

# Medical Staff Briefing

A TRAINING RESOURCE FOR MEDICAL STAFF LEADERS AND PROFESSIONALS

## Five essential tips for being a better proctor today

Physicians are no strangers to concurrent proctoring. At some point in his or her career, every physician is proctored and serves as a proctor, but there is a lot more to this medical staff responsibility than meets the eye. With many other duties, physicians may not take the time to prepare for each case or learn the skills necessary to make the proctoring experience valuable for both the proctoree and the proctor. Below are five tips to help every physician be a better proctor.

### Gauge the proctoree's needs

Three approach proctors take toward proctoring a peer will depend on the reason for the proctoring. Generally, physicians are proctored for one of three reasons:

- The physician is new to the medical staff
- The physician is an existing member of the medical staff who is seeking new privileges

- The physician is an existing member of the medical staff whose competence is in question

If a physician is seeking privileges for a procedure that he or she has seldom or never done before, the proctor may additionally act as teacher, says **Evangeline Gutierrez, MD**, hospitalist medical director at Overlook Hospital in Summit, NJ.

Gutierrez starts off every proctoring relationship involving new privileges with a conversation with the proctoree about his or her past experience. "I like to ask if they have done this procedure before. If the answer is yes,

I like to find out how long ago, how many times, and whether any problems came up," she says.

Gutierrez then gathers educational materials, such as diagrams, manuals, or a video, and reviews them with the proctoree. If a video is the educational medium of choice, proctors should watch the video with the proctoree to answer questions. Proctors can pause videos at key moments to discuss technique, and proctorees can replay sections as many times as necessary until they understand the procedure.

As part of the educational process, proctors may wish to demonstrate a procedure personally. "Sometimes I take them into the room with me and I will do [the procedure] and have them watch. That way, they are prepared when I watch them," says **Maninder Abraham, MD**, hospitalist medical director at Saint Barnabas Medical Center in Livingston, NJ.

The proctor may also wish to walk the proctoree through a new procedure step-by-step while he or she is performing

**Download the January special report on accountable care organizations in the MSB archives at [www.hcpro.com/medical-staff](http://www.hcpro.com/medical-staff).**

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## Proctor

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it. This method works best during surgical procedures where the patient is sedated. "If the patient is awake, it can become uncomfortable, and the patient may lose trust in the physician [who is being proctored]," says Gutierrez.

If the patient will be awake during the procedure, the proctor should spend extra time prepping and educating the proctoree beforehand to limit the amount of direction the proctor needs to provide during the procedure, and thus limit the patient's unease.

Proctors can play a minor role for proctorees who are new to the medical staff but otherwise experienced. The proctor likely will not need to provide the proctoree with education about the procedure beforehand; however, the proctor may wish to review the patient's chart with the proctoree, especially if the procedure in question is risky,

says **Raymond E. Sullivan, MD, FACS**, former chief of staff at Waterbury (CT) Hospital Health Center.

The proctor should also review with the proctoree the expectations for proctoring, including the proctoring checklist (see p. 4) and the applicable section of the bylaws (see <http://tinyurl.com/proctoringresp> for a sample proctoring policy). Reviewing the checklist and the bylaws will give the proctoree an idea of what the proctor will be looking for during the procedure and how the process works.

A proctor may also be asked to assess the competence of a physician whose performance is called into question. Although a proctor may know that another physician's competence has come into question, the proctor should not know why (i.e., the medical staff suspects alcoholism or cognitive decline due to aging). "The proctor only knows that we want to make sure that the physician is clinically competent," says **Dean White, DDS, MS**, medical staff advisor at Texas Health Resources Harris Methodist Hospital HEB in Dallas-Fort Worth. Because the proctor won't know the reason for the proctoring, he or she should always start by gauging the proctoree's needs.

### Know when to intervene

According to Sullivan, during a procedure, it is always better to make an error of commission than omission. "That is to say, you are better off acting than simply standing by in a situation where you perceive a significant problem," he says.

