CMA GUIDELINES FOR MEDICAL STAFF PROCTORING

Approved by the CMA Board of Trustees, April 26, 2012

These guidelines are intended to assist medical staffs with the establishment of a proctoring system that upholds high quality standards for patient care. A well-designed proctoring system provides an objective evaluation of a physician’s clinical competence that can be used to inform medical staff privileging decisions.

INTRODUCTION

CMA recommends that every medical staff establish a system for proctoring new staff members during their initial period of provisional staff membership and existing members requesting additional privileges. Letters of reference, evidence of training, even board certifications, are no substitute for first-hand observation. It is sometimes argued that a physician from the community is “known” to many members of the staff. However, this type of casual professional acquaintance may lead to a less than objective evaluation of the individual’s actual clinical competence.

CMA recommends that medical staff bylaws clearly delineate a policy for proctoring physicians applying for medical staff membership and privileges. This could include new applicants, as well as current medical staff members applying for new privileges that involve direct patient care. Medical staffs may wish to allow departments to develop individual proctoring policies and procedures as appropriate.

WHEN TO PROCTOR

All practitioners are subject to proctoring. Proctoring begins at the time privileges are initially granted at the time of initial appointment, granting of temporary clinical privileges, or granting of any new privileges between appointments.

Initial Privileges. For applicants who do not currently have privileges or a track record at the hospital, the medical staff must define the circumstances that require monitoring and evaluation of a practitioner's performance, which should include proctoring.

New Privileges. For medical staff members who request a new privilege that was not previously granted.

Focused Professional Practice Evaluation (FPPE). When questions arise about whether a practitioner can continue to provide safe, high-quality care. In these cases, the medical staff must develop criteria that address when such a review will be triggered, and the extent to which proctoring will be required.

PROCTORING METHODS
Proctoring involves evaluation of all aspects of the management of any case. There are three
types of proctoring: prospective, concurrent, and retrospective.

Prospective proctoring is a review by the proctor of either the patient's chart or the patient
personally before treatment. This type of proctoring may be used if the indications for a
particular procedure are difficult to determine or if the procedure is particularly risky.

Concurrent proctoring is when the proctor actually observes the physician's work. This is usually
used for invasive procedures so that the medical staff has first-hand knowledge necessary to
satisfy itself that the physician is competent.

Retrospective proctoring involves a retrospective review of patient charts by the proctoring
physician. Retrospective review may be appropriate for proctoring of noninvasive procedures
competency in cognitive care. This review can include conducting case reviews, for processes or
outcomes, after the practitioner has administered patient care, and discussions with other
practitioners involved in the care of the patient. The medical staff should establish a minimum
number of cases to be reviewed over the first six months, as the standard for all new practitioners
and practitioners currently on staff requesting additional privileges.

Every effort should be made to have direct concurrent observation by a proctor, although in some
cases supplementing direct observations with retrospective proctoring may be appropriate.
Regardless of the method, proctored cases should be representative of the physician’s principal
practice. There should be sufficient variety and number of cases observed, depending upon the
scope of clinical privileges requested. Evaluation will include concurrent chart review, direct
observation in the case of invasive procedures, and monitoring of diagnostic and treatment
techniques. More than one person should be involved in proctoring whenever possible. The
minimum duration of proctoring should be specified, either in terms of time or in terms of the
number of cases to be observed. A three- to six- month period of proctoring should suffice if the
applicant to the staff has admitted a suitable number of cases during that period of time. When a
time span is stated, it should be in terms of a specific number of months and not “until the end of
the medical staff year.”

ROLES AND RESPONSIBILITIES

An effective proctoring system requires a collaborative partnership between the hospital, the
medical staff, the proctor, and the proctored physician. The roles and responsibilities should be
clearly defined and communicated to all participants.

Hospital. Proctoring is an important component of the privileging process and is a source of
critical information about physician competency that may be difficult to obtain by other methods.
Historically, members of the medical staff were expected to donate time to quality review
functions such as peer review and proctoring.

However, there is now greater recognition that time committed to proctoring may be a significant
cost for the proctoring physician, making it difficult to recruit proctors. It is the responsibility of
the hospital to fund proctoring as part of medical staff credentialing and privileging functions.
Costs may include paying a stipend to medical staff members who proctor a colleague, paying for the services of an external proctor, or paying the administrative costs that may be associated with coordinating proctoring exchanges with other hospitals or institutions.

