Hospital Privileges for Family Physicians at University Hospitals

Barry D. Weiss, MD
Tucson, Arizona

Of the more than 350 family practice residency programs in the United States, 72 are affiliated with a medical school. Seventy-eight percent of these university programs hospitalize all or some of their patients at a university hospital. These hospitals grant various privileges to family physicians with the following frequencies: general medicine (94 percent), adult intensive care (50 percent), coronary care (65 percent), general pediatrics (81 percent), pediatric intensive care (29 percent), normal newborn nursery (79 percent), intensive care nursery (12 percent), routine obstetrics (77 percent), and high-risk obstetrics (31 percent).

Sixteen (22 percent) of the university-based programs do not use a university hospital at all, either because the university hospital is too far away or because there is no university hospital. Only one program does not use the university hospital because of difficulty in obtaining privileges.

Family physicians are unable to obtain various hospital privileges because of political reasons at the following percentages of university hospitals: general medicine (2 percent), adult intensive care (33 percent), coronary care (40 percent), general pediatrics (8 percent), pediatric intensive care (31 percent), newborn nursery (8 percent), intensive care nursery (29 percent), routine obstetrics (13 percent), and high-risk obstetrics (17 percent).

There is some evidence that family physicians at university hospitals may have greater difficulty obtaining privileges than family physicians at community hospitals. For example, a recent survey of those family practice residency programs that use only a university hospital for care of their patients disclosed that family physicians used the intensive care unit at only 38 percent of those hospitals.[1] In comparison, 75 to 95 percent of hospitals nationwide grant intensive care unit privileges to family physicians.[2,3] The extent to which family physicians' privileges in other patient care areas of university hospitals differ from those in community hospitals has not been studied.

In addition, not all university-based programs use their parent university hospital for care of their patients. Difficulties in obtaining hospital privileges may be a factor in the decision by many university-based family practice programs to use a

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.

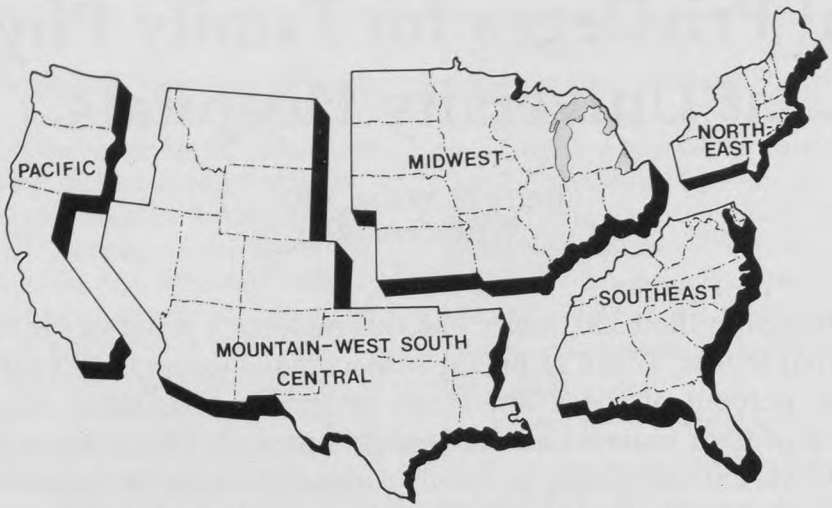

Figure 1. Geographic areas described in Table 1

community hospital instead of or in addition to the university hospital. This also, however, has not been studied.

The purpose of the present study, therefore, was to determine the frequency with which family physician faculty of university family practice residency programs have privileges in various patient care areas of their university hospital and how often a lack of such privileges has been due to the inability to obtain them. The study also examined how often privilege problems resulted in a decision by university-based programs to use hospitals other than their university hospital.

Methods

Of the more than 350 family practice residency programs included in the 1982 *Directory of Family Practice Residencies*,[4] 72 are listed as being located at or affiliated with a university hospital or medical school. A questionnaire was sent to the residency directors of each of these 72 programs during the summer of 1983.

The questionnaire sought information about whether the programs hospitalized all, some, or none of their family practice office patients at the university hospital. If the university hospital was not used, the reason for this was solicited.

