Proctoring in Cardiac and Thoracic Surgery

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Background

Advances in healthcare have resulted in ever-improving outcomes, often with decreasing invasiveness to the patient. It remains essential that patient safety is preserved and that advances in care do not increase the hazard to any patient. At the same time, sharing and dissemination of healthcare advances are required. The introduction of novel techniques or technologies, especially for surgical or other interventional therapies, needs to occur in a safe, monitored environment. This has led to the practice of “proctoring”.

Definitions

Unfortunately, there is some confusion in terminology.

In North America, a proctor is an experienced doctor who is invited to confirm the competence and capability of a newly-recruited member of staff (1). The process of supervision and mentorship in a new procedure or technique is termed preceptorship (1).

In the UK the term “proctoring” is understood as the constructive process for an experienced surgeon (the proctor) to mentor, train, support and supervise a consultant or fully-trained doctor embarking on a procedure for which they have not previously been trained to perform independently.

Arrangements for proctoring in the UK

The introduction of a novel surgical technique or procedure in any UK hospital is intended to improve the patient outcome and experience. To ensure that this process does not entail any increased risk to the patient due to inexperience of the local team during their learning phase, a “Proctor” is appointed to supervise the early stages of the new procedure until the local team are deemed fully competent.

Individual NHS Trusts may have their own guidelines for proctoring. This document, however, is intended to assist surgical teams aiming to develop their practice of introducing novel procedures and the use of Proctors.

Selection of a Proctor

A Proctor must have sufficient experience and expertise in the novel procedure to guide the local team, and to be able to intervene in event of unforeseen difficulty. Considerations in the selection would include the duration and case number of the Proctor's experience, and particularly if there is any previous experience of proctoring for the procedure. The Proctor should be registered with the GMC with a licence to practice.

This includes overseas Proctors as without GMC registration they would not be able to intervene or help with the procedure and would merely be an observer who could offer advice but not actively participate or "scrub" if required.

It is also suggested that if SCTS members are acting as Proctors in countries outside the United Kingdom they must ensure they comply with all local medical regulation policies and are familiar with these.

Duties and responsibilities of a Proctor

1. Preparation and training

The Proctor should confirm that the surgeon(s) have undertaken suitable training prior to the first clinical cases. This could include, but is not limited to:

- Attendance at an appropriate and approved training course in the procedure. Preferably this should include other members of the team such as anaesthetists, assistant surgeons and nursing staff.
- Simulator training e.g. for robotic surgery.
- Cadaveric or animal procedures (UK legislation may render the second difficult in the UK).
- Observation of surgery by an experienced practitioner, such as the Proctor.
- Review of potential cases to confirm suitability. The Proctor should have been given all relevant information and investigations of planned cases in advance of the planned day of surgery.

2. Supervision

It is an absolute requirement that the first clinical cases are supervised in full by a suitably experienced Proctor, until the local team has gained sufficient experience and competence.

In many cases, it may be advisable for preoperative investigations to be reviewed by the Proctor in advance to ensure appropriate case selection. Each case must be discussed by the Proctor and the local team before commencing, including any indications for the Proctor to intervene or for conversion to a more conventional approach where relevant.

During the proctoring period, each patient should be fully informed that they are being offered an innovative procedure for that institution and that the surgery will be overseen by an experienced Proctor. The should also be given the option to decline if they wish to.

Arrangements must be in place for the Proctor to supervise the case throughout. In robotic cases, the ideal would be a second console to allow full 3D vision. In open surgical cases, the Proctor may need to be scrubbed in for the case. The proctor should be physically present during the entirety of the procedure and ideally for a short time thereafter in case of immediate complications. If for any reason the Proctor is unable to be present for the entire case, consideration must be given to converting to a more conventional procedure to optimise patient safety.

3. Intervention

It is intended that the Proctor's role is to supervise rather than perform the procedure. Nonetheless, if difficulties are encountered it may become necessary for a more experienced operator to intervene. The patient's safety must be paramount. For indemnity purposes, it is therefore necessary for any Proctor to hold an honorary contract with the host institution.

4. Aftercare

Unexpected issues may arise in the clinical care of patients following a novel procedure. The Proctor would not be expected to be present during the postoperative stay, but ideally should be available for advice if required.

5. Sign-off

At the end of each procedure, a debrief should be carried out by the Proctor with the theatre team. An evaluation of the procedure should also be recorded, most likely as an evaluation form. It will be the responsibility of the Proctor to judge when the local team are ready to operate independently. Once signed off, it will be considered that the local team are safe to continue without supervision, although the input of the Proctor may be desirable for any particularly difficult cases.

Guide for Proctors

To act as a Proctor for a procedure an individual should;

1) Ensure they have enough competence and experience in the procedure to offer teaching and support to other surgical teams.
2) Have knowledge of the surgical team and hospital at which they are going to proctor cases.
3) Have GMC registration and an honorary contract or equivalent arrangement with the host institution
4) Have been given details and investigations for planned cases and an appropriate amount of time to review these to ensure they are suitable for the planned procedure.
5) Have discussed and agreed with the host surgical team any indications for conversion to a different approach or intervention by the proctor as required.
6) Provide a debrief and feedback to the host team following each procedure.

References

1) STS proctoring policy. https://www.sts.org/about-sts/policies/proctoring-policy
2) The Definitions Document: A Reference For Use Of Sages GuidelinesHttps://Www.Sages.Org/Publications/Guidelines/Definitions-Document-Reference-For-Use-Of-Sages-Guidelines/
3) Zorn KC, Gautam G,Shalhav AL et al. Training, credentialling, proctoring and medicolegal risks of robotic urological surgery: recommendations of the Society of Urologic Robotic Surgeons. J Urology 2009. 182:1126-32.