Commentary

Maximizing the locum experience

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Back from holiday and my secretaries report that the locum saw patients in a timely manner, responded to messages (especially urgent requests), and filled prescriptions efficiently. Our nurses acknowledge reciprocal working relationships with the locum.

My in-box is organized with abnormal test results highlighted and clarity regarding follow-up. Cases are well documented, particularly the handling of challenging issues. Patients provide positive feedback regarding patient-centred care. I do not discover any overlooked test results. The time orienting the locum and reviewing the contract was time well spent.

Locum physicians in Canada provide an invaluable service to family physicians wanting to ensure continuity of care while taking vacations, child care leaves, or other work absences. Changing demographic profiles have implications for greater reliance on locum services. Women make up more than half the family physicians younger than age 35, and there has been a considerable rise in older physicians contemplating retirement in the next 2 years.[1,2] Female family physicians work fewer hours than their male counterparts—in part owing to maternity leave, but also because of a preference for career and family balance.[1] Changing practice patterns, with more emphasis on team-based primary care, also demand that locums work collaboratively. In this paper, we highlight the uniquely Canadian locum experience, explore the legal liabilities of locum and hiring physicians, and seek to build on previous work on the pragmatics of optimizing this arrangement. We also introduce the notion of *office-centred care,* which offers a framework for family medicine practice that reflects team-based care and acknowledges the dynamics of individual offices.

Canada's National Physician Survey reported in 2010 that 13.9% of family physicians had provided locum services in the previous year.[1] Of all age groups, locums make up the largest percentage of physicians among those 35 years of age and younger, at 29.6%.[1] Similarly, Myhre et al found a trend toward younger locum physicians in Alberta,[2] and the 2007 National Physician Survey revealed that 58% of second-year family medicine residents planned to work as locums upon graduation.[3] Indeed, pursuing locum placements in Canada is commonly perceived as a means of career and practice exploration.[2,3] There is an additional cluster of locum physicians among those aged 65 and older,[1] who are likely transitioning to retirement. Of interest, 71.7% of locum placements in the study by Myhre and colleagues were arranged independently, without the use of placement agencies,[2] putting the onus on the hiring physicians to ensure locums have the appropriate credentials, are suitable for practice, and are adequately prepared for placement.

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In other countries

It is difficult to establish the precise number of locum physicians in the United States; estimates ranged anywhere from 4%[4] to 36%[5] of practising physicians for 2008. While there are groups of locum physicians at the start and end of their careers, similar to the situation in Canada, a growing number of physicians in the United States are choosing to do locum placements as a career.[5,6] In the past, locums in the United States were perceived to be physicians who were not suitable for permanent practice owing to competency issues or unwillingness to commit to permanent practice.[5,7] This perception is changing, however, likely in part because of the formalization and organization of locums.

To that end, most locum placements in the United States are organized through locum placement agencies.[8] There are dozens of for-profit placement agencies matching locum physicians to assignments in what has grown to be a billion-dollar industry.[8] These agencies typically review curriculum vitae, check references, and confirm appropriate licensing and credentials for the locum physicians they place.[7] The advent of such a booming for-profit industry has led to the formation of the National Association of Locum Tenens Organizations,[8] which sets standards of practice and codes of ethics for locum agencies, physicians, and hiring organizations.[9] To our knowledge, no comparable standards have been set out for locum physicians in Canada by any of the medical associations or licensing bodies.

Data on locum demographic characteristics in the United Kingdom are more complicated to extract, as most research groups locums together with other GPs who work part time. The National Association of Sessional GPs[10] in the United Kingdom reports that 25% of GPs work as locums; 60% of those who work as locums are between the ages of 30 and 39.[11,12] Similar to the Canadian situation, locums in Scotland[13] are often at the beginning of their careers looking to gain

experience or work part time to balance family commitments, or GPs at the end of their careers who want to work without the responsibility of full-time practice.

