Forming a Department of Family Practice in a Community Hospital

William C. Wadland, MD, Mark A. Eustis, MHA, and Kenneth Bollin, MD
St. Clair, Michigan

Since 1978 the Congress of Delegates of the American Academy of Family Physicians has encouraged a policy to establish in hospitals clinical departments of family practice having all of the responsibilities of other departments, particularly the delegation of privileges. Many hospitals, however, do not have fully effective departments of family practice, in which case other specialty departments decide on privileges for family physicians. Residency graduates may find their requests for privileges denied because other departments are making recommendations for their privileges with little understanding of family practice education.

National surveys of family physicians and residency graduates for the most part show that family physicians are satisfied with their privileges.[1] There are, of course, variations in regions across the country. Hospital privileges in obstetrics and surgery are more likely to be granted in nonmetropolitan areas.[2] There is no mention of a correlation between the departmental status of family practice and the degree of privileges obtained. A Michigan survey (December 1979) shows that more dissatisfaction with privileges occurs among the residency-trained group. The main areas for conflicts are coronary care and intensive care (CCU/ICU) privileges, pediatric intensive care, stress testing, electrocardiogram interpretation, and temporary pacemaker insertion. The Michigan survey revealed that less than one-half of the surveyed hospitals had a service or department of family practice. Few of the departments were allowed to recommend privileges for its members.[3] There is a need for strong departments of family practice in most hospitals to insure equal representation for family practice among other specialties.

Experience in One Community Hospital

This communication describes a three-year experience at River District Hospital, St. Clair, Michigan, in building an effective department of family practice in a community hospital. River District Hospital is a 68-bed community-supported hospital located in southeastern Michigan with a service area of approximately 50,000 persons. In 1981 there were 22 active staff physicians including 4 internists, 5 surgeons, 2 pediatricians, 5 general and family physicians, and other consultants. There was no representation on the executive committee for family practice, and family practice privileges were assigned by other departments. With the addition of two residency-trained family physicians to the staff, family physicians would soon become one of the largest groups in the hospital. The medical staff agreed to allow the group to meet and to send a representative to the executive committee. Since the group consisted of nonboard-certified, older general practitioners, new osteopathic internship-trained physicians, and board-certified residency-trained family physicians, the first difficulty was what name to call the new group. To encompass the diversity of the group, the Department of Family/General Practice was found mutually agreeable to all.

Bylaws for the new department were modified from the model bylaws proposed by the American Academy of Family Physicians. To maintain respectability among colleagues, all members were strongly encouraged to seek board certification by either the American Academy of Family Physicians or the College of Osteopathy. Each medical staff department in the hospital would have a family physician representative, usually as a full voting member. Representation with other departments later proved to be crucial in developing constructive dialogue among departments.

Prior to approval of the family practice bylaws, the entire medical staff became reorganized into a departmental structure. In addition, before approval of the new department bylaws, the categorization of privileges (an eight-month process) was necessary. Categorization was especially helpful for pediatric and internal medicine privileges. The level of care obviously must differ among residency-trained family physicians, internship-trained general practitioners, pediatri-

From River District Hospital, St. Clair, Michigan. Requests for reprints should be addressed to Mark A. Eustis, River District Hospital, 4100 South River Road, St. Clair, MI 48079.

Table 1. Base-Line Privileges for Recommendation by the Department of Family Practice

Medical Privileges*
Category 1. ICU/CCU privileges with consultation

Category 2. ICU/CCU privileges without consultation, unless respiratory arrest

Proctoscopy
Sigmoidoscopy
Aspiration procedures
- Thoracentesis
- Paracentesis
- Joint aspiration
- Lumbar puncture

Pediatric Privileges
Category 1. intensive care with consultation
Category 2. intensive care without consultation, unless respiratory arrest, including:
minor surgical procedures
- Incision and drainage of abscess
- Circumcision
- Meatotomy
- Spinal tap
- Cut down
- Thoracentesis
- Paracentesis

Major surgical procedures
- Postoperative care

Surgical Procedures
General Surgery
- Superficial skin tumors including the face
- Skin lacerations, uncomplicated
- Simple banding of hemorrhoids
- Hand infections, uncomplicated
- Paracentesis
- Thoracentesis

Neurological surgery
- Skull fractures, uncomplicated
- Infant circumcision and meatotomy
- Incision and drainage of abscess, superficial

Gynecological Privileges
Dilatation and curettage
- Diagnostic and therapeutic

Incision and drainage
- Bartholin duct abscess

Biopsy of vulva
Biopsy of cervix, punch biopsy only
Pessary insertion
Removal of foreign body from vagina and uterus
Culdocentesis

