

Hospital Privileges for Family Physicians: Documentation of Family Practice Residents' Experiences in Training

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This report describes a study of the content and uses of the University of Washington Affiliated Residency Network documentation system for future hospital privileges. The selected procedures and problems considered important to document for future hospital privileges were validated by means of a graduate survey conducted in 1985. Fifty percent of the 43 graduates responding used their personal documentation when applying for hospital privileges. Intermediate-sized hospitals of 50 to 199 beds were significantly more likely to require documentation than either small (fewer than 50 beds) or large (more than 200 beds) hospitals. However, 84 percent of the hospitals where graduates are located either require documentation or would find it helpful for privilege application. The three-year cumulative experiences of the 1986 cohort of graduating residents are also presented. Thirty-six of the residents (71 percent) participated actively in the voluntary network documentation system. None of the items selected as important to document for future hospital privileges were recorded by 100 percent of the residents. Obstetric procedures and problems were the items most commonly documented.

Over the past ten years a number of studies have addressed the issue of hospital privileges for family physicians. Several of these have shown that family physicians are successful in obtaining admitting privileges in both the urban and rural settings.¹⁻⁴ Regional differences have been demonstrated, with family physicians in the North Central and West regions more likely to have obstetric privileges and those in the West (Pacific) region more likely to also have surgical privileges.¹ Family physicians in nonmetropolitan (rural) areas are more likely to have obstetric, surgical, and intensive care admitting privileges,¹⁻³ although apparently less so in the Northeast.²

In a survey of graduates of family practice residency programs,^{5,6} it was shown that less than 1 percent of board-certified graduates of family practice residency programs

have been denied hospital admitting privileges, but that 1 to 4 percent were denied specific privileges in obstetrics or surgery.⁵

Documentation of residents' experiences in training has been proposed as essential to support application for hospital privileges.⁷ Increasingly hospitals are requiring specific delineation of privileges requested.⁸ The Special Requirements for Residency Training in Family Practice specify that family practice residency programs must have a documentation system to monitor the educational experience and provide documentation for future hospital privileges.⁹

Most family practice residencies in the United States consist of a three-year continuity-of-care ambulatory experience in a model teaching unit supplemented by inpatient hospital block rotations and subspecialty rotations in office or hospital clinic settings. The multiple training locations create logistic barriers to the development of a unified documentation system. One method, using 3 × 5-inch log cards for recording patient encounters away from the model teaching unit, was developed at the University of Washington in 1974 and subsequently adapted and distributed by the American Academy of Family Physi-

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cians. A similar method has been adopted by other residency programs.^{8,10-13} The specific content of items to be documented has not been presented in the literature, however. One study¹³ described the items documented by residents in North Carolina, but the 30 percent participation rate was very low, and recording was inconsistent.

Before 1980 about 30 percent of the residents in the University of Washington Affiliated Residency Network (7 community hospital-based, 1 university, and 2 military programs) maintained log cards. In 1981 a network faculty committee representing all the programs identified a list of 75 procedures and 39 problems that were considered essential to document for future hospital privileges. These procedures and problems were organized into ten categories, eg, obstetrics, surgery/trauma, and so on (Appendix).

The revised log-card system was introduced in 1982 based on 3 × 5-inch log cards for each patient encounter listing the diagnoses, procedures, and level of resident involvement in procedures. Residents classified their involvement in one of two categories: (1) personally performed or supervised, or (2) assisted. The log cards are coded, summarized, and entered on a computer using a custom-designed computer program at the network office, and then returned to the residents for future reference. Cumulative reports summarizing the log-card data are distributed every six months to residents and faculty.* (Residents can record additional procedures and problems on their log cards, but these are not included in the computer reports). A recent survey of network residents and faculty showed a very high level of acceptance of log cards as a method to document experiences for future hospital privileges.¹⁴

The study reported here was conducted to (1) validate and refine the items recommended by the network faculty as essential to document for future hospital privileges, (2) determine the usefulness of documentation to obtain hospital privileges after graduation, and (3) to ascertain the extent to which residents in training actually document these essential items.