Locums in the United Kingdom tend to be more organized than they are in Canada, with an association that advocates on their behalf to improve access to continuing medical education and to promote appropriate working conditions.[10] In particular, this group lobbies for reducing "enforced underperformance." Essentially, this requires establishing the infrastructure so that locums can safely and optimally care for patients. This includes contracts that clearly articulate locum responsibilities, ensuring access to medical equipment, allowing adequate time to assess patients, and providing a "locum pack" (a standardized folder outlining office protocols and referral processes, resources, local hospitals, and lists of specialists). Locums have more channels to access placements through industry agencies in the United Kingdom and might be placed locally or travel extensively for positions.

Obligations

There have been calls for greater regulation of locums in the United Kingdom and Europe, driven by well-publicized cases of patients who were harmed by locum physicians, including the death of a patient in 2010 and cases where locums were found to have never undertaken medical training at all.[14,15] Recommendations include a centralized system for assessing competence and standardized review of locum references, licensing, and past training.[16-18] The potential for harm compels hiring physicians to carefully consider their professional and legal obligations to patients and to locums in the hiring process.

In Canada there is very little case law concerning the responsibilities of the hiring physician regarding any issues arising from the care of patients by a locum tenens during the hiring physician's absence. A search for cases using the word *locum* resulted in 2 cases that were relevant but contradictory.[19,20]

With such contradictory judgments, the onus must be on the hiring physician to ensure that the locum meets the standards of care, including being in good standing with the provincial College of Physicians and Surgeons, having liability insurance, and having references that attest to his or her clinical competence. The scope of practice during the hiring physician's absence must be made clear, including all expectations for communicating results to patients and to the hiring physician, as well as the appropriate management of those results (eg, follow-up, referrals, treatments). This would be explained in an orientation to the practice, which would include direction about record keeping, office procedures, referral sources, and use of administrative staff.

To ensure this occurs, the legal department of the Ontario Medical Association advises that the locum and hiring physician sign a formal agreement before the start of the contract (such a contract is available from HealthForceOntario[21]). This agreement should clearly state the responsibilities of each party and clarify the relationship between them, including the purpose and term of the agreement, the obligations of the hiring physician, the locum physician's duties, and the distribution of billings. The hope would be that fulfillment of the obligations in the comprehensive agreement would ensure that each party is protected in case of litigation.

Recommendations

With these contractual obligations in mind, the following recommendations for both hiring (**Box 1**) and locum (**Box 2**) physicians are meant to facilitate *office-centred care*. Similar to the pragmatic considerations covered elsewhere,[22] this term covers the physician's experience of returning to a well-ordered office, the locum's experience of integration into the office team, the administrative and interprofessional staff's

Box 1. Recommendations for the hiring physician

Entrance interview
- Requirements: Ensure the locum meets licensing and medicolegal coverage requirements
- References: Check the locum's previous work, particularly patient feedback and the ability to collaborate with other staff
- Review: Ensure agreement by both parties on all points of the contract
- Prepare staff: Highlight office policies and procedures with staff and the locum to ensure common understanding and consistency

Prepare patients
- Remind staff to inform patients when booking that they will see a locum
- Alert patients in crisis about coverage during your absence
- Prepare a list of complex patients with active concerns (eg, dementia patient with suboptimal diabetes control decompensating at home) and a list of important pending results (eg, breast lump biopsy, β-human chorionic gonadotropin measurement for threatened abortion)

Prepare physical space
- Ensure easy accessibility of referral forms
- List preferred specialist services
- Organize brief training for electronic medical record or paper chart use, as appropriate
- Review how to communicate follow-up information

Exit interview
- Organize a check-in for joint feedback

Box 2. Recommendations for the locum

Look
- Read patient charts to appreciate how complex cases are managed
- Aim for a balance between your practice style and the hiring physician's style

Listen
- Work with the office; staff know the practice population
- Seek advice and guidance, where appropriate, from administrative staff, physicians, and allied health practitioners
- Support the relationship patients have with their primary physician
- Acknowledge patient concerns but remember that managing chronic diseases is the concern of the hiring physician (unless this is a long-term locum)

Communicate
- Actively contribute your experience but be sensitive to the culture of the office
- Update the hiring physician on patient status, especially important changes such as hospitalization; provide a list of patients and results for follow-up, both in the short and long term

experience of feeling assisted, and patients' experience of and satisfaction with their care. A little work up front will improve the locum experience for all involved.

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Competing interests
None declared

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