Those programs that did hospitalize their office patients at the university hospital were asked to indicate whether their family practice faculty had hospital privileges in each of several areas of the hospital: general medicine, adult intensive care, general pediatrics, pediatric intensive care, normal newborn nursery, intensive care nursery, routine obstetrics, and high-risk obstetrics.

In those hospitals and hospital areas in which family physician faculty did not have privileges, information was requested to explain the lack of privileges. In addition to direct responses stating that there was a political inability to obtain privileges, there was assumed to be a privilege problem if a response indicated that there were "hospital regulations" that limited privileges to certain specialties or that family physicians had privileges only if they acted as a "co-attending" with a physician of another medical specialty.

Responses were also initially stratified by the nine United States census regions, in a manner similar to that used by Clinton et al[5] in their survey of hospital privileges for office-based family physicians. Because of the small number of university programs in each region, however, no meaningful data could be generated. Therefore, several of the census regions were combined (Figure 1), and data were evaluated to detect differences between these larger areas in the assignment of hospital privileges to family physicians.

Results

Responses were received from 68 of the 72 resi-

dency directors, representing 94 percent of the university programs listed in the directory. Sixteen (22 percent) of the university-based programs, which were evenly distributed throughout the country, reported that they do not use a university hospital for any of their office patients. Only one of these programs stated that the reason for this was difficulty in obtaining hospital privileges. The residency director of that program indicated that ongoing negotiations with other departments at their university hospital are expected to result in the granting of privileges to family physicians within the next six months.

The reasons cited by other programs for not using the university hospital varied. Seven programs were located too far from their parent university hospital to make utilization practical; distances as great as 200 miles were reported. In six cases there was no university hospital; the medical schools utilized community hospitals for their teaching programs. Two programs did not give their reasons for not using the university hospital.

Responses were received from 52 family practice residency programs that hospitalize either all (28 programs) or some (24 programs) of their patients at their university hospital. Of the 24 programs that utilize hospitals in addition to the university hospital, only one did so because of problems with hospital privileges (in the area of obstetrics only).

With this exception, privilege problems were not the reason that university-affiliated family practice programs use hospitals in addition to their university hospital. Reasons that were more frequently cited included unavailability of certain services at the university hospital (unavailability of pediatric, obstetric, or nursery services were cited by seven programs), a more convenient location of a community hospital, and patient preference for a community hospital over the university hospital. In addition, one program reported an affiliation with a community hospital that antedated its affiliation with the university hospital; therefore, that program utilized the services of both.

In Table 1 hospital privileges are displayed for each of the various patient care areas studied by geographic region. The findings from the 52 programs that hospitalize all or some of their patients at a university hospital are combined; the 16 programs that do not use the university hospital at all are excluded.

General Medicine

In general, family physicians have little difficulty in obtaining privileges at university hospitals for routine inpatient adult care. Only three programs (6 percent) report that they have no such privileges. At one program it was felt that the faculty family physicians were not qualified to care for adult general medicine patients. At another the family medicine department employs an internist, and family physicians have had no part in inpatient adult care. Only at the third program (2 percent of the total of these university-affiliated programs) do family physicians cite a political inability to obtain the necessary hospital privileges.

Adult Intensive Care

Family physicians have university hospital adult intensive care (ICU) privileges at only 50 percent of the programs that hospitalize all or some of their family practice patients at the university hospital. At the 24 hospitals where family practice faculty do not care for ICU patients, political inability to obtain the necessary hospital privileges is cited by 17 (33 percent of surveyed hospitals).

Twenty-two percent of programs do not have ICU privileges for their faculty, but feel that this is due to reasons other than political problems. Reasons cited include a lack of interested or qualified faculty (5 programs), a feeling that ICU care in university hospitals is not an appropriate function for family physicians (5 programs), and manpower difficulties that would make ICU care logistically impossible (1 program).