Whenever payment for proctoring is required, however, hospitals should ensure that it does not exceed fair market value (FMV), and should keep careful records of the proctoring services for which compensation is being made and the amounts of any payment. Determining FMV for proctoring is no different from calculating FMV for any physician administrative service, such as paying officers on the medical staff or other committee members. A reasonable compensation rate can also be determined by consulting with other area hospital regarding proctoring rates. The hospital medical staff should be responsible for distributing the payment to the proctor, even if the hospital is providing the funding.

**Medical Staff.** The responsibilities imposed upon medical staffs pursuant to federal and California law, and Joint Commission standards, recognize that patient welfare depends on medical staffs providing the ongoing review, evaluation, and monitoring of the quality of patient care and treatment rendered in hospitals. Accordingly, the medical staff is primarily responsible for credentialing (i.e. assuring the initial and ongoing competence of every physician and, where lawful and applicable, other licensed healthcare practitioners admitted to the staff). The medical staff is responsible for assuring the ongoing quality of patient care rendered in the hospital and state law expressly requires that medical staffs establish, among other things, clinical criteria and standards to oversee and manage quality assurance, utilization review, and other medical staff activities. Medical staff responsibilities with respect to proctoring include:

a. **Proctoring Arrangements.** It is the role of the medical staff to determine the type of proctoring that is acceptable and how proctors should be recruited to meet those needs. There are several ways to procure proctors that vary widely in cost, but feasibility will vary based on the availability of local resources. Proctoring options include:

   - **Solicit volunteer proctors from the medical staff.** Some physicians believe it is their professional responsibility to proctor colleagues and are willing to do so. The department chair, on behalf of the medical staff, should identify and maintain a list of medical staff members who are willing to serve as proctors.

   - **Mandatory proctoring service.** Some medical staffs require proctoring as a condition of medical staff membership. However, mandatory proctoring does not preclude compensation to the proctor. Medical staffs may also wish to accept proctoring service in lieu of other medical staff duties such as serving on an emergency call panel or on a peer review committee.

   - **Proctoring exchange.** In some health systems, arrangements are made for members of one medical staff to serve as proctors for colleagues on another medical staff in the system. Sometimes this arrangement can be made without compensation or at a very modest fee.

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1 California Business & Professions Code §2282.5
• **Other proctoring sources.** In a situation where no staff member is deemed qualified to observe and evaluate the work of an applicant, the medical staff may have to look outside the hospital for a suitable proctor. While first-hand observation is always preferable, using information from another hospital may be a useful supplement if the proctor at the other hospital is someone who would have been eligible to serve as a proctor at the current hospital on the basis of his/her credentials. Another source of proctors may be a local or regional medical university. Some medical school faculty members, particularly at state-supported schools, may be available to perform a reasonable amount of external peer review or proctoring. Medical staffs can also consult the county medical society or California Medical Association for assistance.

b. **Selecting a proctor.** A proctor should have the credentials, proficiency and sufficient documented expertise to judge the quality of work being performed. It is not always necessary for a proctor to have the same specialty qualifications as the person being observed. For example, surgical technique in a number of specialties can often be adequately observed by a surgeon from a different specialty. The proctor should be free of perceived or actual conflicts of interest, which might create a bias against, or in favor of, the applicant.

c. **Appointing the proctor.** To ensure application of legal protections, all proctors should be formally appointed as members of the medical staff committee responsible for proctoring. This helps assure application of several legal protections under various statutes, including Civil Code §43.7 (qualified immunity for medical staff members engaging in peer review actions and activities), Civil Code §43.97 (qualified immunity for peer review activities which result in an 805 report), and Evidence Code §1157 (protection for records and proceedings of peer review committees). Formal appointment to appropriate medical staff committees also helps assure any available insurance coverage will apply for medical staff committee activities. The medical staff should develop a written proctoring agreement that specifies the roles and responsibilities of the medical staff and the proctor, the format and content of the report, legal liability issues and any compensation arrangements.

