Proctoring, FPPE, and Practitioner Competency Assessment
A Clinical Leader's Guide
Todd Sagin, MD, JD

Even as regulators and the public demand more verification of physician competence, physicians have less time—and are less willing—to perform competence assessments and undergo monitoring. With this in mind, medical staffs must develop proctoring and precepting plans that are effective and efficient. Proctoring, FPPE, and Practitioner Competency Assessment: A Clinical Leader’s Guide outlines the steps involved in proctoring, best methods for proctoring, and how to complete assessments. Author Todd Sagin, MD, JD, will help physician leaders and MSPs develop a proctoring program that physicians support.

This guide contains sample forms and checklists that medical staffs can use to conduct proctoring. MSPs and physician leaders will also find answers to common medical staff questions, such as the difference between proctoring and precepting, how ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) relate to proctoring, and how proctoring differs from peer review.
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About the Author

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Acknowledgments

I have been fortunate in my many years of practice and consulting work to have interacted and learned from an amazing group of colleagues and mentors. I have been influenced in different ways by each of them and they have helped me grow professionally in both measurable and immeasurable ways. One of the real joys of the work I do is that I continue to meet so many talented and admirable people working to improve the healthcare field. To all such individuals I have already met and to those I have yet to meet, I dedicate this book.
Practitioner competency is the sine qua non of good quality healthcare. Unfortunately, the past two decades have produced a mountain of data demonstrating that our hospitals and other care facilities deliver medical treatment that is frequently inadequate, inappropriate, and unsafe. The public focus on these concerns ramped up in 1998 following the Institute of Medicine report titled *To Err Is Human: Building a Safer Health System*.\(^1\) At that time, the medical world was stunned by data that suggested as many as 98,000 patients annually died in hospitals from preventable medical errors. In the years since that seminal publication, further research has validated that medical errors are common occurrences in healthcare organizations.\(^2\) These results have gotten the attention of the public, patients, politicians, employers, and payers and have eroded the reputation of the healthcare field in general. Nevertheless, surveys reveal that most patients have great faith in their personal physicians.

The many tactics being deployed by health enterprises to achieve excellent and safe care become less critical when these organizations are diligent in allowing only highly competent personnel to treat patients. Not only do good practitioners personally render good care, but they also attend to the secondary causes of...
diminished quality, such as weak clinical processes, poor deployment of technology, unacceptable variances in results, and colleagues who aren’t practicing at an acceptable level.

To what extent are healthcare quality and safety problems a function of poor practitioner competence? No one knows. American medical schools and residency programs are highly regarded for their rigor, but in many academic institutions, education seems to take a back seat to research priorities and the need to generate clinical revenue. Only recently have some medical schools and residency programs started to add patient safety practices and team leadership skills to their curricula.

But it is not just education in good safety and performance improvement tactics that is lacking; it also appears that some educational programs are simply failing to teach basic clinical skills adequately. Too many times every year across the country, a hospital peer review program finds that a new staff member freshly graduated from residency has not been sufficiently prepared to enter the practice world. While we would like to believe that no residency director would allow an incompetent resident to graduate, the reality is otherwise. Some pundits believe that the rapid expansion of medical schools and class size that has taken place over the past decade, coupled with restrictions on allowable clinical hours in medical school and residency, has led to a greater number of inadequately prepared physicians entering the workforce each year. Hard data to confirm this position is lacking, but this is not an isolated perspective.

There are other signs of apprehension regarding the abilities of the nation’s clinicians. Regulatory and accreditation bodies have responded to concern over practitioner competency by increasing the rigor of their credentialing and peer review requirements. State medical boards have become more aggressive at demanding that practitioners demonstrate competency in the wake of malpractice suits, complaints filed with the board, significant clinical incidents, or a return to medicine
Assessing Practitioner Competency: A Growing Concern

after a hiatus from clinical practice. Worry over the competency of aging practitioners, a growing segment of the practice community, has led many hospital staffs to impose more rigorous reappointment criteria for those in the latter years of their careers.

