

# Having the best of both worlds

**Richard Fieldhouse** makes a case for locum cooperatives

Remember that first time you flew on an aircraft when the stewardess gives the safety talk and there's that moment she tells you, "In case of cabin depressurisation, please put the oxygen mask on yourself before putting one on the child next to you"? It's just not what you'd expected to hear, yet almost instantly you're struck by the realisation that absolute plain common sense can override that terribly basic instinct of putting the survival of your kid first.

## Institutionalised

Yet here, in medicine, as doctors, we're guilty of exactly that. We are institutionalised right from day one that to have the best interests of our patients at heart, we have to be putting them as top priority every time. At medical school, as juniors, and at senior grades and as general practitioners, we all take part in this ritual of self flagellation which somehow makes us think that by whipping ourselves we're going to give a better service. And every directive from on high is centred as patient this or patient that.

So as you've gathered, I'm all about putting the doctor first in order to put the patient first—both crossing that finishing line of aspirational care together. But I'm not going to bang on about exercise, having a life outside medicine, hobbies, interests, and so on. I'm going to tell you how you can be a doctor—from my perspective as a GP—without being institutionalised by the NHS and, indeed, giving the NHS and all its patients an even better service.

## Chambers

I'm talking about working in a chambers. And when we talk to new applicants to our freelance GP chambers about exactly what we're about, they pretty much go through that same sort of realisation as with the oxygen mask: the shackles of our institutionalised NHS job training evaporate in a puff of realisation that they can work in a far more liberating and professional way than they'd hitherto managed and that—bloody



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hell—putting themselves first as a doctor is putting the patient first.

So what is this freelance GP chambers? Ten years ago, a few good friends and I set up the National Association of Sessional GPs (NASGP) to represent GP locums and other "sidelined" GPs, such as salaried GPs and retainers. Why? To misquote Sir Edmund Hillary, "Because it wasn't there." The BMA, General Medical Council, and Royal College of General Practitioners all had almost no idea about us sessional GPs. So we sorted

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that problem out, and after five years we were left with a more level playing field: sessional GPs had roughly equal professional status to other GPs. But there seemed something missing. Various individuals accused us of having our cake and eating it—we had, after all, made a positive career choice for a fantastically flexible way of working.

But the smiles on our faces still concealed the hidden anxieties that we had about professionalism, job security, pay, and the looming spectre of revalidation around the corner. This was especially so when the GMC started to make noises about us locums working "outside managed organisations" and how we would all suffer a "heavier touch when it came to revalidation."

## Easy, simple, and cheap

So we came up with this idea of a locum team, thrashed out one Saturday in London. And what a brilliant idea it was: that every primary care trust should establish a locum team which had its own practice manager and GP clinical director, with a whole bunch of systems and processes to manage the team's clinical and non-clinical aspects of working as a locum. Easy, simple, and cheap. But could we get a primary care trust to adopt the idea? Er, no. I tried twice with my own trust but got that familiar NHS manager reflex response of arse to the sky and head in the sand. Or maybe, "Great idea, just don't expect any help from me."

So sod this, I'll do it myself, were the words

I said to myself as I promised that I could not let this idea die. Here's what I did.

1. My idea became our vision. I knew I couldn't do this alone, and it was, after all, a locum team I wanted. I had two really lovely friends who were both locuming, so we became partners of our own virtual practice.
2. We were given some money—by a different, more progressive, primary care trust. It was actually an advance for a lot of locum sessions.
3. We recruited a manager—in this case, my mum. She now works 25 hours a week for our chambers, and we've just recruited a second manager on the same basis.
4. We work hard, very hard. What we've built is effectively a GP practice, albeit virtual. There are just so many systems, processes, variables, IT requirements, standards, terms, and conditions that we've had to invent from scratch. And all this in a way that engages both our members—now 16 of us—and the 70 practices that we work for.
5. We set ourselves high standards which we've consistently met. In fact, we've created a new benchmark that other locums are now beginning to aspire to. If anything in the slightest goes wrong like a systems failure, our chambers manager automatically generates a "significant event." A director is alerted, the individual member is contacted, and the issue is temporarily resolved. Then, at the next chambers meeting that member presents their case to the group, who all make final adjustments to the solution and the practice

