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Trials & Tribulations with Locum Tenens: One Physician's Journey

Announcer Introduction:
Welcome to *Spotlight on Locum Tenens* on ReachMD, sponsored by CHG Healthcare. Here's your host, Dr. Matt Birnholz.

DR. BIRNHOLZ:
This is *Spotlight on Locum Tenens* on ReachMD. I'm Dr. Matt Birnholz, and joining me to share some trials and tribulations in locum tenens, a few horror stories along the way, but more importantly, how to avoid future horror stories going forward is Dr. Rip Patel, founder and lead for Mercision Emergency Medicine, and Assistant Professor at the Baylor College of Medicine in Houston, Texas. Dr. Patel, welcome to the program.

Dr. Patel:
I really appreciate it.

DR. BIRNHOLZ:
And I want to start off first with a little background. How have you been working as a locum tenens physician? And where has that work taken you over the years?

DR. PATEL:
I had a community job for about a year after I graduated residency. And I did it for a year. It was with a big staffing company. And unfortunately, it wasn't really the best form of medicine that I felt was optimal, you know, for patient care. It was actually the hospital that was born at where I was practicing. And I thought I'd be there forever. And ironically, I ended up doing the exact opposite of what I thought I'd do after residency. And so, I branched out into locums. A colleague had told me about it, it sounded really crazy to go fly around and go to different hospitals and learn different EMRs. And it really made no sense. But as I talked to him more, it seemed like, he's pretty happy with his practice and his life, and the balance is able to achieve with it. And so my first assignment was out in West Texas. I sort of just took the first thing they offered me. And it was a really incredible experience. All the migration issues you're seeing in Texas with border crossings, and how people are being kind of held and pending refugee status so and all that's occurring in that around that town where I worked. And it was just an incredible patient population, very grateful, very underserved. And, yeah, it was very memorable first experience.

DR. BIRNHOLZ:
And let's stay on that for a moment. Because I love the way you frame that, everything you took away from it, how it enhanced your practice. And I imagine in a context of coming into a place that feels like a world apart, even though it's miles away you had to be at your best and you had to learn quick. But let me put another spin on that and look at it from the glass half empty. What were the hard lessons learned in that first experience that set a precedent for you going forward?

DR. PATEL:
Yeah, going into any new hospital setting is always challenging. I equate it to speaking a language where I feel to be fluent in a language, you really don't need to know as many words as you think. And I think starting a new ER, there's really a basic amount of things you need to know. The rooms all look the same, the resuscitation rooms look the same. Usually, the admitting ways you admit, things like that are all the same. But the challenges going in and I completely lost track of what your question was, so ask it one more time.

DR. BIRNHOLZ:

No, it's great. if you could pick right back up on that idea of, you know, the challenges, some of the hard won lessons in that experience, and then I'll go from there.

DR. PATEL:
So I think going into any hospital setting is challenging, especially if you're not aware of the environment, the EMRs, and the people. I think the hard lessons I learned going in initially were I think I mentioned in my article I'd written about being prepared, having equipment so you feel that you have everything you need. If you have a critical patient, things like ultrasounds and video scopes. I learned now before I go to hospitals, I make sure I understand the EMR. I think if you tackle the EMR, it will make your days and your time at the hospital so much easier. And there's some hospitals that really won't go to if they have certain types of EMRs. And I think the big thing also is I go there a day before, I always request to do like a shadow shift, where I'll just be there, follow the doctor around a little bit, get familiar with the staff, the environment, the people, and make sure my logins work, all these really basic things where it will make your first ship go smooth.

DR. BIRNHOLZ:
That's excellent, Dr. Patel, and what I love about your mentality is that you're already in the solutions-seeking zone, which is so critical in your field. But I want to come back to some of the 'my pain is your gain' model of education that, of course, is endemic within medical education in general. And you did, from what I understand, endure some trials and tribulations. And maybe we can focus in on a few of them. You mentioned a go-bag, I'd love to hear about how you came to that realization that you're going to have to supply yourself, and that bag was gonna have to be very carefully considered. What can you tell us about that?

DR. PATEL:
Yeah, you know, emergency medicine is a very high-risk specialty. And some hospitals, I think value what we offer. Some hospitals could probably value what we offer a lot more. The burnout's high, the liability is high. And so I think if something did happen, you know, it's appalling that it would. And a perfect example is like an airway issue. One of the big things we do is managing critical airways, trauma airways. And if for whatever reason, we don't have the proper equipment, and a patient decompensates or has a poor outcome, you don't know how forgiving a family, an attorney, or somebody's going to be. And so one example of that was I had a very critical patient, morbidly obese, that needed an airway, had very, very severe pneumonia. And the video scope that I needed was taken by anesthesia to the operating room for whatever reason, and there was really no time to go get it, the patient's crashing pretty fast. And thankfullyI was able to get an airway with just standardtandard equipment we used, which to me is very antiquated. And we have all these video scopes now. So I think things like that. I also mentioned an ultrasound machine. They're horrible ones now and, boy, for traumas, we do fast exams for trauma patients, meaning we look for internal bleeding, and I that really guide our decision making. And I can just carry it around with me and make so many diagnoses and so many decisions faster for critical patients. And a lot of my hospitals either don't have an ultrasound, or they have an ultrasound that is so complicated to use, nobody knows how to use it, or the ultrasound machine just hasn't been working for weeks, and nobody's fixed it.