METHODS

A single-mailing questionnaire survey of the 1979 and 1983 graduates (n = 77) of the eight nonmilitary programs was undertaken to determine the utility and importance of documenting particular procedures and problems in obtaining hospital privileges. Graduates of the two military programs in the network were excluded, as they are widely dispersed and current addresses were not available for many of them. The 1979 and 1983 graduates were chosen

* More detailed information regarding the log-card documentation system is available from Dr. Ronald Schneeweiss upon request.

TABLE 1. NUMBER OF THE 1986 THIRD-YEAR RESIDENTS DOCUMENTING EXPERIENCES IN THE TEN MAJOR PROCEDURE AND PROBLEM CATEGORIES

Procedure and Diagnosis Categories* Number	Residents Submitting Log Cards	
	No.	(%)
10	11	(27.5)
9	16	(40.0)
8	3	(7.5)
7	1	(2.5)
6	4	(10.0)
5	1	(2.5)
≤4	4	(10.0)
	40	(100.0)

* A detailed listing of the categories is provided in the Appendix

to include older, as well as more recent, graduates who had been through the experience of applying for hospital privileges. The residency graduates were asked (1) to rate the importance of documenting the problems and procedures selected for the network log-card system (essential, helpful, or not important to document) for hospital privileges, (2) to describe the size of the primary hospital in which the graduates practiced, (3) to indicate whether they had personally used their documentation in applying for privileges, and (4) to state whether their hospital used documentation to negotiate privileges (required, helpful but not necessary, not used).

The aggregate cumulative experiences of the cohort of third-year residents graduating in June 1986 (hereinafter referred to as residents) were analyzed. Forty of 51 third-year residents (78 percent) had used the network log-card system to document their experiences during residency training. Seventy-five percent (30 of 40) of the residents submitting log cards had recorded experiences in eight or more of the ten major categories. The most common category not recorded by these residents was "Miscellaneous," which includes cardiac stress test and bone marrow aspiration or biopsy. Four residents submitted cards in fewer than five of the ten specified problem and procedure categories and were therefore excluded from the analysis, leaving 36 residents (71 percent) who had recorded experiences in five or more of the ten categories (Table 1).

The log-card data are presented as simple frequencies, and the responses to the graduate survey were analyzed using chi-square to determine statistical significance.

RESULTS

The graduate survey to validate the network faculty selection of particular procedures and problems had an overall response rate of 56 percent (43 of 77) (Table 2).

TABLE 2. GRADUATE SURVEY: USE OF DOCUMENTATION IN APPLYING FOR HOSPITAL PRIVILEGES

	Year of Graduation		
	1979 (n = 33)	1983 (n = 44)	Total (n = 77)
Response rate	45	57	56*
Family practice department in hospital	67	76	72
Hospital size < 100 beds Personally used documentation	40	24	30
Documentation is required for privilege application	47	53	50
Documentation would be helpful for privilege application	67	36	47
	33	40	37

* Includes 3 respondents with graduation year unknown

Fifty percent or more of those responding considered 75 percent of the procedure items (57 of 75) and 69 percent of the problem items (27 of 39) selected by the network faculty to be essential to document for hospital privileges (Appendix). None of the selected items, however, was recorded by 100 percent of the residents. Forty-one of 75 procedures and 29 of 39 problems were documented by 50 percent or more of the residents. Only vaginal vertex deliveries, low forceps, cesarean section, third- and fourth-degree episiotomy repair, and toxemia were recorded by 90 percent or more of the residents (Appendix).

The log cards represent only those procedures and problems recorded by the residents. It is not possible to determine with certainty whether a given item was not encountered by the resident or simply not documented. The mean number of procedures or problems per resident, therefore, was calculated using as the denominator only those residents who had documented that item. In addition to the mean number of problems and procedures, the actual number of residents recording a particular item is also presented (Appendix). Three of the items considered by the graduates to be essential to document if hospital privileges were to be sought, namely, tympanostomy tubes, adult circumcision, and colposcopy, were not recorded by any of the residents.

