General Practice Observed

The American General Practitioner in Hospital

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Summary

In the U.S.A. and Canada full access of general practitioners to hospital beds and facilities is regarded as an essential privilege of their work. All hospital constitutions require a review of the credentials of staff applicants and continuing evaluation of their performance. Staff appointment carries administrative as well as clinical responsibilities and hospital work occupies a considerable proportion of the general practitioner's day. The disciplinary machinery for safeguarding standards is strict by comparison with British hospital practice.

This system produces an obvious excellence of clinical standards, postgraduate education, and communication between specialist and general practitioner and is attractive to the more able young British graduate. A pilot experiment of hospital staffing on North American lines in one of our new district general hospitals would be a worthwhile proposition.

Introduction

Partial reintegration of general practitioners with the hospital service in Britain is now accepted as inevitable. Debate centres on the status, scope, and responsibilities of general practitioners within hospitals and whether their services are best employed as assistants in special departments, or in more or less self-contained general-practitioner units dealing with prescribed conditions only. In this connexion American organization and experience is of interest. In the United States and Canada the general practitioner has always held some kind of hospital staff appointment, considering this to be an essential privilege of his work. I was fortunate in being able to spend two months in 1970 studying the conditions under which American general practitioners have access to hospital beds and facilities.

Background

There has been little federal or state control of the supply of doctors and general acute hospital beds in the U.S.A. Thus, by comparison with Britain, there is a large establishment of specialists (63%) compared with general practitioners (37%). The national ratio of doctors to population is 1:650, but the uneven distribution of medical manpower leaves many states in the South and West 30% below this figure—whereas California and the populous New England states exceed it by 50%. Since the morbidity patterns resemble those in the United Kingdom it follows that specialists frequently act as doctors of

first contact, performing work which in Britain is the responsibility of the general practitioner. There are no formal practice lists and the patient is free to choose a general practitioner or specialist at will for each episode of illness.

Provision of acute hospital beds varies similarly, the national average being 4.5 per 1,000 population, but rising to 8.0 per 1,000 in some urban areas. (4.5 per 1,000 is the upper limit in the United Kingdom). About half the total acute hospital beds are in public hospitals and federal hospitals. The former comprise state and city hospitals and are financed primarily by local taxation. Their responsibility is to provide free care for the indigent and primary care of unidentified patients (for example, from road traffic accidents) before being transferred to the hospital of their own choice. Generally these hospitals are under-financed and they compare in many respects with most National Health Service hospitals in Britain. Federal Hospitals comprise Military Veterans administration and Public Health hospitals, each providing free care for selected elements of the population. All these hospitals depend largely on salaried staff, and general-practitioner work is limited to rare participation in outpatient or emergency room cover.

The other half of acute hospital beds are in private voluntary, or community hospitals,¹ which are independent and autonomous, frequently under the auspices of a religious order. Most are non profit-making, but must budget to be self-supporting. The average size is about 190 beds, and since in urban areas these hospitals are in competition both for staff and patients the standard of buildings and equipment is very high, comparing with that in the few new district general hospitals in Britain; 99% of general practitioners hold staff appointment in these hospitals, only 1% being without formal hospital attachments.² Many are on the staff of several hospitals.

Accreditation of Hospitals

Some 4,000 of the 5,900 hospitals in the U.S.A. are now formally accredited by the Joint Commission on Accreditation of Hospitals, set up by the American Medical Association, the American College of Surgeons, the American College of Physicians, and the American Hospital Association. Accreditation involves 3-yearly inspection of buildings, equipment, and clinical records, and also ensures a standardized constitution, bylaws, and internal organization of hospitals. Together with examination of postgraduate educational programmes the ultimate effects of accreditation on clinical standards are considerable.