Coronary Care

Sixty-five percent of the 52 programs report that their family physicians have coronary care (CCU) privileges—a slightly greater number than had privileges for ICU care. The number of programs at which physicians cannot obtain CCU privileges for political reasons (40 percent), however, is also greater than the number at which ICU privileges cannot be acquired. In most cases hospitals that deny CCU privileges to family physicians are the same as those that deny ICU privileges. As with ICU privileges, hospitals in the Pacific states are less likely than those in other

Table 1. Hospital Privileges for Family Physicians at University Hospitals

Patient Care Area	Pacific No. (%)	Mountain and West South Central No. (%)	Midwest No. (%)	Southeast No. (%)	Northeast No. (%)
General adult medicine					
Have privileges*	7 (100)	7 (78)	16 (94)	12 (100)	7 (100)
Cannot obtain privileges**	——	1 (11)	——	——	——
Adult intensive care					
Have privileges*	1 (14)	4 (44)	8 (47)	9 (75)	4 (57)
Cannot obtain privileges**	5 (71)	3 (33)	5 (29)	2 (17)	2 (29)
Coronary care					
Have privileges*	1 (14)	3 (33)	10 (59)	8 (67)	2 (29)
Cannot obtain privileges**	6 (86)	4 (44)	4 (24)	3 (25)	4 (57)
General pediatric care					
Have privileges*	5 (71)	7 (78)	14 (82)	10 (83)	6 (86)
Cannot obtain privileges**	1 (14)	1 (11)	1 (6)	——	1 (14)
Regular (normal) nursery					
Have privileges*	5 (71)	6 (67)	13 (76)	11 (92)	6 (86)
Cannot obtain privileges**	2 (29)	1 (11)	——	——	1 (14)
Pediatric intensive care					
Have privileges*	1 (14)	4 (44)	5 (29)	3 (25)	2 (29)
Cannot obtain privileges**	4 (57)	2 (22)	3 (18)	3 (25)	4 (57)
Intensive care nursery					
Have privileges*	1 (15)	1 (11)	2 (12)	1 (8)	1 (14)
Cannot obtain privileges**	3 (43)	2 (22)	5 (29)	2 (17)	3 (43)
Routine obstetrics					
Have privileges*	5 (71)	6 (67)	13 (76)	12 (100)	4 (57)
Cannot obtain privileges**	2 (29)	2 (22)	——	——	3 (43)
High-risk obstetrics					
Have privileges*	2 (29)	3 (33)	6 (35)	5 (42)	——
Cannot obtain privileges**	4 (57)	3 (33)	——	——	2 (29)

*Hospitals at which family physicians have these privileges
**Hospitals at which family physicians cannot obtain these privileges because of political reasons. Note that there are other reasons physicians do not have privileges besides the inability to obtain them (see text)

parts of the country to grant CCU privileges to family physicians.

General Pediatrics

The majority (81 percent) of the 52 surveyed university hospitals grant general pediatric privileges to family physicians. General pediatric privileges occur with similar frequency throughout the nation. Of those programs at which family practice faculty do not have these hospital privileges, political inability to obtain them is cited by four programs (8 percent of the total).

It should be noted that six programs give inpatient care to their pediatric patients in community hospitals instead of their university hospital. The reasons for this choice included lack of a pediatric department at the university hospital (4 programs), geographic considerations (1 program), and patient preference. None did so because of difficulty in obtaining privileges at the university.

Regular (Normal) Nursery

The situation for normal nursery is almost identical to that for general pediatrics. The majority (79

percent) of the 52 surveyed hospitals grant these privileges to family physicians. These programs are evenly distributed throughout the country.

Of the remaining 11 programs at which family physicians do not have nursery privileges, only four (8 percent of the total) cite political inability to get them as the reason. None of the programs that use hospitals other than the university do so because of privilege problems; more commonly, they do so because their university hospital does not have a nursery.

Pediatric Intensive Care

Family physicians have pediatric ICU privileges at only a minority (29 percent) of the surveyed university hospitals. The majority of the programs that do not have these privileges state either that their family physicians are not qualified or that it is inappropriate for them to render this type of patient care. Nine programs report that there is no pediatric ICU at their hospital.