According to **Robert J. Marder, MD, CMSL**, vice president of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, there are two schools of thought when it comes to intervening while proctoring. "The traditional definition of proctoring is that the proctor is an evaluator and does not perform the case. If you use that definition of 'proctoring,' then you don't step in," says Marder.

Although some medical staffs do not allow proctors to step in, some do. Some medical staffs have difficulty with the idea that a proctor wouldn't step in if a procedure

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was about to go south. However, stepping in creates a potential liability for the proctor if he or she does not have a relationship with the patient. A patient may be more likely to sue if a physician other than the one he or she has a relationship with causes harm.

To reduce that liability, the medical staff may wish to create an action plan by which the proctor alerts the operating room staff and chief of surgery or chief of staff that he or she is concerned about the proctoree's ability to complete the procedure safely. "In that case, you [the proctor] go up the ladder—you don't take care of it yourself," Marder says.

However, Sullivan notes that there may not be enough time to go up the ladder, causing yet another dilemma. Be sure your medical staff bylaws enumerate what a proctor should do in either circumstance.

To protect proctors when a procedure results in a poor outcome, the medical staff and governing body bylaws should spell out that the hospital will indemnify proctors and provide them with the proper insurance. Proctors should review this section of the bylaws prior to proctoring.

If your hospital allows proctors to step in, they should be prepared. "You have to be scrubbed, you have to wear sterile gloves, you have to be masked," says Gutierrez. However, the proctor's main focus should be preventing errors. When Gutierrez sees that a physician has chosen the wrong tool during a surgical procedure, she points it out. "I don't let them make a mistake because it jeopardizes patient safety."

Rarely do proctors have to guess whether they should step in. "I would say that 90% of the time when a new physician begins to recognize that something may go awry, he or she asks for assistance," says Sullivan. Proctors should stress to proctorees that asking for help isn't a sign of weakness. "A good physician is one who knows his or her limitations and recognizes when he or she needs advice or assistance," he says.

Although physicians may need to step in to avert a medical error while proctoring surgical cases, proctors may wish to hold off on intervening when the

procedure in question is a simple exam during which the patient is awake.

"I usually don't step in in front of a patient," Abraham says. Rather, she lets the proctoree finish the examination, and if the proctoree missed a step, Abraham jumps in to do whatever he or she failed to do. "You shouldn't interrupt them while they are doing [the exam]. You don't want to turn them off," she says.

### **Patient introductions**

If the procedure a proctor is evaluating is a simple examination, the proctoree should introduce the proctor to the patient. "We introduce ourselves and say that we work together, but I don't necessarily explain to the patients that I'm observing the physician," says Abraham. If patients know that the proctor is there to observe and evaluate the physician who is providing their care, they may become uneasy and lose trust in their physician. However, if the patient starts asking questions about why another physician is in the room, the physician under review and the proctor must answer honestly.

If the procedure being proctored is a risky surgical procedure, the proctoree should introduce the proctor to the patient, says Sullivan. "But for routine procedures that the individual has indicated that he or she has done many times before, there is not an indication of having to introduce yourself to the patient beforehand," he says. Thus, the patient may never meet the proctor.

### **Listen to the proctoree's side of the story**

If a physician is being proctored because of a potential competence issue, it is important for the proctor to stay calm and friendly when discussing opportunities for improvement with the proctoree. "Explain to them the problem and get their feedback—their perception may be completely different from yours," says Abraham.

Prior to being told by the peer review committee that they aren't performing up to par, most physicians don't know that they are doing anything wrong, Abraham explains. Ask the proctoree why he or she thinks this

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## Proctor

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particular problem occurred and listen intently to what he or she has to say. A systematic issue may be at play. If so, the proctor should report that issue to the peer review committee, which should then alert the MEC. If the problem is not systematic, but rather a lack of technique or knowledge on the proctoree's part, the proctor should begin educating the proctoree.

Throughout the entire proctoring process, the proctoree should feel comfortable speaking with and asking questions of the proctor. "It defeats the purpose if the relationship becomes adversarial because the person may feel that you are picking on them," says Abraham.