A growing number of formal competency assessment programs have become a national resource to assist entities that suspect they have an incompetent clinician in their midst.

The explosion of websites that rate and rank physicians on multiple parameters are yet another indication of the public’s focus on the abilities of their doctors. Online programs like Health Grades (www.healthgrades.com) and Vitals (www.vitals.com) market themselves as resources where patients can learn more about the quality of their healthcare providers. Motivated and increasingly sophisticated healthcare consumers now challenge their practitioners to provide evidence of their personal clinical experience. These patients want data. How many times has the doctor performed a particular procedure? What are the doctor’s complication rates? What outcomes data exist for the doctor’s care of particular medical conditions? Payer websites that provide some of this information will become more common in the next few years. One such site is The Center for Medicare & Medicaid Services (CMS) Physician Compare (www.medicare.gov/physiciancompare), which is planning a significant enhancement in its data components before the end of the decade.

The historic mainstays for determining the competency of a doctor have been evidence of education and training, licensure, and board certification. We will discuss further the utility of each of these markers of ability. Increasingly, however, an armamentarium of customizable tools is being deployed to assess practitioner competency with greater precision. These will be described in the pages that follow, with a major focus on the most popular of these tools: proctoring.
Assessing the Adequacy of Education and Training

Historically, the most fundamental tool to ensure practicing physicians are competent has been to require they receive adequate education and training. This has generally served the public well, and most doctors are considered well prepared to engage in clinical medicine. Physicians in the United States are required to complete a basic medical school education, and most states require some amount of postgraduate clinical training. The specific requirements vary from state to state. While all states accept a medical degree from American medical schools accredited by the Liaison Committee on Medical Education (LCME) or osteopathic equivalent, most will also recognize degrees obtained in other countries as well.

However, the rigor with which individual states examine the quality of medical education acquired abroad and recognize its adequacy to justify licensure varies greatly. Foreign medical school education that is acceptable for licensure purposes in some states is considered insufficient in others. Many states do very little to validate the quality of foreign medical education. Some of these schools exist in countries that themselves regulate medical education rigorously. In other countries, medical schools have very little oversight. Because some of these schools do a poor job of selecting their students and educating them, we still find doctors practicing in communities across America who lack the requisite fund of knowledge and fundamental clinical skills to carry out their work competently.

In 2014, about 500 graduates of U.S. medical schools and some 6,000 from foreign medical schools didn’t find places in accredited residency programs. Some may find opportunities in Missouri and like-minded states if residency training requirements for licensure are eroded. For example, a law recently put into effect in Missouri allows medical school graduates to practice immediately upon receipt of their medical degree. They must have passed the first two sections of the national licensing exam, though not the final one, and be approved by the state Board of Healing Arts, which issues medical licenses. These newly minted doctors must be
supervised in person by a collaborating physician for 30 days and can then treat patients on their own as far as 50 miles away and prescribe most medications. Many physicians believe this will place patients at inappropriate risk of bad care. Others argue a doctor with limited training is better than having no doctor at all. Hopefully, with time and experience, we will learn the outcome to this debate without too many patients being seriously harmed.