d. **Managing conflict.** If at any time during the proctoring period, the proctor notifies the department chair that he or she has concerns about the practitioner’s competency to perform specific clinical privileges or care related to a specific patient(s). The department chair shall review the medical record of the patient(s) treated by the practitioner being proctored and any available data regarding the practitioner’s performance to make an independent assessment of the practitioner’s performance. Based upon this assessment and the findings from proctoring, the department chair shall take one or more of the following actions:

- Continue the proctoring process without changes
- Refer one or more cases to the peer review committee for further assessment
• Recommend to the Medical Executive Committee additional or revised proctoring requirements

• Recommend to the Medical Executive Committee that corrective action be undertaken.

e. **Review of proctoring reports.** Upon completion of the proctoring period, the proctor will submit a written report in the specified format to the department chair, credentials committee, or other relevant medical staff committee. The proctor’s report should be taken into consideration at the time the new staff member is considered for promotion from the provisional medical staff category. In addition to the report, the department chair should recommend to the executive committee that the physician either (1) continue to exercise the clinical privileges initially granted, (2) be required to extend the proctoring period, or (3) have privileges restricted or terminated in accordance with the bylaws.

f. **Record retention.** A physician's individual credentials file should contain any and all information specific to that physician which is relevant for the medical staff in its determination of whether or not to recommend initial or renewed medical staff membership and privileges. The proctoring report should be maintained in the physician’s credentials file, remain confidential and be handled as other medical staff peer review information, pursuant to Evidence Code §1157. The medical staff should determine where the files will be kept, who will have access, when and in what format; the procedure for physicians to appeal the reports or question the proctor who wrote them; and policy on retention of proctoring reports.

**Proctor.** A proctor represents the medical staff and is responsible to the medical staff. Proctors generally observe the applicant's performance of procedures for which clinical privileges are being requested and report back to the medical staff on the applicant's or member's qualifications, as demonstrated during the period of observation. The proctor’s roles and responsibilities should be specified in the proctoring agreement and the proctor should carefully review the agreement.

a. **Observation --** The proctor’s role is to observe and report, not to intervene. A proctor does not directly participate in patient care, has no physician-patient relationship with the patient being treated, and does not receive a fee from the patient. However, if, at any time during the proctoring period, the proctor has concerns about the practitioner’s competency to perform specific clinical privileges or care related to a specific patient(s), the proctor should direct the proctored physician to halt the procedure and contact the department chair regarding the issue.

b. **Report to the Medical Staff --** The proctor should prepare a written report, in the agreed upon format, describing the type or number of cases proctored and evaluating the applicant's performance pursuant to the parameters set forth in the proctor’s appointment letter. The written report should be submitted to the department chair, the Credentials Committee, or other relevant medical staff committee. Copies of the actual proctoring reports should be kept in the individual’s credentials file in each institution.
Proctored Physician. For concurrent proctoring, the physician being proctored should make every reasonable effort to be available to the proctor, including notifying the proctor of each patient where care is to be evaluated in sufficient time to allow the proctor to concurrently observe or review the care provided. For elective surgical or invasive procedures where direct observation is required, and the department requires proctoring be completed before the practitioner can perform the procedure without a proctor present, the practitioner must secure agreement from the proctor to attend the procedure. The physician being proctored should also provide the proctor with information from the patient’s medical record for purposes of evaluating the quality of care provided. The proctored physician should contact the department chair if he or she believes that a change in proctor is necessary.

USING PROCTORING DATA

The Credentials Committee (or other designated medical staff committee) should review the proctor report in conjunction with other available data and information pertaining to the proctored physician’s skills and experience. The report from the proctor is intended to answer the question of whether the proctored physician performs specified skills and procedures with competence and within the standard of care at that hospital. In developing a recommendation on whether certain clinical privileges should be granted, the Credentials Committee should consider the proctor report as a necessary, but not sufficient, source of information about the physician’s performance.

The proctor report should adhere to a format specified by the medical staff to ensure that the feedback is complete and organized in a standardized manner. If the Credentials Committee requires an overall assessment from the proctor regarding the proctored physician’s skills, it should indicate the specific criteria and elements to be considered and the extent to which the proctored met or did not meet those objectives. This will produce a more informed response rather than a general question regarding whether the proctored physician has passed or failed.