Internal Hospital Organization

All larger hospitals are organized on a divisional basis, which can be summarized diagrammatically (see Fig.) The degree to which smaller hospitals follow this system depends on the number of beds and size of staff involved. Within departments

the staff is classified as honorary (emeritus), consulting (specialist), active, or associate staff. The last category absorbs all recently appointed staff members, while the courtesy staff comprises doctors who use the hospital in question only occasionally.

Heads of departments and divisions up to and including chief of staff are subject to annual re-election or reappointment. They are responsible for overall discipline within departments, guided by standing committees of which the following are the most important.

EXECUTIVE COMMITTEE

Consists of the chief of staff and deputy administrator, medical staff secretary and treasurer, chairman of the departments of medicine and surgery, and one or two elected members. This small committee is responsible for co-ordination of activities and policies of the various medical departments and deciding all staff appointments. It is the effective hospital decision-making body.

CREDENTIALS COMMITTEE

A similar small committee with the duty of investigating the credentials of all applicants for membership of the medical staff, and also of determining from the applicant's training, experience, and demonstrated competence his degree of hospital privileges.

MEDICAL RECORDS COMMITTEE

Consists of at least three members of the active medical staff. The maintenance of adequate up-to-date records is its concern. It meets monthly to consider a random selection of hospital records to include all deaths, all blood transfusions, all primary Caesarean sections, etc. Medical audit is a function primarily of the medical records committee, though the tissue committee may collaborate in this duty.

TISSUE COMMITTEE

Consists of members from departments of surgery, medicine, obstetrics and gynaecology, and a pathologist. Its duty is to review at monthly intervals all surgical and gynaecological cases of the month. It maintains an individual audit on all surgeons, and investigates all cases of removal of normal tissue, all discrepancies between preoperative and postoperative diagnoses, all sterilizations, and all cases of possible unjustified surgery.

UTILIZATION COMMITTEE

Consists of the chairman and one designated member of the surgical and medical departments, and the director of the out-patient department. Ex-officio members are the administrator and members of the radiological, pathology, and anaesthetic departments. Its purpose is to review long-stay and short-stay patients, handling of emergencies, and queries relating to payments by the various financial agencies, Medicaid, Medicare, etc. The object is to secure the best possible use of beds and facilities.

All these committees generally are small, hard-working, and effective. Acceptance of appointment to the active staff of a hospital implies willingness to serve on any committee, if asked to do so.

Ruling on Consultations

Of the numerous written hospital rules that on consultations is the most important for the general practitioner. Consultation with another qualified physician is *required* for the following:

- (1) First caesarean sections.
- (2) Curettages or other procedures by which a known or suspected pregnancy may be interrupted.
- (3) Operations performed for the sole purpose of sterilization.
- (4) Cases in which the patient is a poor risk for operation, the diagnosis is obscure, or there is doubt as to the best line of treatment.

Consultation should preferably be with a specialist for the illness concerned. Nevertheless, in an emergency it is accepted that any doctor may consult with any other. The responsibility for requesting a consultation rests with the patients' doctor, whatever his specialty or status. Infringements of this rule are rare and invite severe stricture, if not suspension of privileges.

G.P. Access to Hospitals

Application for staff membership is made in writing to the hospital administrator, who verifies the applicant's qualifications. He then forwards the application to the credentials committee, which in turn informs the executive committee of its recommendation. This is put to a full meeting of the medical staff and a three-quarters majority of those present is required for election. The general practitioner is appointed into the department of medicine or surgery, depending on his experience and interest, and remains under the aegis of that department and answerable to its chief.

Staff privileges are classified into major and minor, the former involving treatment of life-threatening conditions, and the latter less serious disease. Privileges are further exactly delineated for each individual practitioner. Thus internal medicine is divided into some 11 subspecialties, and special procedures listed under some 30 headings, from arterial puncture to sigmoidoscopy. In surgery minor privileges include treatment of common lacerations and injuries not involving joints, tendons, or nerves; simple uncomplicated fractures; dilatation and curettage for incomplete abortion or diagnosis; biopsy of the cervix; removal of common benign tumours, fibromas, and moles; diagnostic proctoscopy and sigmoidoscopy; incision of superficial abscesses; burns not requiring grafting. For the general practitioner permission to perform major operations such as tonsillectomy or appendicectomy is individually specified.