The American medical education system relies on residency education training to give doctors the rigorous clinical skills necessary to practice a medical specialty competently. In general, this system works well, and the vast majority of doctors graduate their clinical residencies with adequate skills. Nevertheless, some of the thousands of physicians who graduate from residencies each year are not competent. We know this because members of hospital peer review bodies have been complaining with increasing frequency that new staff members fresh out of residency lack necessary clinical skills. While some of this may be the result of diminished clinical exposure in residency that has resulted from mandated limits on resident work hours, it is clear that there are residency directors who either do not adequately assess their trainees or who are not willing to remediate or fail substandard residents prior to program completion. One study of doctors who engaged in unprofessional behavior on their hospital medical staff also found these same doctors had frequently exhibited behavioral problems in their residency training programs. It seems that these programs failed to inculcate appropriate professional boundaries into these doctors and also neglected to mention their deficits in professionalism in letters of reference they provided to hospitals where these trainees applied after residency.
Adequate education is a fundamental building block of clinical competence. When assessing competence, a practitioner’s educational background should be scrutinized for “red flags.” For example, has the practitioner had unusual gaps in his education; has she transferred between multiple educational programs; are the educational venues institutions with which you are unfamiliar? If so, added research is warranted to learn more about the quality of the education or the circumstances around any unusual pattern of attendance. This same caveat applies when a practitioner’s background reveals a deviation from a typical pattern of residency education. If a clinician has gaps in residency training, has switched programs mid-residency, or has changed specialty, these should be considered red flags, and further explanation for the unusual pattern should be sought.

Role of State Medical Licensure

The grant of a state medical license is seen by many as government endorsement of a practitioner’s competence. In most states, the requirements for licensure are fairly minimal and largely consist of evidence the practitioner actually went to medical school and engaged in at least some postgraduate clinical training. The ongoing maintenance of state medical licensure typically has limited requirements as well. Most states require doctors to undertake some amount of continuing medical education (CME), but the number of required credits varies and compliance is usually on an honor system.

In 2014, the Wisconsin Medical Examining Board found that nearly one in 11 licensed physicians in the state were not in compliance with its continuing education requirements. This poor compliance occurred despite the fact that Wisconsin had CME licensure standards that were the lowest in the country (15 CME credits
per year). It would seem that even this minimal safeguard to ensure that a patient sees a competent doctor is too frequently ignored.

In addition to a medical degree, most states require at least a one year postgraduate internship to hold a medical license, and many require at least two or three years of residency. However, the growing shortage of physicians in many locales is driving some states to lessen these requirements (as mentioned above with Missouri).

### Practical Tip

Problems with licensure should always raise a concern about competency. Most states will have websites where actions against a license can be found, including restrictions or suspensions. If a physician is licensed in an unusual number of states, an explanation should be sought. Keep in mind that most state medical board have little skill in competency assessment and frequently overreact or underreact to incidents which should raise questions about a practitioner’s ability.

### Continuing Medical Education: A Common Requirement to Promote Competency

As indicated above, the main requirement most states impose to maintain a license is some ongoing CME that is recognized by a certifying agency. In years past, CME credits were easy to obtain from organizations that produced educational materials of questionable quality. The Accreditation Council for Continuing Medical Education (ACCME) has worked hard to improve the quality of CME, and its standards have become more and more stringent in recent years. Where CME is required, it is generally left to each practitioner to select relevant coursework. There are no minimal content requirements imposed to ensure competence. Using CME to keep up with advances in medicine makes intuitive sense. However, there is
no substantial evidence linking CME to clinical competence, and CME has proven most effective at enhancing knowledge but not other components of competence. For example, CME generally cannot test technical skills, clinical judgment, professional demeanor, physical exam skills, and many other elements that together produce a competent practitioner.

**Practical Tip**

Most physicians approach CME seriously and use it to maintain their clinical knowledge in fast moving specialty areas. However, some doctors see CME as an annoying requirement and a hurdle to surmount. They tend to avoid attendance at live conferences, often obtaining CME through “throw-away” magazines. They also pursue topics from CME offerings easy to obtain rather than relevant to their practice needs or clinical deficits. A perusal of the CME record of a physician can provide useful insights into the attitude with which he approaches his ongoing medical education.

