 Appleton-Century-Crofts

For the small number of family practice residency programs that hospitalize their patients exclusively at a university hospital, intensive care unit (ICU) privileges are of critical importance. Although the American Academy of Family Physicians recommends that ICU privileges be granted to appropriately trained physicians regardless of specialty, some critical care physicians feel that family physicians should not utilize intensive care units at referral center (university) hospitals. They believe that it is not consistent with current standards of care. This study attempted to define, on a nationwide basis, the standards for intensive care privileges for faculty of family practice residency programs that hospitalize their patients exclusively at university hospitals.

Methods

According to the *1982 Directory of Family Practice Residency Programs,*[10] there are 21 approved programs that hospitalize their patients exclusively at university hospitals. University programs listed as admitting patients to hospitals other than or in addition to a university hospital were not included in this survey.

A questionnaire was mailed to the residency director of each of these 21 programs. The questionnaire sought information about whether the program's family practice faculty had privileges to use the medical intensive care unit. Information was also solicited about requests for ICU privileges that had been denied and about who cared for ICU patients if not the patients' family physician. Comments regarding mandatory consultation policies or other unusual arrangements were made by nearly all residency directors. Residency directors who did not respond to the mailed survey were contacted by telephone and asked the same questions that were included in the written questionnaire.

Results

Eighteen program directors responded to the mailed questionnaire and the remaining three were contacted by telephone. Therefore, responses from 100 percent of family practice residency programs that hospitalize their patients exclusively at a university hospital are included in these results.

Programs With ICU Privileges

Thirty-eight percent of the programs (8/21) reported that all family practice faculty members have admitting privileges to the medical intensive care unit. At one medical center, family practice ICU privileges do not include pulmonary medicine cases; these are cared for by a designated group of subspecialists. No family physician had ever been denied ICU privileges at these hospitals.

At all eight of these university hospitals, cases are managed and orders written by family practice house staff. Two of the hospitals reported a requirement for consultation by a critical care specialist.

Programs Without ICU Privileges

At 62 percent of the university hospitals (13/21), family practice faculty do not have ICU privileges. At 11 of the 13, no one had ever requested privileges. At two hospitals, family practice departments had made informal requests for privileges and were informed that ICU privileges were not available to their faculty; a formal application with credentials review was apparently not made.

At hospitals in which family physicians do not have ICU privileges, care for family practice patients in the medical intensive care unit is provided by various specialists in internal medicine and critical care. Orders are generally written by house staff in internal medicine or critical care; family practice house staff write orders when they rotate through these specialty services.

Discussion

The results of this survey demonstrate that there is a precedent for the use of medical intensive care units by family physicians at university medical centers. Faculty at 38 percent of family practice programs that hospitalize their patients

exclusively at university hospitals have ICU privileges. These hospitals are diverse in their geographic distribution and include institutions in the Northeast, Midwest, Southeast, Southwest, and West Coast. The institutions are in small, medium, and large cities.

Family physicians had been denied ICU privileges in 5 percent (2/21) of these university hospitals. However, the requests for privileges were informal and did not undergo standard procedures such as credentials committee review. Thus, at 95 percent of the programs that use only a university hospital, family physicians either have ICU privileges or never formally tried to get them.

The issue of why family physicians at some of these programs have never applied for ICU privileges was not addressed in the questionnaire. It can be hypothesized that ICU care at these hospitals had traditionally been delegated to critical care or internal medicine physicians and that this was the standard procedure when family practice training programs began to appear in the 1960s. To avoid conflict with established medical specialties, family physicians did not attempt to alter the status quo. In addition, during the early years of development of family practice, residency faculty often did not include family physicians with training in intensive care. In recent years, however, residency-trained physicians with ICU experience have joined departments of family practice, and the need to utilize intensive care units is now being realized.

Another reason why family physicians at some universities have not applied for ICU privileges may have to do with residency size and the manpower requirements needed for intensive care patients. Twenty-four-hour house staff coverage under the supervision of a faculty member must be available, and this service cannot be provided by some of the smaller residency programs.

Finally, most university-affiliated family practice programs hospitalize their patients at institutions other than or in addition to their parent university hospital. In some cases this may be due to geographic considerations; in others it may relate to a lack of willingness of subspecialty faculty to educate family practice residents. It is not known how frequently these programs decide to use nonuniversity hospitals because of problems concerning hospital privileges.