## Lead by example

Proctors should not expect proctorees to do anything that the proctors themselves don't do, says Abraham. For example, by making sure their own medical records are completed on time, proctors demonstrate to proctorees that medical record compliance is not an unreasonable expectation. "If I am doing it, there is no reason they can't do it," Abraham says.

Proctoring should be a learning experience for both the proctor and the proctoree. With these five tips, physicians should feel more comfortable offering and receiving performance feedback from peers. ■

### Proctoring checklist

Proctors must be on the lookout for signs that indicate whether a physician is competent to practice. Whether you are proctoring a physician during a surgical procedure or a simple history and physical exam, keep the following checklist in mind.

#### Body language

- ✓ Is the physician uncomfortable with the procedure? (e.g., is he or she sweating? Are his or her hands shaking?)

#### Communication with patients

- ✓ Is the physician able to confidently explain the procedure or process to patients and families?
- ✓ During exams, does the physician explain what he or she is doing so that the patient understands?
- ✓ After a surgical procedure, does the physician take the time to speak with the patient and family members about the success or failure of the procedure?
- ✓ Does the physician have an appropriate bedside manner?

#### Knowledge of the procedure

- ✓ If the procedure is surgical, does the physician know how to prepare the surgical field (e.g., clean the site, drape coverings, open up the surgical packet)?

- ✓ If the procedure is surgical, does the surgeon realize when or if the instruments on the tray are out of order?
- ✓ Does the physician understand the anatomy of the patient? (i.e., does the physician know where to look to find the problem?)
- ✓ If the procedure is surgical, does the physician know how to close the surgical site and clean up after the procedure? (e.g., does the physician appropriately dispose of dressings and sharps, or does he or she leave these tasks for the nurses?)
- ✓ If equipment is involved, is the physician fumbling with it, or does he or she appear comfortable?
- ✓ If the procedure is surgical, does the physician have the manual dexterity to perform the procedure?

#### Documentation

- ✓ Does the physician document the procedure and outcome accurately and in a timely manner?

Sources: Maninder Abraham, MD, hospitalist medical director at Saint Barnabas Medical Center in Livingston, NJ; Evangeline Gutierrez, MD, hospitalist medical director at Overlook Hospital in Summit, NJ; and Raymond E. Sullivan, MD, FACS, former chief of staff at Waterbury (CT) Hospital Health Center.

**MSP perspective**

## Use infographics to turn humdrum data into actionable, attention-grabbing statistics

### ***A case study of Good Samaritan Hospital***

We've all done it—read through tedious reports filled with paragraphs of blocky text, tables, and footnotes but walked away with zero useful information. We get so bogged down in the bulk of the information that we fail to see what the data mean. That's where infographics can help. Infographics summarize meaningful information into easy-to-read, attention-grabbing graphics that don't require much reading but drive the point home. You may have seen infographics in *The Wall Street Journal* and other mainstream publications but never thought that the concept could apply to the medical staff office. Au contraire.

To help MSPs understand the usefulness of infographics in their everyday work, **MSB** spoke with **Guenther Baerje, BSIT, CPMSM, HACP**, director of medical staff management at Good Samaritan Hospital in Los Angeles.

#### **MSB: How do infographics apply to the medical staff services department?**

**GB:** I am always looking for different ways to capture our physicians' attention. I first thought to apply infographics to our OPPE [ongoing professional practice evaluation] reporting process. One of the things we have been working on is doing a generic OPPE report that compares each department's performance against the other departments. I was looking to take all of the data elements that we have in our OPPE report and create a one- or two-page report that physicians could look at quickly and comprehend the issues that require their attention.

We also took all of the core measures and other publicly reported data and created a board of trustees report. It has 40 or 50 pieces of data on one sheet, like a dashboard, and just from taking a quick look at that, the board can see where any trends are.

The whole point is to get physicians' attention in three seconds. I want them to see where the opportunities for

improvement are so they can focus their energy on that, rather than picking apart the data.