Again, I could go on and on about these things. But you can either take the attitude and complain about it, or just say, that's fine, I'll deal with it. And I will kind of find a way around these issues. And so I think that enough, I have enough stuff and I'm comfortable enough. And every time an issue arises, I'm like we may need to purchase this.

DR. BIRNHOLZ:
That's excellent. Great insights, Dr. Patel.

For those just joining us, this is *Spotlight on Locum Tenens* on ReachMD. I'm Dr. Matt Birnholz, and I'm joined by Dr. Rip Patel, who's walking us through some of the more challenging experiences that can be encountered in locum tenens careers, how to deal with them proactively, and how to become a better physician by extension.

So on that last point, Dr. Patel, let's focus on the tools or strategies that you've built to help confront or even get ahead of potential pitfalls. And you mentioned doing better local diagnostic screening by having portable technologies. I imagine diagnostic screening or tests sometimes are not in great supply where you go. How do you deal with that?

DR. PATEL:
Yeah, you know, it'll vary. I think every hospital is going to have different resources. And I think you need to be aware of how comfortable you feel. I think one of the nice things to me about locums is I've working in enough places now where, you know, emergency medicine is sometimes if you don't have a specialty backup, you're still expected to know how to do things. And I think in being in critical access places, your skills are really put to the test of knowing multiple types of procedures and pathologies that you need to manage without having backup. But like I mentioned, having checklists, meaning what you need to know. Something as simple as going into work and your logins don't work and your single coverage, it's going to take an hour. I mean, that could be a disaster. So, making sure your logins work. I speak to physicians that work at the ER to make sure they don't have anything negative to say what their

experience is like. And then just getting a feel for it really. I tell people if you use what locums agencies, usually they have good relationships with the hospitals, so they've sent multiple people there in the past, so they know the environment pretty well. And the nice thing about locum tenens work to me is if you have an issue with the hospital, because unfortunately in residency, they don't teach you about the politics and the metrics, and it's a very ideal way of medicine, which I think it's important learning, but you don't get the other side of it. And I think that other side of it is what causes so much burnout. And I don't think quitting medicine is the answer. I don't think that, and accepting that people are looking for other things to do outside because, you know, the world really needs compassionate physicians.

And so I think with all those things, in mind locums isn't perfect. But if you find those ways around it, and building up tools to make it more feasible, it's very, very enjoyable, actually.

And I think in my seven odd years of doing this I've had a few bad situations, but I learned from them. And like I learned, call the hospital before you go there. Why are they paying so much money? Ask the question, why. But if you have an issue anywhere, you don't have to go back. And I like that relationship where, unfortunately, in my line of work, I'm not an orthopedic surgery group. I'm not a neurosurgery group. I'm a shift worker. And I don't mean to, you know, downplay what I do, but that's really what we are to some capacity. And so, you know, if we don't need to go back somewhere, because management changes, medical directors change, a new CMO comes in - for emergency, it's really staffing companies. Some of them are good, and are in line with proper patient care. Some may not be, especially when they're owned by private equity companies. And so if you're in that kind of environment, and you're locums, you can, you know, not go back. And when I was working in Arizona, a great group, democratic group, I was locum tenens with them, and then their contract got sunk by a big staffing company. And I know that company, andI would, you know, I'd never work with them. And so I was able to just politely bow out. And so having those options, it's kind of like a stock portfolio. I think having a diversified portfolio of places to work, gives you that longevity, that diversity, and, that experience as well.

DR. BIRNHOLZ:
I think you've effectively answered one component of this, but I'm going to put it out there too anyway, which is, as you think about other clinicians, let's say.

Residents getting going with their careers now considering this, anything that you wish you'd known or been told earlier, that would have made things so much easier breaking into and then maybe even thriving in the locum tenens community?

DR. PATEL:
Yeah, boy, I was so naive when I graduated residency. I don't think it was too long ago, but I really just had no conception of the landscape of healthcare and medicine and how things worked and specifically within my specialty. And like I said, I think that leads to a lot of frustration, a lot of burnout. And I'm really glad my first year I left my job and I started doing this because, after doing this, I don't know what else I would really do just because I love the autonomy of it.

But I tell my residents just look into all the models, see what fits best for you, and then keep an open mind. If you move to a big city, your spouse moves there with you, there may not be a job. It may be so saturated, or the market is so saturated that the rate they're paying is terrible, or they have so many other positions that want to work that they may take advantage of you a little bit and say we want you to do more nights and more weekends and more Christmas and New Year's.

And so, locums is just a good thing to have in the back of your pocket to think about as another tool to practice medicine. And it's for some people and it's not for other people, but just looking into how healthcare works, and I would say, if you're trying to be perfect in a very imperfect system. And that's how I go into work every day, nothing's gonna be perfect. But you just try to be your best physician within that system for optimal patient care.

DR. BIRNHOLZ:
Well, with that fantastic encapsulation of memorable experiences and points of advice in mind, I very much want to thank my guest, Dr. Rip Patel, for joining me to share these trials, tribulations, and a fair number of triumphs gleaned along the course of a locum tenens career thus far. Dr. Patel, it was great having you on the program. Thanks so much.

DR. PATEL:
Thank you so much for having me. I really appreciate it.

Announcer Close:
This was Spotlight on Locum Tenens sponsored by CHG Healthcare. To access other episodes in this series, visit reachmd.com/LocumTenens, where you can Be Part of the Knowledge. Thanks for listening!