The great majority of all the selected items were recorded with a mean frequency of ten or fewer per resident. There were eight procedure and problem items documented with a higher mean frequency including vaginal delivery (103.6), cesarean section (49.2), internal fetal monitor (20.4), pediatric ventilator (17.7), pudendal or paracervical block (16.0), gastrointestinal hemorrhage (14.6), external fetal monitor (13.0), fetal distress (14.3), and toxemia (11.0). (The Appendix provides a detailed listing of documented procedures and problems recorded by the residents.)

Seventy-two percent of the graduates had privileges in hospitals with family practice departments. There was no

TABLE 3. HOSPITAL SIZE AND DOCUMENTATION REQUIRED FOR ADMITTING PRIVILEGES

Hospital Bed Size	Number of Graduates No. (%)	Documentation Required* Yes (%)
Fewer than 50	8 (19)	38
50 to 199**	14 (33)	71
More than 200	20 (48)	35
Total	42*** (100)	48

* Chi-square = 6.05 (.025 < P < .05, 2 df)
 ** Fifty to 99 beds and 100 to 199 beds combined, because responses were similar
 *** One respondent did not indicate hospital size

statistical difference between the 1979 and 1983 graduates regarding presence of a family practice department or the size of the hospital where they work. Fifty percent of the graduates responding personally used their documentation in applying for hospital privileges. Forty-seven percent indicated that their hospitals currently required documentation, and another 37 percent noted that documentation would be helpful in applying for hospital privileges (Table 2). Intermediate-sized hospitals (50 to 199 beds) were significantly more likely to require documentation than larger (more than 200 beds) or smaller (fewer than 50 beds) hospitals (P < .05, Table 3).

DISCUSSION

The need for adequate documentation of family practice residents' experiences in training has never been more important. In addition to operative reports and discharge summaries, it is very helpful for residents to maintain logs summarizing their experiences in training. Three- by five-inch log cards completed by the residents for each patient, then coded and summarized using customized computer programs, have proven to be practical and have been implemented in several residencies.¹⁰ What should be documented remains, however, an unanswered question. The ideal theoretical list must be balanced against the experience available in a residency training program and the likelihood that residents will record those experiences.

Residents most commonly document their experiences in obstetrics, critical care, surgery, and trauma. The degree to which documentation occurs no doubt reflects the perceived importance of documentation of experiences in those areas as well as a reflection of the residents' exposure to these procedures and problems. It was not possible to determine what percentage of the recommended procedures and problems actually performed by residents are not recorded. Residents who bother to document particular experiences, however, would be expected to be consistent in recording those items. The relative frequency of documented items reported in this article is probably a fair reflection of the procedures and problems considered

to be important by residents and, therefore, documented by them in these eight residency programs.

Thirty-six of the 51 residents who graduated in 1986 participated actively in the network log-card documentation system over their three years of training. Only 41 of the 75 procedures (55 percent) and 29 of the 39 problems (74 percent) selected by the network faculty were recorded by 50 percent or more of the residents, however. This relatively low rate probably reflects the fact that residents do not necessarily obtain experience in all the selected areas during their training. It is also possible that residents do not bother to document certain items, but this is unlikely given the critical nature of these procedures, eg, fractures, temporary pacemaker, amniocentesis, curettage of retained products, cervical laceration repair, and burns (Appendix).

This study reports on the specific content areas that are included in the University of Washington log-card documentation system. The University of Washington network committee found it helpful to focus the log-card system on those procedures and problems considered essential to document for future hospital privileges. Seventy-four percent of the 75 procedure and 39 problem items selected by the network faculty committee were also considered essential to document for future hospital privileges by more than 50 percent of the graduates surveyed. This information could be helpful to other programs in defining the content of their documentation system. Obviously items could be added or deleted in response to local needs. Some items proposed by the network committee were not included in the final list. These items describe procedures usually performed in the office, including excision of skin lesions and biopsy of cervix. Other procedures selected by the committee but not considered essential to document for hospital privileges by two thirds or more of the graduates include external and internal fetal monitoring, pudendal and paracervical block, and vasectomy. These procedures have been dropped from the list as a result of this study.