Neonatal Privileges
Circumcision of infant
Resuscitation of infant

Orthopedic Privileges***
Closed fracture not compound
Upper and lower extremity fractures and dislocations
Forearm fractures
Metacarpal and metatarsal groups
Phalanges

Obstetrical Privileges**
Without consultation:
- Spontaneous delivery, vertex presentation
- Episiotomy and repair
- Low forceps, occiput anterior
- Manual removal of placenta
- Repair of cervical lacerations
- Repair of vaginal lacerations
- Anesthesia, pudendal block, local
- Evacuation of vulvar hematomata, simple
- Repair of third- and fourth-degree lacerations
- Curettage, postpartum, uncomplicated
- Excision of vulvar lesions at delivery
- Augmentation of labor

With consultation:
- Pre-eclampsia, mild, moderate
- Treatment of medical complications of obstetrics: heart, lungs, kidney, anemia, diabetes, etc

*EKG interpretation, stress testing, and temporary pacemaker insertion may be obtained by application to the Department of Medicine
**Vacuum extraction is not performed at River District Hospital
***Consult authors for special features

cians, and internists. Obstetrical and surgical privileges are usually granted on the basis of procedures performed and documentation of case experience, not the length or intensity of training.

The main issue was patient care in CCU/ICU. It was decided that Category 1 physicians (internship

or limited training) would need consultation for intensive care management. Category 2 physicians (family practice, residency trained) would not require consultation in the intensive care unless an extreme critical status existed, ie, respiratory arrest. Category 3 physicians (usually trained in other specialties) would require consultation only in very complicated cases.

Finally, after 14 months of numerous committee hours, the family practice department bylaws were approved. An essential element of the bylaws was the right to recommend privileges for new members. The new family practice bylaws necessitated revision of medical staff bylaws.

The real test of the Department of Family/General Practice was whether it could actually recommend privileges for new staff applicants. In 1982 two residency-trained family physicians applied, and the executive committee did not accept the family practice department's recommendation of approval. Other departments wanted to review the applicants in their own areas. The Department of Family/General Practice was ineffectual as a department. To be more effective, it was necessary to have a general agreement by all departments on the base-line privileges for family practice in the hospital (Table 1).

The Department of Family/General Practice proposed the privileges already granted to residency-trained family physicians on staff as the base line. The base-line privileges would be considered within the realm of family practice and would be recommended directly to the executive committee. These privileges would not be granted routinely to new applicants; each applicant would be considered individually, based on training, competence, and experience. However, the Department of Obstetrics wanted full responsibility to supervise new members, and the Department of Surgery would not agree to family physicians managing displaced fractures. Finally, it was agreed that obstetrical supervision would be a joint responsibility, and only certain displaced fractures would be included in the base-line privileges. The need for selective granting of privileges based on training, competence, and experience was reinforced during intradepartmental discussions. The entire dispute took nine months to resolve.

Obviously, base-line family practice privileges should have been delineated earlier in the process of forming a department. The first applicant to be approved by the Department of Family/General Practice was in the summer of 1983, an easy effort after the long process of debate and dialogue in securing base-line privileges.

Comment

Even within the small community hospital, the formation of a family practice department can be of great benefit to its members. Family practice residency graduates may not receive their full request for privileges without effective departments of family practice in the hospital. For instance, after 14 months of dispute, one family practice residency-trained physician received cesarean-section and postpartum tubal-ligation privileges. Without a family physician advocate on the executive committee arguing that equivalent training and experience in obstetrics and gynecology should be considered in place of board certification, the privileges would probably not have been granted.

None of the changes at River District Hospital would have occurred without tremendous support from the hospital administrator and the community board. To have an effective department of family practice there must be a high level of respect for family physicians. The best way to gain and maintain community respect is to provide high-quality patient care. Developing comprehensive bylaws, categorizing physician privileges, and defining base-line family practice privileges with support from other departments are basic elements in forming an effective department of family practice.

The formation of a family practice department in the community hospital enhances patient care, assures just assignment and advancement of privileges, affords fair representation during disputes and grievances, and promotes closer intraprofessional communication.

References

1. Clinton C, Schmittling G, Stern TL: Hospital privileges for family physicians: A national survey of office based members of the American Academy of Family Physicians. J Fam Pract 1981; 13:361-371

2. Stern TL, Schmittling G, Clinton C, Black RR: Hospital privileges for graduates of family practice residency programs. J Fam Pract 1981; 13:1013-1020

3. The Health Services Commission of the Michigan Academy of Family Physicians: Overview of Hospital Privileges in the State of Michigan. Mich Fam Pract Bull, May-June, 1980, pp 22-33