- is then involved in the final outcome. This is only one of six other multisource feedback loops, each one generating evidence for our members' appraisal folders. In fact, to a large degree, gathering appraisal evidence for our members entails not much more than opening an annual envelope from our chambers manager, who's collated it all for them.
6. We developed a specific professional ethos, to which all new recruits have to adhere. All members get a set of door plates, name badges, and their own "GP profiles" that they use at each surgery. All practices have to give each member a unique, secret, username and password for the practice's IT system. All this is so that our patients and our members don't feel second class or get second class treatment.
  7. We oversee a strict diet of continuing professional development—regular monthly meetings complement the ongoing multisource feedback.
  8. The three of us—we call ourselves clinical directors—met almost weekly for the first year and now meet twice a month in "business development." On top of that we're interviewing new candidates and attend each chamber's monthly educational meetings.

#### Absence of whinge

What's interesting about these meetings is that no one whinges and everyone smiles. Contrast that with any multidisciplinary meeting or practice meeting you've been to. As a chambers, run by its members, for

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its members, we totally control our working environment. In all the 5000 sessions that we've worked, not one minute of that time has one of us been compelled to work that session—we choose when to make ourselves available to work (of course, once work is booked we never cancel it). And virtually every minute of every session is clinically based—what other type of doctor can honestly say they spend 0.1% of their time in non-clinical management?

To us, it was putting on that oxygen mask and knowing we could come out of this alive.

**Competing interests.** RF is a clinical director of Pallant Medical Chambers and chief executive officer of NASGP.

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#### FREQUENTLY ASKED QUESTIONS

##### • Don't we miss the continuity?

To a degree—it's often nice to see the same patient more than once. It's nice, but any more than that? A good clinician keeps clear and concise contemporaneous notes, so continuity is not required for better care, surely? Actually, continuity could be a double edged sword—doesn't familiarity breed complacency? Sure, patients like to see the same doctor again, and again, and again. But as I alluded to in my introduction—who gets first go of the oxygen? There may even be an argument that no patient should be allowed to see the same doctor more than three times in a row. And that continuity is too often used as an excuse for poor note keeping. How many patients say they can never get to see the same doctor in their practice anyway?

##### • What of the doctor-patient relationship?

"They know more about [the locum] than they do about me," said a senior partner recently to me. Each of our members carries a small stack of their personal GP profiles with them—an A5 laminated card with their photograph, name, full qualifications, and a précis of their professional and private lives. The receptionists hand these out to patients before they see each member (an idea spawned the moment a patient once tried to thump me on the basis that I wasn't the female GP she'd expected to see). But also, GP locums are highly skilled in developing instantaneous good rapports with patients—how else could we do our job? We have to go from 0 to 60 in 5 seconds. We have to instil fresh confidence and trust in virtually every patient we meet, because they're

all new to us. And we can't have these patients go out of the room other than "at least satisfied" because it's all too damned easy for them to "report" us to a receptionist and we'd simply never be asked back. One adverse comment about a locum can be a professional death sentence.

##### • Just a locum?

Listen, mate, we're more than "just a locum." Indeed, to self diagnose institutionalisation, just ask yourself if you've ever used that phrase? Think about it—if you've ever needed to see a doctor all you want is a good doctor who'll look at your symptoms objectively and without any baggage.

##### • Baggage?

Yes, baggage. Admit it, patients have baggage, and it's not always Louis Vuitton. It's what "heartsinks" bring with them by the bucketload. It gets in the way of their management and it's what covers our eyes. All locums are equipped with "objectivity-o-scopes" that see right through baggage.

##### • Are we shirking "responsibility"?

Responsibility for what? We locums do all the clinical stuff—I'm as well qualified to manage a patient as the next doctor. Oh, you mean stuff like managing diabetic clinics, prescribing budgets, quality and outcomes frameworks, departmental budgets . . . hold on, hold on. Stop. We're doctors, not managers. It's the institution that needs to take responsibility for the management. It's institutionalisation that tells us that we should be feeling guilty for it. Pass the oxygen, please.