**Board Certification: An Appropriate Proxy for Competence?**

Medical specialties began to emerge in the United States in the mid-20th century. As the medical community recognized that certain areas of medicine require specialized training and devotion to one area, physicians were no longer expected to practice and perform procedures in every area of medicine. For example, although surgery and medicine had already existed as separate disciplines, surgery started to further divide into orthopedics, neurosurgery, thoracic surgery, and so on. Medicine also began to divide and establish specialized practitioners in areas such as cardiology, gastroenterology, oncology, and others. Postgraduate residency and fellowship training became the norm, allowing for a systematic oversight process to evaluate the skills of physicians in training. Little formal evaluation of the practicing physicians occurred before the formation of specialty societies.
Specialty boards concurrently developed out of the various specialties and, by the last quarter of the 20th century, certification in one’s specialty became a threshold requirement to be able to practice in that specialty. Today, board certification—the formal demonstration of knowledge through written and oral examination—stands almost universally as a baseline requirement for membership on hospital staffs, even in small, geographically remote hospitals.5

The oldest and most established umbrella organization of specialty boards is the American Board of Medical Specialties (ABMS). For those trained in programs sponsored by osteopathic organizations, the parallel organization is the American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS). As board certification has grown in importance as a marker of competence, a considerable number of additional organizations have been formed to confer “board certification” designation. Some represent physicians from multiple specialties, e.g., the American Board of Physician Specialties (ABPS), and many represent single specialties, e.g., the American Board of Anesthesiology. The rigor with which these organizations function and assess practitioner abilities within a specialty varies widely.

Board certification by medical specialty societies is frequently used as a proxy to indicate a minimal level of professional competency. Indeed, board certification is emerging as a de facto requirement for full participation of physicians in the U.S. healthcare system. Not only hospitals but also managed care networks, accountable care organizations, and clinically integrated networks frequently require board certification. Physicians who are not certified by some specialty board are becoming an increasingly marginalized group. The willingness to demonstrate ongoing clinical competence through the rigorous examination processes of widely recognized specialty boards is increasingly being seen as an important act of professionalism.
While critics of certification acknowledge it shows a commitment to quality, they claim that board certification does not actually *demonstrate* competency. Written testing of knowledge has many limitations. For example, as physicians have become increasingly specialized, it is common to find that certification tests ask questions unrelated to a physician’s actual practice. In addition, clinical situations are rarely “black and white,” but a test question generally requires one best answer. In a world where medical knowledge is instantly available in digital format to practicing physicians, secure, closed-book testing seems a variance from the needs of actual clinical practice.

In recent years, board certification has moved beyond simple testing of rote memory and has become a more sophisticated process. It can involve peer review of medical records, evidence of quality improvement efforts, oral testing, computerized simulation, and more. However, rigorous testing of these additional modalities to determine whether they truly reflect practitioner competency has not been carried out. Furthermore, there is great variance within the community of specialty boards regarding how they carry out certification testing. Many physicians chafe at the unfairness of tying a label of competency to board certification when some boards have more stringent requirements than others.

Initially, grants of certification from specialty boards were timeless and did not have to be renewed. However, given the rapid rate at which medical science advances, “once-in-a-lifetime” certification has proven hard to justify. The American Board of Family Practice (ABFP), founded in 1969, was the first specialty board to grant time-limited certification. The ABFP administered its first recertification exams in 1976, and other specialty boards began to follow suit by the 1980s. Recertification requirements vary by specialty, but those issuing time-limited certification generally require reexamination every six to 10 years. The stated purpose of recertification has been to ensure physicians engage in CME and periodic examination to maintain competency in their given specialty.
More recently, those certifying boards that are members of the ABMS have advocated continuous certification or Maintenance of Certification (MOC). Advocates of continuous certification argue it will benefit physicians, because it drives focused learning based on individual practice needs, may reduce malpractice premiums, can reduce duplicate demands for evidence of competence from credentialing bodies, and can be used to market the quality of a physician’s care. However, the approach has vocal detractors who see MOC as burdensome requirements that do not appear to accurately ascertain competency and are imposed on physicians to meet the growth demands of sponsoring organizations. As one commentator in the *New England Journal of Medicine* noted, the MOC processes “fall short in terms of relevance and the time, effort and expense it requires of candidates.” For a thoughtful discussion of the strengths and weaknesses of MOC, see *Ensuring Physician’s Competence—Is Maintenance of Certification the Answer.*

