# Consensus Development for Research and Patient Care

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Exponential increases in the complexity and diversity of biomedical research have raised many difficult scientific, medical, social, economic, ethical, and legal issues. Until recently, there has been no organized way to deal with many of these issues in a coordinated way. An important advance in this respect is the Consensus Development Program of the National Institutes of Health, now over two years old.

This program is part of a larger forward planning process affecting the directions and priorities of the future research activities of all of the 11 Institutes of Health. In his excellent new book, *National Priorities for Health: Past, Present and Projected,* Rushmer clarifies the role of this new program in the (1) identification of gaps and opportunities in research, (2) assessment of research results in terms of safety, usefulness, cost, and relative effectiveness, and (3) wide dissemination of valid clinical knowledge to the health care community. Figure 1 illustrates the elements of this process.[1]

The keystone of this program is the Consensus Development Conference, bringing together practicing physicians, research scientists, consumers, and others for discussion and debate of a clinical subject of current or potential importance to public health. Perry and Kalberer have recently reported on the process and experience of these conferences, during the last two years.[2] The clinical importance and breadth of subjects of these conferences are demonstrated by the following content areas already addressed: mass screening for colorectal cancer, treatable brain diseases in the elderly, tonsillectomy and adenoidectomy, antenatal diagnosis, devices for blood pressure measurement, amantadine and influenza, febrile seizures, cesarean section, and computerized tomographic scanning of the central nervous system.

Each Consensus Development Conference deals with specific, practical (and usually controversial) clinical questions. A recent conference dealing with febrile seizures, for example, addressed the following kinds of questions: (1) what are the risks facing a child who has a febrile seizure? (2) what can chronic or intermittent prophylaxis accom-

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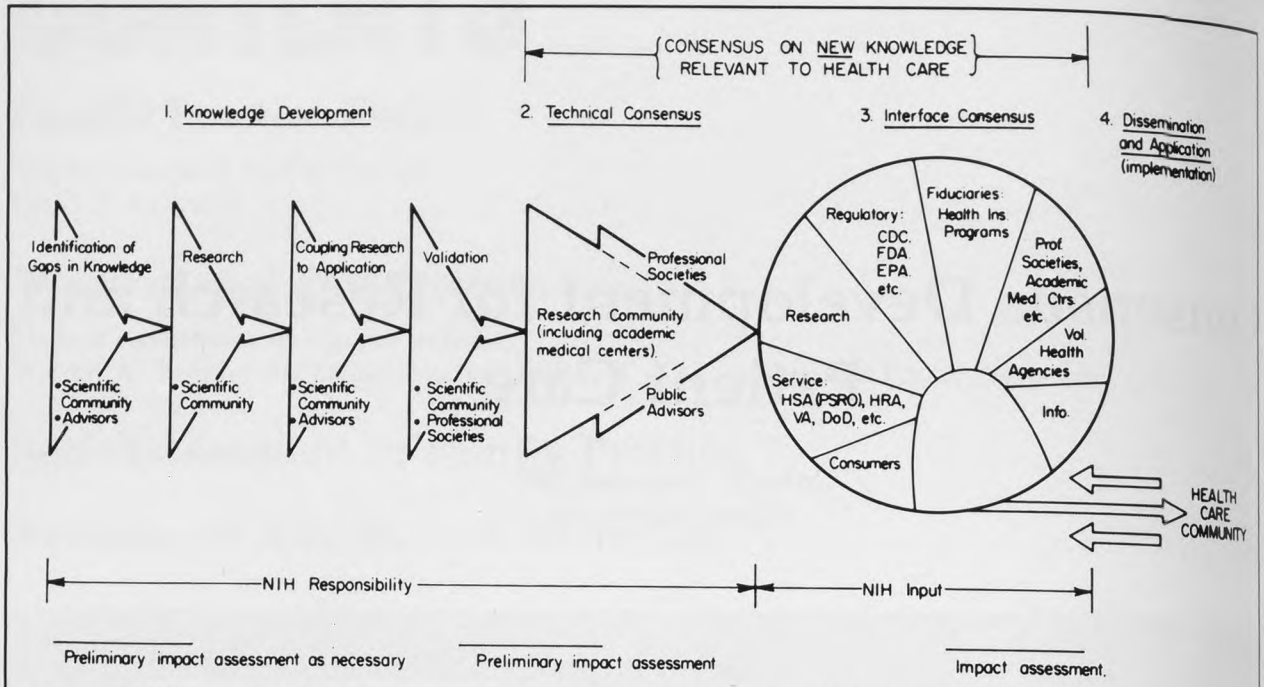