**Note:** Baerje uses Microsoft® Excel® 2003 to create his infographics reports. The program allows users to organize data, create graphics, and import photos.

#### **MSB: How do you decide what data to highlight?**

**GB:** I work closely with quality management, and both of our departments report to the same person. Together with some of the medical staff leadership, we're identifying where the issues and trends are. We run each new report by the medical executive committee (MEC) first to see if we are highlighting the appropriate data. Let's say the MEC likes the format of the report, but instead of highlighting delinquent operative reports, it wants us to highlight infection rates. After the MEC approves of the report, we send it to the various departments and committees. I wanted to make sure I have the MEC's buy-in and support.

#### **MSB: How do you decide how to depict data points?**

**GB:** There are a couple of generic rules. Usually, if you want to depict data over a period of time, you want to use a run chart. If you want to identify the biggest percentages of a set of data, a pie chart is useful. If you want to compare data, use a bar graph. For bar graphs, I usually put the data in the order of best to worst or least to greatest. The pie chart may give you the same feel, so sometimes it is a matter of style.

I have an officer's meeting once a month with the chief of staff, vice chief, and secretary, and I show it

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## Infographics

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to them and ask if they think the infographic I've chosen gets the point across. They give me valuable feedback.

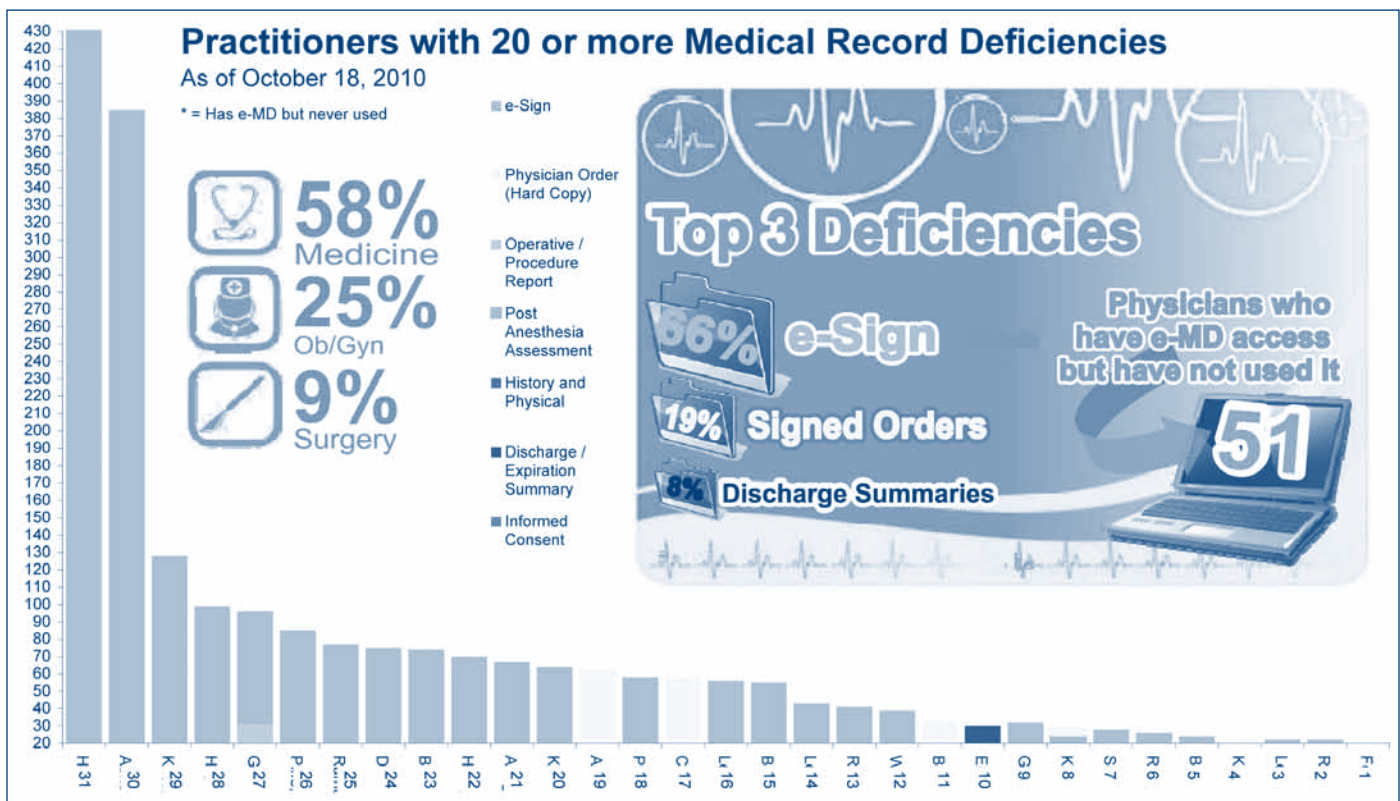
**Note:** Don't limit yourself to pie charts, run charts, and bar graphs. Use photographs; icons, such as arrows, dollar signs, thermometers, and thumbs-up; and maps to get your point across. Check out [www.ColumnFiveMedia.com](http://www.ColumnFiveMedia.com) and [www.CoolInfographics.com](http://www.CoolInfographics.com) for examples (some silly) of how you can put infographics to work. Also refer to Baerje's "Practitioners with 20 or more medical record deficiencies" below.