A general practitioner wishing to extend his privileges on acquiring a new skill may apply to the executive committee, backing his application with reports from his colleagues and the medical records and tissue committees. There is a feeling particularly among urban general practitioners that more flexibility in awarding and reviewing privileges is desirable.

Emergencies and Training

General practitioners provide 24-hour cover as in Britain, deputies being employed when necessary. Home visits or house calls are rare since most patients have both a telephone and a car. Increasing use is being made of hospital emergency rooms, which are better equipped than most doctor's offices, in dealing with episodes of acute or severe illness. Thus a doctor receiving a message from the home of a patient with sudden chest pain will usually arrange immediate transport to the emergency room for examination, electrocardiograph, and an x-ray film together with routine blood tests, followed by admission if necessary. In smaller hospitals he may perform the examination himself, but most of the large hospitals have 24-hour emergency room cover provided by a syndicate of doctors, frequently general practitioners, working on an 8-hour shift basis. In any event the general practitioner is responsible for the patient's further management, and his deputy must arrange this if he is absent.

Universities have been encouraged to establish departments of family practice in an effort to direct more graduates into this new "specialty" and thus remedy the serious shortage of general practitioners throughout North America. All universities agree that hospital staff appointment will remain an essential privilege of family practice, and though the image of the general practitioner having an inalienable right to be—and do—all things to all men is disappearing his role in hospital is assured, not least as a co-ordinator and interpreter of team effort where his patients are concerned.

Discussion

The American general practitioner's access to hospital facilities is exercised in a well-established disciplinary tradition. In common with all hospital staff his performance is subject to continuous review and evaluation via the universal framework of hospital standing committees. The standards are strict. Thus it is mandatory that a full history and physical examination be entered into the notes within 24 hours of a patient's admission, and a discharge summary must be completed within 14 days of the patient's discharge. A medical audit will immediately question any discrepancy between admission and discharge diagnosis; if operative findings are at variance with preoperative diagnosis; and if the required consultations have not taken place. The notes are returned to the doctor in question for comment. Frequent lapses may result in temporary suspension of privileges; the ultimate sanction of being refused re-election to the staff is very rarely invoked.

Daily contact with specialists in every field, both in enabling easy communication and in continuing education, gives the American general practitioner an appreciable advantage over his British counterpart and the resulting standard of general practice is high. Involvement in hospital work adds a considerable amount to his working day. Typically he starts his hospital rounds at 8.0 a.m. and is frequently not free for office consultations until midday. Junior staff in hospital may be few, and a hospital of 500 beds may have no resident staff at all, so that much of the emergency care required falls to his lot.

A small minority of British general practitioners have comparatively free access to cottage hospitals, where they enjoy clinical freedom comparable to that of their American counterparts, but without the restrictions or processes of evaluation demanded by American hospital constitutions. A minority hold appointments as clinical assistants in special departments, but this work is episodic and the practitioner is not involved, except fortuitously, in the treatment of his own patients.

DISTRICT HOSPITALS

The district general hospital is now the lynch-pin of hospital planning, and it is worth considering the feasibility of integrating general practitioners into the staff of district general hospitals on American principles. There are two important statistics to be balanced here. Firstly, 47% of our hospital junior staff are Commonwealth-trained. This supply may shortly be curtailed. Secondly, between 60 and 70% of the younger British general practitioners wish to have formal hospital access.³ Hence there is a strong case for implementing an experimental staffing structure as a pilot scheme, preferably in a new district hospital in an area where most general practitioners wish to have access.

