



# The practice of locum tenens:

## *Views of a senior surgeon*

by Ronald M. Tolls, MD, FACS

**I** have heard it said that without a surgical service, a rural hospital is little more than a clinic. There are very practical lifestyle and professional concerns for those who would attempt a solo rural practice, namely professional isolation, less time for recreation and family, and a patient volume that might be insufficient to warrant the hiring of another surgeon. Bringing another surgeon into a practice where volume scarcely supports one may lead to degradation of skills, loss of income, alienation, dissatisfaction, and an association not likely to survive. Although not universally accepted, the use of locum tenens surgeons is a practice that, if within the ethical guidelines of the American College of Surgeons proscriptio of itinerant surgery, may be a solution—albeit an imperfect one.

### ***Who are the locum tenens surgeons?***

For many younger surgeons, locum tenens is a temporary way to become acquainted with a community and surgical practice without a costly commitment for surgeon and family. Older surgeons who seek freedom in scheduling, less fixed overhead costs, and a means of practicing surgery in localities where part-time malpractice insurance is not available appreciate that the placement

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agencies purchase and provide coverage on an hourly basis. For others, the opportunities for travel and varied experiences is attractive even in mid-career.

Assignments vary from an occasional weekend to six months or more. They occur most frequently during holiday periods, summer vacations, and important surgical meetings but may occur for prolonged periods while clients are seeking permanent surgeons or in the event of surgeon illness. Most placements are done through various agencies that assist with license preparation, travel, lodging, and credentialing. Such agencies exact substantial fees for their service, with their share often exceeding that of the surgeon with whom all responsibility for patient care ultimately falls. Personal service contracts with client hospitals would avoid much of this, but like a multiple listing service program in real estate, often opportunities are only generally known through the various agencies.

Once a curriculum vitae has been presented, the agency claims ownership for a two-year period such that it is not possible for a surgeon to work with that client directly or with another agency. Although they compete intensely for control of a surgeon, employees in the agency are generally devoid of any surgical background, understandably are motivated by physician placement fees rather than quality of care, in the event of conflict are focused on client satisfaction rather than due process for professionals, and bear no liability in the event of malpractice. Likewise, a high finder's fee is granted to the agency whereupon a locum tenens surgeon takes on a permanent position.

### ***The downside for locum tenens surgeons***

The seemingly carefree practice style of locum tenens surgery has its downsides, including the following:

*Performance degradation.* It is the unusual locum tenens opportunity that provides the surgeon with a caseload that is varied and of high volume. Most assignments are to cover call only rather than follow a clinic and an elective surgery schedule. Because of continuity issues, primary care physicians may rightly be hesitant to refer elective surgery to surgeons who cannot ensure continuity of care. Not simply in jest,

some of my regular surgical colleagues have said that the principal function of a locum tenens surgeon is to maintain practice viability so that referral patterns are not lost. Ironically, clients in search of prospective locum tenens surgeons will insist on documentation of substantial caseloads, a near impossibility if one were to do locum tenens surgery for an extended time.

*Boredom and loneliness.* Although a locum tenens surgeon must constantly be ready to respond to an emergency, workloads are generally light. Time management—with studying, exercise, computers, and activities that can be immediately set aside—requires discipline.

*Isolation.* Surgical practices in metropolitan areas can generally be cross-covered by colleagues. It is in rural America and small-town practices where locum tenens coverage is most needed. The locum tenens surgeon quickly learns that quite often he or she is asked to cover because of conflicts, particularly between surgeons and administrators on matters of call coverage. The locum tenens surgeon arrives as a total stranger and must adroitly identify the political process without becoming a casualty.

*Due process.* Unlike his or her permanent colleagues, a locum tenens surgeon is not entitled to a “bad day.” Past performance is unknown, and he or she is likely to be judged by superficial attributes, his smile, demeanor, self-effacement, and trivial likes and dislikes, particularly as he or she interacts with the nursing staff. Hospital bylaws protect medical staff. Errant physicians are disciplined only after meetings with peers and a series of steps, including formal written allegations, case reviews, confidential meetings with peers in attendance, and a forum for rebuttal. The locum tenens surgeon has no such protection. Any apparent infraction—such as an allegation that he could not be reached even though he or she may have been in assigned quarters, an error in posting his or her phone number, or the pager provided was not the one on the call roster—is sufficient that he may not be invited to return.

*Adaptability.* Rural hospitals may be surprisingly insular. Caseloads are light. Because of limited resources, a surgeon may be required to work with unfamiliar equipment. There is often but one way of doing things with which the

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nursing staff is familiar. Any departure from a predecessor's practice even months before may be quite unacceptable with resultant inaction, nursing debriefings, and formal complaints. It is the locum tenens surgeon's challenge to practice in a manner he has learned to be safe and comfortable while blending with local practice standards.

*Risk management.* Upon arrival on a new assignment, the surgeon must quickly identify the availability of specialty consultations; evacuation capabilities; competence of assistants, nurses, and anesthesia providers; blood products; and a host of similar concerns. Often he or she is asked to provide cover over holidays when hospital services and staffing are minimal. He or she must always remember that when his or her assignment is over, he or she remains the outsider in a tightly knit team and may not be there to defend his or her actions or maintain the essential rapport with patient and family to avoid litigation in the event of an adverse outcome. Much like the commando who drops out of the sky on a clandestine mission, the locum tenens surgeon must quickly identify those staff members he or she can trust; learn telephone numbers, names, and personalities; and be prepared even upon arrival for a life-threatening emergency wherein he or she may mobilize and direct a dozen players.

*Acceptance.* One of the most appealing aspects of a rural practice for an established surgeon is the high esteem he enjoys with hospital team and community. To many there is no one, certainly not a locum tenens surgeon, who can match up. Satisfying as that may be for the established surgeon, if he requests the support of a locum tenens surgeon in his absence, it is only fair that he encourage his entourage to provide the fullest support for the locum tenens surgeon, though his ways may be different. To bask in adulation upon his return to the detriment of the locum tenens surgeon is egoistic and unprofessional behavior that does not merit his further temporary reprieve by a locum tenens surgeon.

*Continuity of care.* The American College of Surgeons regards as itinerant surgery the practice of leaving the care of postoperative patients with someone other than a trained colleague until they have recovered sufficiently. Although of no concern to the agencies compensated for

placing surgeons, on various occasions I have learned, when taking an assignment, that upon my departure, there was no surgical coverage other than vague plans of distant referrals or the possible coverage by a busy colleague miles away. The pressures by colleagues and administrators to operate without adequate follow-up can be overwhelming. In such circumstances, it is the locum tenens surgeon's responsibility to declare outright what he can safely do and no more.

### **Conclusion**

I am an avid reader of the *Bulletin of the American College of Surgeons*, but over the years I have seen little or nothing about the practice of locum tenens surgery, specifically no position statement as has been written for many other areas of interest. I know that the practice is not proscribed because of the job postings for many locum tenens positions I have seen in times past on the College's Web site. Locum tenens surgeons fill a much-needed role in the support of surgical practices in rural America. I believe it is time we define as an organization what is expected of a locum tenens surgeon, provide opportunities for client hospitals and surgeons to work without exorbitant fees to placement agencies, and welcome our locum tenens surgical colleagues as fellow professionals in the fullest sense. Ω

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