**Practical Tip**

The world of board certification is complicated by the fact that many physicians subspecialize and many specialty societies offer subspecialty boards or “certificates of added qualifications.” It is often a challenge for these doctors to maintain board certification in their original board and subspecialty board(s). For example, should a physician who becomes board certified in child and adolescent psychiatry also be expected to maintain her boards in general psychiatry? In evaluating the board certification history of a practitioner, it is important to look at her training and practice chronology and match this up with the actual boards she chooses to maintain. Where doctors choose not to participate in a maintenance of certification (MOC) program, it is always prudent to ask whether this is a reflection on that clinician’s competence. While many competent physicians will forgo MOC, there are certainly doctors whose competence is marginal or inadequate who would not be capable of achieving ongoing board certification.
Chapter 1

Accreditation Organizations and the Determination of Clinical Competence

Healthcare organizations cannot assume a doctor is competent simply because he has completed medical school and residency training, holds a valid state medical license, and obtains some ongoing medical education hours. The Joint Commission and other accrediting organizations recognize that additional assessment is needed beyond these minimal markers of ability to practice. It is for this reason that accrediting organizations impose extensive credentialing and privileging standards on hospitals and other healthcare entities they review. Such credentialing requirements typically include the historic proxies for competence: adequate education and training, licensure, and board certification. However, they also require additional evidence of sufficient clinical ability. In general, hospital accreditation organizations carry out their work on behalf of CMS to ensure hospitals meet Medicare’s Conditions of Participation (CoP). CMS has demanded that practitioners caring for hospitalized Medicare patients demonstrate that they have current competency in the activities they undertake. Furthermore, hospitals (generally through their medical staffs) must continuously monitor the clinical practice of providers holding clinical privileges to ensure that they do not deviate from competent practice.

Early in the 21st century, increasing revelations of poor quality care in American hospitals put great pressure on The Joint Commission to strengthen its requirements relating to practitioner competence. In 2007, The Joint Commission introduced the concepts of ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE). While the standard for OPPE meant medical staffs would monitor clinical competence on a routine basis, the standard for FPPE required medical staffs to create a process to evaluate, in a timely manner, clinical competency in two situations. The first is when the organization has no direct data confirming a physician’s competency, such as a new
practitioner joining the medical staff. The second is when continuous surveillance of a practitioner’s practice (OPPE) suggests that a clinical competency or professional behavior problem may exist. Other accrediting agencies with deemed status to inspect hospitals on behalf of CMS use different terminology for their requirements to monitor competence. The Healthcare Facilities Accreditation Program (HFAP) adopted the language and standards of FPPE and OPPE and put them into effect in 2015.

As medical staffs across the country have struggled to find effective ways to perform FPPE, increasing attention has turned to a long-standing performance evaluation tool known as proctoring. Today, proctoring is widely deployed as an approach to competency assessment. Proctoring can take various forms and has strengths and weaknesses as an evaluation tool. The next sections of this book discuss this technique in depth.
References

1. *To Err Is Human: Building a Safer Health System* is a report issued in 1999 by the Institute of Medicine and is available from the National Academies Press ([www.nap.edu](http://www.nap.edu)) for purchase or free download. The report looks at multiple studies to reach a conclusion that between 44,000 and 98,000 individuals die each year as a result of preventable medical errors.


3. For example, see *Assessing Late-Career Practitioners: Policies and Procedures for Age-Based Screening*, a guideline from California Public Protection & Physician Health (2015).

4. See a list of such programs in this book’s Appendix.

5. For a general overview of the topic of board certification, see *A Short Guide to the Specialty Certification of Physicians* by Todd Sagin and published 4/2013 by the Foundation of the American Association of Physician Specialists.


Even as regulators and the public demand more verification of physician competence, physicians have less time—and are less willing—to perform competence assessments and undergo monitoring. With this in mind, medical staffs must develop proctoring and precepting plans that are effective and efficient.

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