### MSB: What process improvements have you seen as a result of using infographics?

**GB:** The number of delinquent medical records has dropped within the OB department by about 50%. We displayed the poster depicting that data in the physicians' lounges, and it quickly forced a change. At the MEC meeting and at the OB department meetings, OBs could see that they were the biggest offenders and how much they stood out from everyone else. This helped us with our Joint Commission survey in May 2010. The medical record infographic also pointed to some issues with how the medical records department recorded delinquencies. That led to some internal changes.

### MSB: How will using infographics benefit MSPs?

**GB:** To me, it is a nice break from some of my other responsibilities. Plus, as an MSP, you're always trying to work smarter, and this is one way of doing that. Yes, you are investing some time, but you are getting a whole lot more out of it because it is driving improvements on the medical staff. Plus, you're creating a lot of value for yourself in the organization because you are helping to drive real process improvement. ■



***Out with the old, in with the new***

## **MSPs and leaders share New Year's resolutions**

After the confetti falls, the champagne is sipped, and the last chorus of “Auld Lang Syne” is sung, it’s time to get back to work. The new year is a great opportunity to throw out your old medical staff traditions and implement strategies to help you work smarter. Check out what these medical staff leaders and MSPs have in store for 2011.

### **Thomas Huth, MD, MBA, FACP, vice president, medical affairs, Reid Hospital & Health Care Services, Richmond, IN**

My New Year’s resolution is to engage the medical staff in hospital performance improvement. That includes clinical documentation improvement for appropriate disease severity; compliance improvement for orders, documentation, and medical necessity; quality improvement for metrics and best practices; cost-effectiveness improvement; patient satisfaction improvement; and support for service line development.

To accomplish these goals, we plan to grow our employed physician network and align it with the health system’s goals. We will also be working on developing flexible and scalable business intelligence tools to give just-in-time performance feedback to individual physicians and groups of physicians. For each improvement project, we will assign a physician champion and work groups to review clinical effectiveness research and design implementation projects. We will also develop meaningful and actionable metrics.

### **Michael Haynes, MD, chief medical officer, St. John Hospital and Medical Center, Detroit**

Our New Year’s resolution is to train the medical staff in the principles of a High Reliability Organization (HRO). We will start by training trainers this December and begin team training throughout the hospital in early February. As part of our parent organization, Ascension Health, I am committed to our initiative,

“Healing Without Harm.” The foundation of this journey is to educate ourselves in safety science and become an HRO.