Still, at 31 percent of the surveyed hospitals, family physicians feel that they are competent to render pediatric ICU care, but that they cannot obtain privileges because of political reasons. There is a greater tendency for family physicians to have difficulty in obtaining pediatric ICU privileges in the Northeast and the Pacific states, but the difficulty occurs in all parts of the country.

Intensive Care Nursery

Only a minority (12 percent) of the 52 surveyed programs report that their family physicians have privileges to use the intensive care nursery. Most of the programs at which family physicians do not have privileges feel that their faculty are not qualified or that it is inappropriate for them to attend patients in the ICU nursery. Nonetheless, 29 percent of programs (15 of 52) felt that their physicians are qualified to render this type of patient care but cannot obtain privileges because of political reasons. Again, there is a greater tendency for this to occur in the Northeast and the Pacific states.

Obstetrics

Seventy-seven percent (40/52) of the university hospitals grant routine obstetrical privileges to their family physicians. Of the remaining 12 hospitals, the majority (seven) reported that their family physicians cannot get privileges because of political reasons. Such privilege problems are not reported to occur in the midwestern and southeastern states.

Only a minority (31 percent) of programs, on the other hand, reported that their family physicians have privileges to manage high-risk obstetrical cases. Only at a minority of those programs at which family physicians do not have these privileges is the political inability to obtain them cited as the reason. More commonly, family physicians do not feel that they are qualified or feel that it is inappropriate for them to care for such patients. At 17 percent of the surveyed hospitals, however, family physicians feel that they cannot obtain high-risk obstetrical privileges because of political reasons. Just as with routine obstetrics, this appears to be least likely to occur in the midwestern and southeastern states.

Discussion

The results demonstrate that family physicians have privileges in most patient care areas of university hospitals having family practice residency programs. In the majority of these university hospitals, family physicians have privileges in general adult and pediatric medicine and routine obstetrical and newborn care. At just over one half (50 percent and 65 percent, respectively) of the surveyed hospitals, family physicians also have privileges in adult intensive and coronary care.

In other more specialized areas of patient care, such as pediatric intensive care, intensive care nursery, and high-risk obstetrics, only a minority of family physicians have privileges. In general, this is not because of difficulty obtaining privileges. More commonly, it is felt that these patient care areas are beyond the skill of or inappropriate for family physicians.

Coronary care is among the most commonly cited patient care areas in which privileges cannot be obtained because of political reasons, surprising when one considers that the American College of Cardiology and the American Academy of Family Physicians have developed and approved a core curriculum for training family practice residents in cardiology.[6] The suggested curriculum requires 400 hours of structured educational cardiol-

ogy experience and includes training in specific cognitive and skill areas. Although not specifically designed for designating hospital privileges, this document represents an important collaborative effort between family practice and another medical specialty. Despite these training guidelines, cardiology is the area in which university hospital family physicians most often have privilege problems.

University-based family physicians also have difficulty in obtaining obstetrical privileges, a problem that seems to occur with greater frequency than it does at community hospitals. The present study found that family physicians have difficulty in obtaining routine obstetrical privileges at 12 percent of university hospitals and cannot obtain privileges for high-risk obstetrics at 17 percent. Nationwide, privileges in these practice areas are denied to only 1 percent and 3 percent of office-based family physicians, respectively.[5,7]

Good nationwide data describing standards for family physician privileges in adult, pediatric, and neonatal intensive care do not exist. Therefore, a comparison of university family physicians' privileges to those of other family physicians cannot be made.

Interestingly, university hospitals often appear to grant privileges to family physicians according to institutional policy and specialty affiliation without regard for the training or skill of individual physicians. Evidence comes from questionnaire responses stating that such institutional policies exist, as do the data collected in this survey. For example, family physicians cannot obtain adult intensive care privileges because of political reasons at 33 percent of the hospitals. They cannot obtain coronary care privileges at nearly all of the same hospitals. Similarly, 8 percent of hospitals deny general pediatric privileges to family physicians, and nearly all the same hospitals deny nursery privileges to these physicians. Thus, at university hospitals, privilege delineation may be more dependent on factors other than physician qualifications.

