editorials

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Locums . . . and the light at the end of the tunnel

Some of my best friends have been locums. But there are now mercenaries roaming the country earning or costing up to quarter of a million a year, to the chagrin of lesser-paid career consultants committed to the local service. There are undoubtedly some able clinicians doing locums, but others prefer easy decision-making, filling up beds with a decided lack of interest in community care. And, it has to be said, there are locums whose work worries everybody stiff. A recent survey of medical directors of trusts in the north-east, Yorkshire and Humberside revealed the locum issue to be top of their list of serious concerns. Conference gossip suggests the same may be true elsewhere in the country.

Medical directors can spend huge amounts of their precious time chasing locums to fill vacancies, and then huge amounts of time going through the delicate process of getting rid of them when things do not work out. And when that has been successfully achieved, there is the further worry of how to prevent other services being similarly beleaguered, using some pretty unclear and shaky procedures.

Cost and quality

Locum costs are accounting for all, or a large proportion of, considerable financial deficits in a number of trusts. Those medical directors are under pressure to do something about the financial problem as well, not only to help the chief executive keep his job, but also to avoid the money for worthwhile service improvements being frittered away. So, the effects on quality of care can be a 'double whammy'. What is to be done?

In addressing the problem, we must not blackguard locums in general. There are specialist registrars sensibly making first moves into the consultant grade as locums to test out whether a particular service is one that deserves their long-term commitment. There are also retired consultants coming back for a spell of work to help out former colleagues. There is nothing wrong in principle with consultants capitalising on their scarcity by attracting higher rates of pay. In fact, it serves the powers that be right for creating scarcity by letting conditions of service deteriorate for so long. But when services are getting so desperate that they are tempted to pay just about anything for anyone, we have to stop and think about other solutions for the sake of all patients and the majority of consultants.

It was estimated recently that there are just over 200 locum consultant psychiatrists currently employed across the country, with the preponderance in the major shortage speciality – general psychiatry. There are just under 1500 general adult psychiatry consultant posts, and so approximately one locum for every nine or ten established consultants. Not such an impossible ratio, perhaps, to imagine doing without the locum by changing the ways in which the other ten consultants work. Paradoxically, there are prospects of achieving this with smaller rather than larger individual caseloads.

New roles

Two early spring conferences took place in Swindon and Newcastle, sponsored by the National Institute for Mental Health in England and the National Director for Mental Health, under the title 'New roles for psychiatrists shaping the national debate'. Hundreds of consultants attending these oversubscribed events heard how some colleagues are selecting much smaller caseloads of the more complex cases, leaving time to be consulted, when asked, by other mental health professionals who are taking responsibility for the majority of secondary care referrals. These conferences were supported by the British Medical Association, General Medical Council, Royal College of Psychiatrists and Department of Health, whose representatives fully accepted in debate that central guidance on 'medical responsibility' might need some recasting to support consultants (and the other professions) in such creative changes driven by necessity.

Although it is clear that medical responsibility for in-patients lies with the consultant, and for out-patients with the general practitioner, all agreed that there needs to be much clearer and written guidance on responsibility within multi-disciplinary community teams. If nurses and others take direct referrals and provide continuing care, does the consultant in the team carry any responsibility for patients never seen? Probably not, was the general view. The College has long held that consultants cannot be responsible for patients of whom they do not have 'specific knowledge' (Royal College of Psychiatrists, 1996: 7). But what responsibility does a consultant have for the

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overall quality and safe functioning of a multi-disciplinary team and for the competencies of its members? It is the employer that delegates responsibility to others in the team, not the consultant, said a chief executive. It would follow, therefore, that as far as the consultant is concerned, responsibility in the team is distributed, not delegated.

However, there was consensus on the need for clear written guidance on the limits of responsibility for advice given to others in the team about patients the consultant has not seen. All such guidance must be developed with the other mental health professions and general practitioners. Nurses and psychologists at the meeting said they would welcome dialogue on developing new guidance as well as the move to greater clinical autonomy with ready access to medical advice when needed. Hitherto, the absence of clarity and consensus on such matters among consultants and across the mental health professions has given licence to coroners, inquiries and courts to make their own interpretations of the limits of medical responsibility. This has sometimes resulted in the doctors involved feeling very unfairly treated.

A representative of the General Medical Council suggested that any new guidance would best be developed under the auspices of the Royal College of Psychiatrists consulting with the other professional bodies. It must be realistic and meaningful to all front line clinical staff if the final drafting, and approval by the General Medical Council and Department of Health, is to be really helpful. New guidance should also be comprehensible to managers, lawyers and coroners to whom it should be promoted.

Those who worried that risk management in secondary care would be less effective if many patients were not seen personally by a consultant were countered by the argument that focusing on the more complex high-risk cases, with adequate time to do a proper job, could improve risk management. Experience shows that other professionals do use consultants quite appropriately, if the consultant is available when needed. Handling consultancy relationships with other professions might well be an important training issue for specialist registrars and consultants. Those who worried that distributed responsibility in teams meant diminished status for consultants were reassured by others who had found that this consultancy relationship actually emphasised clinical primacy of the consultant in the team and enhanced status.

There was concern that focusing on more complex cases might be equated with treating only cases of severe and enduring psychosis. Such over-simplification must be countered with the facts, that complexity and resistance to treatment may affect the full spectrum of mental disorders and that the management of chronic psychotic disorders can be relatively straightforward. There was unanimity of view that psychiatrists must not make the mistake of some other professions by being promoted away from direct care of patients. No-one could be a credible consultant to other professions on clinical matters unless they themselves remained immersed in direct patient care.

Medical directors

Besides removing any central policy obstacles, it was recognised that excellent local leadership is also needed to manage changes in professional practice, not least from medical directors. Yet second only to locums, among the serious concerns of medical directors surveyed in the north of England, was concern about the medical director role itself. Many medical directors feel bogged down with administration and operational problems. They are under pressure to focus on the supposedly urgent (like sorting out a locum) rather than what is really important (like forecasting shortage and having alternative solutions in place). 'We should have seen the consultant shortage coming more than a decade ago and had the time to analyse and experiment', said one medical director.

It is in everyone's interests for medical directors, and all consultants, to have the space and time to focus on the higher-level more complex work that only they can do. Distributing work that others can do should be mutually enhancing of professional status. And it is certainly time for consultant psychiatrists to stop the benefits of their financial bargaining power from scarcity being creamed off by peripatetic locums.

Reference

ROYAL COLLEGE OF PSYCHIATRISTS (1996) *The Responsibilities of Consultant Psychiatrists*. Council Report CR51. London: Royal College of Psychiatrists.

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