These results need to be interpreted in the light of the 55 percent response rate to the single-mailing graduate questionnaire. Nevertheless, there were no statistically significant differences between the 1979 and the 1983 graduates in terms of hospital size. The 43 respondents represent the spectrum of smaller rural to larger urban communities (Table 3), which reflects the distribution of network graduates overall as described in the network graduate follow-up survey.¹⁵

Eighty-four percent of the 1979 and 1983 graduates indicated that their hospitals either required documentation (47 percent) or that it would be helpful (37 percent) in applying for privileges (Table 2). Documentation was significantly more likely to be required by intermediate-sized hospitals with 50 to 199 beds ($.025 < P < .05$). This finding probably reflects that family physicians usually have little or no problem in obtaining hospital privileges in the smaller rural hospitals of fewer than 50 beds. It is more difficult to explain the finding that larger hospitals

of more than 200 beds are less likely to require documentation, which could be a result of a restriction of privileges either sought by or permitted family physicians in larger urban settings. Alternately, it could be a reflection that graduates in larger urban settings may obtain privileges in the hospital where they trained and therefore have less difficulty.

The current climate in medicine has created a situation in which family practice residents are highly motivated to document their experiences in training. A log-card documentation system is practical for residents to maintain and feasible to implement even in a network of residencies. Identifying a limited list of procedures and problems is helpful to residents by defining what should be documented. The list should reflect the kind of procedures and problems for which family physicians are potentially likely to seek hospital privileges. At the same time it must be recognized that some of the listed areas may be pursued by only a small number of residents. This list will no doubt change as new technologies are introduced and as family practice defines its turf as a specialty.

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APPENDIX. THE UNIVERSITY OF WASHINGTON AFFILIATED RESIDENCY NETWORK SELECTED PROCEDURES AND PROBLEMS CONSIDERED ESSENTIAL TO DOCUMENT FOR FUTURE HOSPITAL PRIVILEGES

The appendix presents (1) the graduates' perceptions regarding items essential to document for hospital privileges, and (2) the aggregate cumulative documented experiences of the 1986 cohort of graduating third-year residents in the University of Washington Affiliated Residency Network (July 1983–June 1986)

	1979 and 1983 Graduate Survey Percent Considering Items Essential (n = 43)	1986 Residents	
		Mean Number per Resident	Number of Residents Recording Item (n = 36)
Procedures			
Obstetrics			
Cesarean section	84	49.2	33
Amniocentesis	77	3.0	9
Spinal/caudal/epidural anesthesia	77	1.5	6
Vaginal delivery—twins	74	1.9	16
Vacuum extraction	72	6.0	28
Forceps and rotation	72	1.2	15
Vaginal delivery—vertex	70	103.6	35
Forceps—low	70	13.3	34
Curettage of retained products	70	1.0	1
Vaginal delivery—breech	67	1.3	14
Cervical laceration repair	63	1.6	8
Fourth-degree episiotomy repair	56	4.9	33
Scalp pH	51	2.1	12
Removal of retained placenta	49	2.4	22
Induction of labor	47	4.6	23
Third-degree episiotomy repair	42	9.4	33
Oxytocin augmentation	40	9.8	27
Pudendal/paracervical block	33	16.0	23
Fetal monitor—internal	30	20.4	25
Fetal monitor—external	23	13.0	16
Surgery/Trauma			
Appendectomy	84	4.7	24
Herniorrhaphy—inguinal	84	6.6	19
Breast biopsy—open	81	5.1	19
Skin graft—split thickness	79	2.0	5
Tendon repair	79	1.0	1
Hemorrhoidectomy	77	5.4	8
Tympanostomy tubes	77	—	—
Skin graft—full thickness	77	1.0	1
Herniorrhaphy—umbilical	74	3.9	18
Tonsillectomy/adenoidectomy	72	1.5	2
Circumcision—adult	72	—	—
Fracture, open—reduction	72	1.3	4
Paracentesis	70	2.0	19
Abdominal lavage	67	1.0	2
Thoracentesis	65	3.8	31
Chest tube	65	3.0	19
Fracture, closed—femur	60	2.0	7
Fracture, closed—tibia, fibula	51	3.2	9
Dislocation—hip	51	1.5	2
Fracture, closed—radius, ulna	49	4.1	12
Fracture, closed—humerus	49	1.4	8
Dislocation—other	44	1.7	3
Dislocation—shoulder	42	1.7	3
Fracture, closed—hands	38	3.6	9
Fracture, closed—other	35	7.2	20
Vasectomy	23	6.0	14
Critical Care			
Swann-Ganz catheter	77	4.0	29
Tracheotomy	77	2.0	5
Temporary pacemaker	77	1.8	6
Cardioversion—elective	72	1.8	17
Respirator/ventilator	67	7.5	20
Arterial line	67	4.1	29

