



# The practice of locum tenens:

## *Commentary*

by Stuart A. Reynolds, MD, FACS

**I** have the pleasure of commenting on the nicely composed article outlining the vagaries of locum tenens coverage for rural hospitals by Ronald M. Tolls, MD, FACS. All of the points are well taken and expressed concisely. My experience is that of three years of locum services in four states and seven facilities, limited to two weeks' coverage at a time.

The experience proved to be a pleasure in almost all instances, with the opportunity to meet a wide variety of pleasant people; to make new friends, some permanent; to help some known colleagues; and to escape the inevitable two years of incessant telephone calls that follow retirement from a rural practice. Overall, the locum tenens surgeon is appreciated, for the service being provided is important in maintaining continuity by covering for the office or department while it is recruiting or for an absent or ill solo surgeon. In my experience, there was always available a qualified surgeon to immediately replace me upon leaving. However, there are some caveats that need attention.

The maintenance of professional standards, and relationship with other professionals, remains the responsibility of the surgeon who should be sure that basic principles are not compromised. Sometimes this system requires limiting services that are provided if the

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infrastructure for optimal performance is not provided. Rarely was this a problem for administration or colleagues. All rural facilities have a long-term staff that will provide guidance in dealing with local issues, and the tertiary referral and transport processes are well defined for patients whose needs exceed the ability of the facility to provide care. Standards are not, and should not be, the concern of the contracting agency that simply provides a business conduit for the hospital in need and the appropriate physician. The two agencies that I worked for simultaneously were quite flexible and cooperative with me and each other and the “handlers” were well trained and skillful.

The rural locum tenens surgeon for the most part is relegated to providing low-volume urgent and emergent care for the reasons expressed in Dr. Tolls’ article. However, in the rural setting, the services tend to cross a broad spectrum of surgical practice, including many urban subspecialties. Therefore, the practice load is not conducive to maintaining knowledge or skills over the long haul, a fact that the locum tenens surgeon must seriously consider.

I have two concerns for the potential locum tenens surgeon that I believe are imperative for ensuring optimal performance and patient care.

My first concern is experiential match. The young, just-trained surgeon might fit either a rural or urban setting, but the older surgeon will not do so. The urban surgeon may very well have had a practice that is narrowly restricted by subspecialists and not have the broad skills that are commonly required in the rural setting. Conversely, the rural surgeon has, of necessity, maintained a broad array of surgical subspecialty skills suitable for the rural setting but may have (appropriately) abandoned procedures for which the rural facility cannot provide infrastructure, though those skills may be required in the urban setting. Therefore, the rural surgeon should stay rural as a locum tenens surgeon and the older urban surgeon should be careful in covering the rural facility.

My second concern is locum tenens time limit. As noted, knowledge and performance degradation must be recognized as an inherent outcome of a low-volume, basically nonelective, surgical

practice. The locum tenens surgeon should impose a time limit for performing in that venue and must honestly assess skills and knowledge levels on a regular and planned basis. The inevitable degradation must be compared with acceptable levels during a normal surgical practice, and the locum tenens activity discontinued when personally acceptable performance is not possible. This approach requires a high degree of honesty and is quite difficult because it imposes a negative evaluation of oneself. In my case, an upfront limit of three years was imposed and proved to be the correct assessment.

I agree that locum tenens surgeons fill a much-needed and appreciated role in the support of surgical practices in rural America. The continuity of surgical care during my experience left no implication that the activity implied itinerant character. The development of guidelines by the American College of Surgeons might be beneficial to surgeons contemplating a locum tenens practice. □

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