Figure 1. NIH responsibilities at the health-research/health-care interface

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plish in reducing those risks? (3) what is a rational approach to management of this problem? and (4) are further clinical, experimental, or epidemiologic studies needed?[3] This meeting involved open debate and interdisciplinary discussions, and included representatives from the American Academy of Pediatrics, the American Academy of Family Physicians, the American Academy of Neurology, and the Child Neurology Society.

This issue of *The Journal of Family Practice* includes a report of a 1979 Consensus Development Conference on estrogen use in post-menopausal women.[4] This journal welcomes the opportunity to participate in the dissemination phase of this important program, which is a promising approach to the evaluation and transfer of biomedical advances to improved patient care in the community.

## References

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4. Gastel B, Cornoni-Huntley J, Brody JA: Estrogen use and postmenopausal women: A basis for informed decisions. J Fam Pract 11:725, 1980

# Letters to the Editor

The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

## Hospital Care by Family Physicians

To the Editor:

Several papers have been published recently concerning the granting of hospital privileges to the family physician.[1-3] It has also been shown that there are striking regional differences for granting similar privileges to family physicians.[1] Assuming relatively equal ability and educational experience throughout the United States, the basis for this difference must surely be economic as well as political in nature. It has been argued that this is the accepted "lot" of the family physician but, as a specialist, I find this hard to accept. It is even harder to convey understanding of this problem to family practice residents when they are working side-by-side with medicine, pediatric, and obstetrical peers in a university setting. Not only do they compete for patient care experience, but also attempt to establish "self-identify" in an atmosphere of subspecialization exactly parallel to that encounterd in a private practice. In the community based family practice program, with no other competing residents, acceptance and identification problems are probably of less magnitude, but still present.

How can we as faculty for the up and coming family physicians help them gain acceptance by their subspecialist peers, hopefully circumventing the question of political and economic prejudice, and gain privileges strictly on the basis of their ability? One step would be to form a firm consensus at the national level of what is needed to be taught during the three years of residency. More critical is whether or not the core or foundation of family practice should be mostly behavioral, or should be the basic clinical sciences with a working knowledge and appreciation for the psychodynamics of the family unit. Whatever skills and objectives are selected, it is then the individual program's responsibility to educate the resident to the level of *any* specialist for those given skills and objectives. Once the resident has the cognitive skills and documentation of procedures, he should then be able to successfully apply for privileges based upon objective data. It is not surprising that with-

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out this data, regional differences occur depending upon the executive committee of a given hospital. With the federal funds available to family practice, with the current patient acceptance, and, lastly, with the residency trained teachers coming into the field, we have the tools to give the residents what they need.

The ultimate question is whether or not the family physician should care for certain selected hospitalized patients. Without the above mentioned objective data he certainly cannot. My bias is that a family physician trained in a behaviorally oriented program will also have difficulty. Even with excellent training and documentation, economic and political factors may make some hospital privileges difficult to obtain. Success in that situation will depend upon the determination of family practice at the individual as well as the national level to become an accepted specialty within the medical community. Establishment of clinical Departments of Family Practice responsible for "Level 1" privileges seems to be an excellent model which, if accepted through the nation, could be the basis for more self-determination by family practice in the hospital setting.

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2. Geyman JP: Clinical departments of family practice in hospitals. J Fam Pract 9:791, 1979
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