Mandatory consultations are required at 28 percent (2/7) of hospitals in which family physicians have ICU privileges, a frequency similar to that with which family physicians are required to obtain consultations on their ICU patients in community hospitals on a nationwide basis (10 to 35 percent).[8,11] In practice, however, family physicians obtain voluntary consultations on 57 to 76 percent of hospitalized patients,[12,13] suggesting that concern about this matter may be unnecessary.

The controversy over intensive care privileges is probably part of the larger "turf" issue that has evolved between family practice and other medical specialties.[14-16] However, privilege problems are important to resolve because of the key role that family practice faculty have in educating family practice residents.

Subspecialists in internal medicine and critical care feel their expertise in intensive care makes it optimal for family practice residents to learn critical care skills from them. In fact, there is no doubt that any physician planning to care for seriously ill patients should receive part of his training from a critical care specialist. On the other hand, after residency training, that young physician will likely be granted privileges in a community hospital ICU[7,8] and function as a family physician, not as a critical care specialist. It is important, therefore, that the resident be given the opportunity to observe a family physician faculty member functioning as a role model in an intensive care setting. The resident must learn how the family physician utilizes consultants and works with subspecialists, provides emotional support for the seriously ill patient and family, and recognizes the limitations of his or her medical abilities. It is unlikely that any of these skills are better taught to the family practice resident by a critical care specialist than by a faculty family physician.

Another issue of importance to directors of training programs in family practice, internal medicine, and critical care is the importance of ensuring an adequate patient volume to support teaching requirements. Competition for patients is becoming acute, and academic medical centers are being forced to compete in the marketplace to maintain their patient census.[17] While this issue is certainly of concern to educators, competition for patients probably should not be considered when granting hospital privileges to individual physicians.

The standards of the Joint Commission on Accreditation of Hospitals require that "privileges

granted shall be commensurate with the training, experience, competence, judgment, character, and current capability of the candidate."[18] It is important that family physicians be granted intensive care privileges only if their clinical skills and training justify it. That eight hospitals in this survey grant ICU privileges to all members of their family practice faculty suggests that clinical skills may not always be considered. All members of a family practice faculty are unlikely to be competent to render ICU care, just as it is unlikely that all members of an internal medicine faculty are so qualified.

References

1. Clinton C, Schmittling G, Stern TL, Black RR: Hospital privileges for family physicians: A national study of office based members of the American Academy of Family Physicians. J Fam Pract 13:361, 1981
2. Stern TL, Schmittling G, Clinton C, Black RR: Hospital privileges for graduates of family practice residency program. J Fam Pract 13:1013, 1981
3. Mainen MW: The surgical role of family physicians. Am J Public Health 72:1359, 1982
4. Nickerson RJ, Colton T, Peterson OL, et al: Doctors who perform operations. N Engl J Med 295:921, 1976
5. D'Elia G, Folse R, Robertson R: Family practice in nonmetropolitan Illinois. J Fam Pract 8:799, 1979
6. Slabaugh RC, Ringiewicz M, Babineau RA: The hospital work of a family practice group in a medium size community in New England. J Fam Pract 11:287, 1980
7. Warburton SW Jr, Sadler GR: Family physician hospital privileges in New Jersey. J Fam Pract 7:1019, 1978
8. Sundwall DN, Hansen DV: Hospital privileges for family physicians: A comparative study between the New England states and the Intermountain States. J Fam Pract 9:885, 1979
9. Shapiro BA: Critical care medicine. JAMA 247:2945, 1982
10. 1982 Directory of Family Practice Residency Program. Kansas City, Mo, American Academy of Family Physicians, 1982
11. Hansen DV, Sundwall DN, Kane RL: Hospital privileges for family physicians. J Fam Pract 5:805, 1977
12. Maguire PH, Cook PD: Inhospital family practice: A one year summary. J Fam Pract 8:1019, 1979
13. Medley ES, Holstead ML: A family practice residency inpatient service: A review of 631 admissions. J Fam Pract 5:817, 1978
14. Proger S: A career in ambulatory medicine. N Engl J Med 292:1318, 1975
15. Aiken LH, Lewis CE, Craig J, et al: The contribution of specialists to the delivery of primary care. N Engl J Med 300:1363, 1979
16. Weiss BD: The delivery of "primary care" by specialists. N Engl J Med 301:894, 1979
17. Hoft RH, Glaser RJ: The problems and benefits of associating academic medical centers with health maintenance organizations. N Engl J Med 307:1681, 1982
18. Delineation of Privileges. AMA resolution on JCAH requirement for delineation of staff privileges. Document 252-C. Kansas City, Mo, American Academy of Family Physicians, 1976