The effects of such a structure on specialist career prospects would need careful assessment, but should eventually prove favourable, since there would be a reduced requirement for hospital junior resident staff. In the long run promotion should be quicker for those intent on a specialist career, since the base of the promotion pyramid would be narrowed. This might avoid the difficulties expected in a much enlarged establishment of consultants.⁴

The exact status of the general practitioner in hospital is of less importance than his presence on the active staff. Guided by American experience it might be wiser to lay down comparatively rigid criteria and rules for appointment into a division, for scope of clinical work within hospital, and for evaluation before the renewal of the appointment. It is always easier to relax regulations than to tighten them.

Recent discussion of the Cogwheel⁵ and Salmon⁶ reports has highlighted the importance of good communications in the hospital service.⁷ Undoubtedly total integration of general practitioners within specialist departments is the best way of

breaking down communication barriers. If this is a desirable end in itself then creation of more or less water-tight general-practitioner units within district general hospitals should be viewed with reservation. The isolated unit may be a geographical necessity in many areas, but problems of communication will remain unsolved unless frequent visits by specialists can be arranged.

SHORTCOMINGS

Shortcomings in the delivery of health care in the U.S.A. derive from irregular distribution of resources—manpower and hospital—inherent in a system governed by the economic laws of supply and demand. Where facilities exist their utilization is efficient. Local over-provision, with corresponding deprivation in poor rural and urban ghetto areas, can be corrected only by federal government action. Together with the increasing and paralysing individual cost of care in hospital there are major problems requiring solution at political level.

In Britain a relatively even distribution of care has been achieved, but at the cost of widespread mediocrity, so that it is necessary to strike a warning note in conclusion. A British graduate in medicine now enters a world market for his services. Probably clinical satisfaction is his main requirement after qualification and financial considerations are of secondary importance. The higher standards of vocational training now being implemented are going to raise the graduate's requirement for full facilities for investigation and treatment of his patients rather than otherwise.⁸ These facilities are available only within hospital. The North American general practitioner enjoys them to the full, whereas his British opposite number is at present unlikely to have more than a limited access to them. In addition, the American general practitioner's income and standard of

living are appreciably higher than that of his British counterpart. Together these advantages exert a compelling influence on many of our most capable young doctors. It is beyond our power to remedy the financial differential, but to alter the British general practitioner's clinical opportunities by integrating him fully with the hospital service would cost nothing. It may demand faith, courage, and submission to an unwonted degree of discipline on his part. At its best in North America such integration produces some of the finest possible medical care. After 22 years of experimentation there is now no reason for the British National Health Service to aim at anything less.

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Reorganization of the N.H.S.

Effective Management of Health

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The "basic difference" between the latest, presumably final, consultative document on N.H.S. reorganization¹ and its two predecessors^{2,3} is, to use Sir Keith's own words, in the emphasis on "effective management", particularly at the regional level. Thus the document is very much in line with the present Government's entire thinking about public spending.⁴ Whatever changes are made in the details of the proposals after consultation with the profession, it would be naive to imagine that there will be any lessening in this emphasis on "effective management". In this paper we examine the implications for the professions and the N.H.S. as a whole of this proposed managerial revolution, without attempting to discuss all the aspects of the document.

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Case for Management

What does "effective management" mean? We define it as a system of decision-making which works within a framework of clear objectives, which has a hierarchy of consistent and coherent priorities, and which allocates resources in a rational manner. Equally our system includes a continuing capacity to monitor the results of decisions taken and, where necessary, to redeploy resources accordingly. The usefulness of this definition is that it emphasizes the absence of good management in the N.H.S., which has been largely run on the basis of a well-meaning stewardship.

To take the most outstanding example, one of the objectives of the N.H.S. was to secure an equitable distribution of resources across the country. In general practice the use of the designated areas system has contributed towards this aim. In the hospital services—which take over 60% of the N.H.S. budget—the historical inequalities of the regions inherited in 1948 have been perpetuated virtually unchanged. The amply bedded, high-spending regions of the past are still the amply bedded, high-spending regions of today. The top region spent almost 69%