Committee on Hospital Care

Relationship Between Hospital-Based and Private Practice Physicians

For a number of reasons, hospitals appoint full-time and part-time physicians to practice medicine within the hospital or its outlying divisions. Such physicians provide a wide variety of primary, specialty, and subspecialty services. Among other advantages for hospitals are a potentially tighter rein on quality control and an increased bed occupancy and revenue at a time when financial issues have become increasingly important.

Physicians engaged solely in administration or research rarely pose a problem in the relationship between the hospital and private practice physicians. However, it is more likely that friction (which might adversely affect patient care) may occur when there is overlapping of services provided by the private practice physicians and the hospital-based physicians, whether they are salaried by the hospital or on a fee-for-service basis. Therefore, the Committee on Hospital Care of the American Academy of Pediatrics offers the following guidelines concerning this interface.

ROLE OF HOSPITAL-BASED PHYSICIANS

The Committee on Hospital Care believes that many appropriate roles exist for hospital-based physicians. Certain specialties may advantageously be hospital based, or regional hospital units are involved. Such specialists might include (among others) those involved in burn care, spinal cord injuries, dialysis, cardiac surgery, emergency medicine, pediatric and neonatal intensive care, medical education, radiology, pathology, and anesthesiology. Certain hospital units benefit from continual organization and supervision which may best be provided by hospital-based physicians.

The Committee believes that research and teaching (including primary care teaching) must be maintained in certain hospitals. Commonly, these programs are centered around hospital-based physicians, although private practice physicians have participated productively in most programs. Teaching and research should not interfere with and, indeed, may enhance patient care when done well.

Within pediatrics, certain subspecialists may best be attracted to a community by an offer of a full-time or part-time, salaried position. In this way, the hospital may serve the community by acting as a focal point for recruitment.

GUIDELINES FOR HOSPITAL ORGANIZATIONS

The Committee on Hospital Care offers the following guidelines for hospital organizations in the employment of hospital-based physicians. The primary goal of the hospitals employing physicians should be to meet the unsatisfied medical needs of the area or community. The private practice community should be consulted in the process of evaluating the medical needs of the community before any definitive action to employ or terminate employment of physicians is taken by the hospital.

Remuneration of hospital-based physicians may be done in various acceptable ways. This is an important and sensitive issue. Ideally, the physician's income should be commensurate with the services provided in the hospital, although it is recognized that there are several factors influencing physicians' salaries.

Granting, increasing, decreasing, or termination of hospital privileges should be based on demonstrated current clinical competence. The bylaws of any hospital governing admission to the medical staff and delineation of clinical privileges and access to hospital facilities should be the same for hospital-based and private practice physicians. In the event of termination or alteration of privileges, a hospital-employed physician should have access to due process procedures.

Attending physicians, as well as parents, should be able to choose between available consultants rather than be limited to those employed by the hospital. An employed physician, as well as a private physician, must never let allegiance to the hospital take priority over allegiance to a patient.
When families initially seek hospital care for their children, they should be apprised of the choices of physicians. It is not appropriate for a hospital to automatically assign the care of a patient to a hospital-based physician if the attending private practice physician has the appropriate privileges to provide that care. For example, a newborn infant should not automatically become the patient of a neonatologist if the patient’s medical condition can be managed by a pediatrician appropriately accredited by the hospital. However, an infant’s condition certainly may properly warrant immediate involvement of the neonatologist, either on a consultative or ongoing basis. Assumption of care should be based on the nature of the patient’s illness, and the knowledge, skills, and experience of the available physician provider. Initial assignment of a patient’s care to a hospital-based specialist may be appropriate when the coordinated and complex function of a team of medical care providers is necessary and when the specialist directs that team.

INTERACTION BETWEEN HOSPITAL-BASED AND PRIVATE PRACTICE PHYSICIANS

The Committee on Hospital Care strongly believes that patients are best served by a single physician providing and/or coordinating their care. Any medical care arrangement that unnecessarily interferes with a strong, single doctor-patient relationship is less desirable than one that does not. At times it becomes necessary to involve more than one physician in a patient’s care, but one physician should act as coordinator or director of the medical team. There should be clear understanding of which responsibilities each physician is assuming at any time.

A cooperative, harmonious relationship between hospital-based and private practice physicians is beneficial for patient care, especially in view of the increasing complexity of medical care. Referrals should preferentially be made from physician to physician with appropriate written documentation, rather than relying on communication via intermediaries such as paramedical personnel or house officers. While the patient is under the care of the hospital-based physician, clear communication with the referring physician is vital. Mutual planning for follow-up is encouraged to assure continuity of care. An understanding, give-and-take attitude between physicians is extremely helpful in this team approach to patient care.

Hospital-based specialists should generally assure early involvement of the patient’s personal physician (commonly in private practice) in the care of hospitalized specialty patients. This will provide smoother transition in his assumption of total care when appropriate (eg, the newborn infant after recovery from hyaline membrane disease). Follow-up care may be shared by both physicians. For example, the pediatrician may assume responsibility for general health care while other specialists retain the responsibility for care of a certain disease process such as cancer.

RESPONSIBILITIES OF THE MEDICAL STAFF TO THE HOSPITAL

Finally, all physicians, whether in private practice or salaried, should be knowledgeable regarding numerous serious problems facing the hospital administration, and should avoid making demands that are incompatible with current fiscal realities. Certain administrative initiatives and practices, such as hiring of physician employees, may be threatening to the practicing physician, but may be helpful for optimal hospital function and economic survival. Cost containment is now a shared responsibility of all physicians, administrators, and patients. Physicians should be encouraged to advise hospital administrators and trustees, and government officials, about means to ensure quality of care within the constraints mandated by prospective reimbursement, diagnosis-related groups, preferred provider organizations, and other new fiscal policies.

Physicians should make themselves available for service on hospital boards and committees to help them make appropriate decisions regarding the hiring of hospital-based physicians, other hospital policies, and long-range planning. There should be an equitable distribution of hospital-based and private practice physicians on these committees.

The Committee believes that the most important factor in determining the desirability of hospital employment is the ability to serve patients best.

COMMITTEE ON HOSPITAL CARE, 1983–1984
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REFERENCES
1. Committee on Hospital Care: Delineation of pediatric privileges in hospitals. *Pediatrics* 1982;70:813–818

INTERNATIONAL SYMPOSIUM ON NEONATAL INTENSIVE CARE

Co-sponsored by the National Research Council, University of Milan and University of Michigan, the symposium will be held Oct 11–13, 1985, Portofino, Rapallo, Italy. CME credits will be offered. This course will be in English and will cover all of the major problems in neonatal care.

The distinguished faculty consists of: I. Minoli, Italy, *Chairperson*; E. Cosmi, Italy; G. Duc, Switzerland; V. Dubowitz, United Kingdom; J. Emery, United Kingdom; T. Fujiwara, Japan; A. Huch, Switzerland; R. Huch, Switzerland; S. James, USA; M. Klaus, USA; J. Lucey, USA; A. Marini, Italy; R. Michaelis, W. Germany; R. Milner, United Kingdom; J. Overall, USA; M. Raiha, Sweden; L. Rossi, Bernardi, Italy; H. Shinefield, USA; W. Tooley, USA; and J. Volpe, USA.

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