**Note:** To learn more about becoming an HRO, visit [www.ahrq.gov/qual/hroadvice](http://www.ahrq.gov/qual/hroadvice).

### **Guenther Baerje, BSIT, CPMSM, HACCP, director of medical staff management, Good Samaritan Hospital, Los Angeles**

The first thing I want to work on in 2011 is revising the bylaws. I inherited a skeletal set of bylaws and now have to put some meat on it, per MS.01.01.01.

The second thing is realigning the medical staff so that when healthcare reform hits, they are prepared for the bundled payment system. The idea is that the medical staff will no longer be structured by discipline-based departments (e.g., anesthesiology, medicine, surgery), but rather by service line departments (e.g., cardiology, women’s health, oncology).

In theory, this will break down traditional department silos and put all of the key stakeholders together in the same room. I think MSPs are in the ideal role to lead our physicians in this needed restructuring.

Third, I am figuring out how to work smarter. I am playing with some electronic readers, and if I can find something that will work nicely—and affordably—I will move to paperless meetings.

Fourth, I’m finishing my privilege form remodeling project. It’s been a four-year endeavor in which we bundled privileges and established minimum competency requirements.

### **Donnie Sauls, MBA, CPMSM, manager of medical staff services, Mount Sinai Medical Center, New York City**

We are currently in the process of creating an automated license, DEA, infection control, and health

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## Resolutions

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assessment tracking system. It will e-mail initial and follow-up information to the practitioners and provide e-mail lists of expiring documents to the chairs and administrators.

We are currently working with our information technology department to build the portal and e-mail generator. Achieving this project will allow us to accurately

and efficiently send out information to our medical staff without having dedicated resources manually sending e-mails or folding paper. ■

*Editor's note: Commit to your own New Year's resolutions and share them online at [MedicalStaffLeader.com](http://MedicalStaffLeader.com) or e-mail associate editor Liz Jones at [ejones@hcpro.com](mailto:ejones@hcpro.com).*

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- *Engage and Align the Medical Staff and Hospital Management*
- *The Greeley Guide to Medical Staff Bylaws, Third Edition*
- *The Greeley Guide to Physician Employment and Contracting*
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Sample bylaws language: Conflict resolution.

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Sample hospitalist program dashboard. Aug., p. 4.

Sample letter: Appropriate care. March, p. 11.

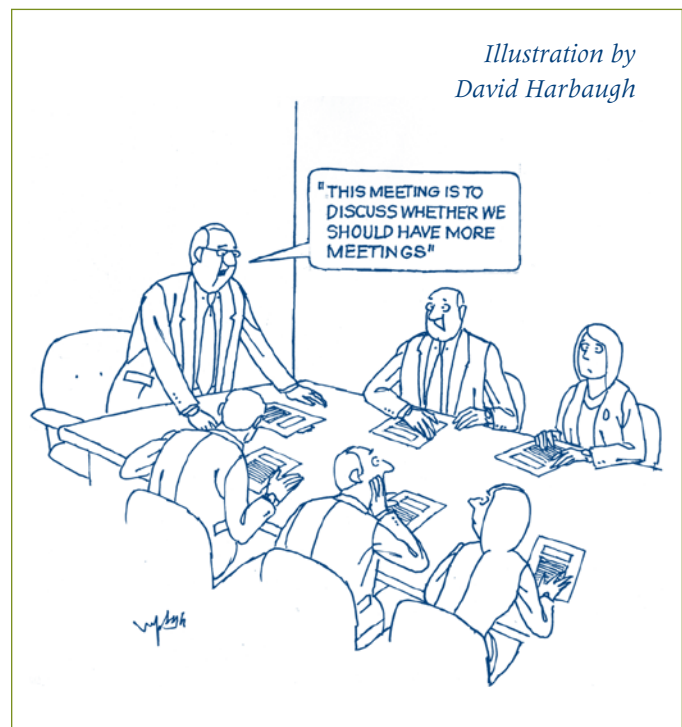
Sample letter: Exemplary care. March, p. 10.

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# January special report: Are ACOs the cure for what ails our country's healthcare system?

