Clinical Departments of Family Practice in Hospitals

John P. Geyman, MD

As the 1970s close, completing the first ten years of family practice as a specialty, one of the important trends to emerge is the formation of a growing number of clinical departments of family practice in US hospitals. This development has significant implications for the future practice of family medicine throughout the country.

The generalist role within the medical staffs of hospitals has traditionally lacked an organizational or scientific base. The customary organizational structure in the past has been the *administrative* department of general practice. These departments have usually been weak and loosely organized, lacking both a recognized clinical service and formal mechanisms for assessment of quality of care by their members. Most of the essential affairs of the medical staff were carried out in other specialty departments.

Since the advent of the American Board of Family Practice in 1969 and the subsequent widespread growth of three-year family practice residency programs, this situation has been abruptly altered. Departments of family practice are being established as *clinical* departments in both community hospitals and academic medical centers. Guidelines have been formulated for these departments by the American Academy of Family Physicians, calling for the following primary responsibilities:

1. Assurance of the best possible care by family physicians in the hospital.
2. Assessment of the qualifications of and assignment of privileges for its members.
3. Provision of direction, leadership, and teachers for the family practice residency program in hospitals with such training programs.
4. Cooperation with other departments, the hospital administration, and the board of trustees in solving staff problems and intraprofessional conflicts.
5. Assistance in the supervision and staffing of the hospital Emergency Room where applicable.
6. Promotion and organization of training programs that will prepare practicing physicians, as well as residents, for the family practice board examination.

With respect to hospital privileges, these guidelines recommend the following process[1]:

"Privileges should be assigned to members of the family practice department by the executive committee of the family practice department after interview and thorough evaluation of the applicant. If the applicant requests privileges in another clinical department, privileges will be assigned in the same manner with the approval of the appropriate clinical department."

Changes made by the Joint Commission on Accreditation of Hospitals in 1977 specifically charged the department chairman with the responsibility of recommending to the medical staff the criteria for the granting of privileges in the department.[2] A consensus is developing nationally that a clinical department is expected to recommend for its members those privileges for which training is normally received in its residency programs. In addition, the frequency of overlap between residency programs in different specialties requires increasing participation between departments through privileges in areas of overlap.[3] Although the ultimate responsibility for delineation of hospital privileges for physicians in any specialty rests with the Executive and/or Credentials Committees of the medical staff and the governing board of the hospital, the review of applicants' qualifications and recommendations for privileges within departments is central to this process.

Two examples provide more specific perspectives of the kinds of changes underway across the country concerning hospital based departments of family practice. Table 1 illustrates categories of

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Table 1. Delineation of Privileges in Department of Medicine*

Prerequisites	Privileges**
Group 1. At least one year of clinical post-graduate hospital training	Group 1. Admit and attend uncomplicated medical problems. Request consultation in all diagnostic, or therapeutic problems and all patients admitted to Intensive Care Units.
Group 2. Certification by the American Board of Family Practice or recent completion of training sufficient for eligibility to take the certifying examination	Group 2. Admit and attend all medical problems. Request consultation in all unresolved diagnostic or therapeutic problems and serious or life threatening conditions.
Group 3. Certification by the American Board of Internal Medicine or completion of training sufficient for eligibility to take the certifying examination	Group 3. Admit and attend all medical problems. Request consultation where specific subspecialist expertise is appropriate.
Group 4. Certification by a subspecialty board or completion of training sufficient for eligibility to take the certifying examination	Group 4. Admit, attend, and perform consultations in area of subspecialty.

*Fairfax Hospital, Vienna, Virginia (personal communication, Robert Quinnell, MD, Department of Family Practice)
**Annual renewal of privileges based on performance

privileges in internal medicine developed in a 700-bed teaching hospital in Virginia which recognizes Board eligibility and certification in family practice in the review of these privileges.

The two community hospitals in a Washington State community of 60,000 have charged the Department of Family Practice with the responsibility to review Level 1 Privileges and refer its recommendation directly to the Executive Committee of the Medical Staff for approval. Specific Level 1 privileges have been identified which represent the usual range of competencies of family practice residency graduates, including such procedural skills as circumcision, thoracentesis, closed reduction of uncomplicated fractures, uncomplicated obstetrics, dilatation and curettage, vasectomy, and breast biopsy. Privileges in any of the other departments may be advanced beyond Level 1 Privileges by application to the appropriate department with documentation of training, experience, and demonstrated ability.

While some variation is likely among hospitals of different sizes in different parts of the country concerning departmental structure and procedures, the presently available national guidelines of the American Academy of Family Physicians provide a useful blueprint for the organization and function of clinical departments of family practice in hospitals, including a model set of bylaws for such departments. These departments are welcomed as an essential part of the development of family practice as a specialty. The vigorous process of self-discipline, audit, and evaluation within these departments will inevitably lead to improved quality of patient care and to more effective contributions of family practice within the medical staffs of hospitals throughout the country.

References

1. Family Practice in Hospitals. Kansas City, Mo, American Academy of Family Physicians, 1977
2. Accreditation Manual for Hospitals. Chicago, Joint Commission on Accreditation of Hospitals, 1977
3. Hospital privileges problems come before AAFP Board. AAFP Reporter 6(4):5, 1979