There are many factors other than competency that can result in difficulties in obtaining hospital privileges. Among the most obvious are economics and the supply of physicians. In cities and areas where competition for patients is great, qualified physicians may be denied hospital privileges. This problem is experienced by qualified medical and surgical subspecialists as well as by family physicians.[8] The prerogative of a hospital staff to deny privileges to competent physicians because of a local surplus of physicians has, at times, been upheld by courts of law when a hospital is shown to be operating near the limits of its capacity.[9-11] However, denial of privileges has been declared invalid when it was done solely to enhance an existing medical staff's economic advantage.[9,12]

Another important factor in assignment of hospital privileges is the perception of family physicians' skills held by local specialists and the family physicians themselves. Various medical specialties desire that the scope of patient care currently provided by family physicians should be narrowed, a position that some family physicians are beginning to accept. Support for this contention is seen in the present study, in which failure to hold certain hospital privileges is felt to be due to political problems in certain areas of the country, whereas in other areas it is thought that the same privileges are beyond the abilities of family physicians. For example, in the Pacific states, family physicians have high-risk obstetrical privileges at only 29 percent of university hospitals. At nearly every hospital at which they do not, it is felt that politics prevent them from obtaining these privileges. In the Midwest, on the other hand, a similar minority hold university hospital high-risk obstetrical privileges. However, midwestern family physicians denied these privileges do not blame politics. Rather, they cite such reasons as insufficient qualifications to render this type of care. The majority of midwestern physicians do not feel that it is appropriate for them to have privileges in high-risk obstetrics; some West Coast physicians feel they are being denied these same privileges because of politics.

Finally, there are factors involved in assigning hospital privileges that may be unique to university hospitals. Most important of these are the educational requirements of various teaching programs. Each specialty service at a teaching hospital must ensure an adequate supply of patients to support its teaching program. When board-certified family physicians join a hospital's staff, they often request privileges to practice in areas traditionally in the domain of other medical specialties (eg, intensive care or obstetrics). These other departments find that their pool of teaching

patients decreases as patients are diverted to family practice residents. In an era when university hospitals increasingly are being forced to compete with community hospitals for patients, a decrease in any one department's patient census may be critical to its teaching program and may lead to attempts to restrict family physicians' privileges as a defensive measure.

Acknowledgment of this educational factor may enhance the opportunity to resolve some hospital privilege disputes. Family physicians might consider accepting "mandatory consultation" requirements when they negotiate for hospital privileges. Such requirements can assure the involvement of as many learners as possible in every patient's case. The other specialty services may then consider their teaching programs to be less threatened by the involvement of family physicians in "their area." This issue was critical in the recent successful negotiations for intensive care privileges for family physicians at the Arizona Health Sciences Center.

In addition to increasing teaching opportunities, involvement of consultants removes any perceived economic threat when family physicians practice in the consultant's traditional patient care area. Subspecialists can bill for their consultations without incurring any significant real or perceived loss of revenue.

When physicians encounter difficulty in obtaining hospital privileges, numerous critical procedures should be followed, all of which have been carefully outlined by the American Academy of Family Physicians and others.[13,14] These procedures are useful and effective in the majority of cases, especially in community hospitals. Recognition of the unique political concerns that exist at university hospitals, particularly the requirements of teaching programs, may also aid in resolution of privilege conflicts.

Conclusions

When university-based family practice residency programs use community hospitals instead of, or in addition to, their university hospital, it is almost never because of difficulties in obtaining privileges at the university hospital.

University hospitals grant general medicine privileges to family physicians in nearly all cases and grant routine obstetric, nursery, and inpatient pediatric privileges in the majority of cases.

Only about one half of university hospitals grant intensive care and coronary care privileges to family physicians. These privileges are least likely to be granted at university hospitals in the Pacific states. At those hospitals at which family physicians do not hold ICU and CCU privileges, it is felt that political considerations are the reason in most cases.

Only a minority of university hospitals grant high-risk obstetrical or neonatal intensive care privileges to family physicians.

Although data allowing direct comparisons are limited, it appears that family physicians at university hospitals are more restricted in their hospital privileges than their community-based counterparts.

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