APPENDIX. (CONTINUED)

	1979 and 1983 Graduate Survey Percent Considering Items Essential (n = 43)	1986 Residents	
		Mean Number per Resident	Number of Residents Recording Item (n = 36)
Procedures			
Critical Care			
Pericardiocentesis	65	1.8	4
Manage code (CPR)	58	5.0	22
Central venous line	51	9.0	31
Intubation	49	5.4	18
Venous cutdown	49	1.5	2
Neonatal/Pediatrics			
Umbilical catheter	74	4.6	14
Ventilator	67	17.7	6
Intubation—neonatal	63	4.7	16
Resuscitation of newborn	60	5.4	10
Lumbar puncture	58	6.2	30
Suprapubic bladder tap	49	2.5	13
Circumcision	47	6.7	28
Gynecology			
Sterilization—postpartum	84	10.0	31
Sterilization—minilaparotomy	84	3.1	18
Dilation and curettage	81	5.3	27
Sterilization—laparoscopic	79	2.2	9
Therapeutic abortion	74	3.8	23
Colposcopy	65	—	0
Culdocentesis	58	1.3	7
Biopsy—cervix	51	1.4	5
Miscellaneous			
Cardiac stress test	72	5.6	9
Bone marrow aspiration	58	3.2	6
Bone marrow biopsy	56	3.6	5
Problems			
Critical Care Adult			
Acute myocardial infarction	77	11.2	29
Diabetic ketoacidosis	65	3.3	24
Status asthmaticus	63	5.5	24
Burns—third-degree	63	1.3	3
Septic shock	60	2.7	19
Coma	60	2.6	16
Epilepsy	60	1.9	11
Respiratory failure	58	5.7	30
Meningitis	58	3.3	21
Chest pain, rule out infarction	53	22.1	24
Stroke/cerebrovascular accident	53	6.0	26
Pulmonary edema	53	5.0	25
Gastrointestinal hemorrhage—upper	51	5.5	28
Gastrointestinal hemorrhage—not specified	51	6.4	23
Gastrointestinal hemorrhage—lower	51	2.7	19
Drug overdose	47	4.1	22
Delirium tremens/detoxification	44	3.2	18
Burns—second-degree	41	1.3	7
Obstetrics			
Toxemia	75	11.0	33
Diabetes	70	4.1	24
Premature labor	65	8.1	29
Premature rupture of membranes	65	6.0	28
Fetal distress	63	14.3	31
Dystocia	63	6.8	31
Antepartum hemorrhage	58	5.1	28
Postpartum hemorrhage	58	2.3	20
Arrest of labor	56	7.3	28
Postpartum endometritis	40	2.5	8

APPENDIX. (CONTINUED)	1979 and 1983 Graduate Survey Percent Considering Items Essential (n = 43)	1986 Residents	
		Mean Number per Resident	Number of Residents Recording Item (n = 36)
Problems			
Neonatal/Pediatrics			
Premature infant	65	6.8	26
Respiratory distress—newborn	63	5.0	20
Sepsis	60	4.8	28
Convulsions	47	2.4	16
Narcotic withdrawal	47	2.0	3
Hyperbilirubinemia	44	4.8	22
Psychiatry			
Acute psychosis	49	2.6	18
Major depression	49	1.9	10
Schizophrenia	47	1.7	9
Manic-depressive psychosis	44	1.3	6
Suicide attempt	33	1.5	10