## A closer look at ACOs' effect on physicians, patients, and hospitals

There's no doubt about it—the healthcare industry needs a makeover. The Centers for Medicare & Medicaid Services and other leaders in the healthcare realm have developed a handful of models that could hold some promise for reducing healthcare costs and improving the quality of healthcare for all Americans. Such models include accountable care organizations (ACO), medical homes, and value-based purchasing.

Not one of these models holds the golden ticket to healthcare reform; rather, the industry must experiment with and deploy several models to address all the problems that plague the current healthcare climate.

"It is a good thing we are doing all these things at the same time because we are going to have to hit it from all angles; it is going to take a lot to change our culture, and just changing the payment system alone isn't going to cut it," says **Jonathan Lovins, MD, SFHM**, hospitalist and assistant professor of medicine at Duke University Health System in Durham, NC.

It is important for physicians and medical staff leaders to understand the gamut of healthcare reform models so they can begin to contemplate their own futures as healthcare professionals. Will they, as physicians, be willing to sell their practice to a large health system that has

formed an ACO? Do they subscribe to the idea that primary care physicians should coordinate care for patients across the spectrum? Will they be on board with a new reimbursement model for the work they do?

In this **MSB** special report, we hone in on ACOs, what they mean for the future of healthcare, and how they will affect physicians, medical staffs, and hospitals. ■

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## Organizationwide conflict of interest policies shine the spotlight on potential conflicts



by *Joseph D. Cooper, MD, CMSL*,  
senior consultant with *The Greeley  
Company, a division of HCPro, Inc.,  
in Marblehead, MA*

As a member of the board of directors, I would be dismayed if another board member (say, a contractor who bid on a job) stayed in the meeting while the board discussed who would be given the job on which the board member bid. Imagine if that individual was awarded the job, as low bidder, but sat through the entire discussion and vote and then said, "Please make the minutes reflect that I abstained from that vote." In that type of situation, which happens quite frequently in hospitals across the country, did the bidder really remove himself from the obvious conflict of interest? Did his presence at the vote sway the board's decision?

The Joint Commission (formerly JCAHO) includes in its leadership standards specific language about dealing with conflicts of interest. LD.02.02.01 requires that "the governing body, senior managers, and leaders of the organized medical staff address any conflict of interest involving leaders that affect or could affect the safety or quality of care, treatment, and services." In addition, LD.04.02.01 requires that "the leaders address any conflict of interest involving licensed independent practitioners and/or staff that affects or has the potential to affect the safety or quality of care, treatment, and services."

The best way for an organization to manage potential conflicts of interest is to have an organizationwide conflict of interest policy that requires those involved to declare any potential conflicts. These may be personal conflicts, such as having a spouse, sibling, parent, child, or partner involved in the matter at hand. Conflicts may also be financial, where an individual is part owner in a competing ambulatory surgery center.

The medical staff should require, at least annually, each physician serving in an elected or appointed position of the medical staff to complete a conflict of interest disclosure form. The form should identify any activities, interests, relationships, or financial holdings that create or have the potential to create a conflict of interest for the physician as he or she carries out the responsibilities of that position. When an issue comes before the individual physician as a result of serving in a position on the organized medical staff, such as a department chair or member of a committee, to which an actual or potential conflict of interest may be relevant, the physician should disclose the conflict of interest prior to participating in the discussion of that issue.

If the physician who has a conflict is on the credentials or medical executive committee, he or she should disclose the conflict to the committee as a whole. For example, a department chair who sits on the credentials committee and is considering a privileging issue for a direct competitor should disclose the potential for a conflict of interest to the credentials committee. The physician should then remove him- or herself from the committee while the committee determines whether and to what extent the physician may participate in consideration of the issue—in this case, whether the department chair should make any recommendations concerning the competitor's privileges.

It is the responsibility of the committee to determine on a case-by-case basis whether a relative conflict is substantial enough to prevent the individual from participating in committee discussions. When either an absolute or substantial relative conflict exists, the individual should recuse him- or herself and not participate or be present during either the discussions or decisions, unless the committee asks him or her for specific, clarifying information. ■