

Surgeon unemployment: Would practice sharing be a viable solution?

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Accepted for publication
Nov. 9, 2015

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DOI: 10.1503/cjs.014015

SUMMARY

Surgeon unemployment has become a crisis within Canadian surgery in recent years. Without dedicated governmental workforce planning, ensuring that new residency graduates can find employment will require new models of employment. Practice sharing, whereby a new graduate and a senior surgeon partner to divide their practices, allows the senior surgeon to wind down and the newer surgeon to ramp up. Importantly, this arrangement builds in formal mentoring, which is so important in the early years of starting a surgical practice. Practice sharing may be a solution for the workforce issues currently afflicting new surgical graduates across Canada.

Canadian health care faces many challenges, such as the rising cost of care and an aging population. Provincial government payers in particular struggle to foot the bill for substantial health care costs — just over 12% of gross domestic product in provinces such as Ontario and about half of the government budgets in many provinces. Despite an investment of this magnitude, our outcomes lag when compared with those of other developed nations.¹ Surgery is no exception, with long wait times being the most frequently cited evidence of a costly system that is failing to bring sufficient access to its citizens.²

These are the problems that we most often hear about, but surgical trainees in this country are most likely to hear about another problem: unemployment. It is not an issue that the general public associates with the medical profession or is even aware of, but across the country the issue is unrelenting. Young graduates of our surgical programs languish, taking locum jobs or moving great distances and even countries to find work, or retraining in more employable specialties. Cardiac surgeons were the first ones affected; many have been under- or unemployed since the decline in open bypass surgeries led to a decreasing need for cardiac surgeons. Next came difficulties for orthopedic surgery graduates, and most recently general surgeons have had difficulty finding work. This is extraordinary and unprecedented though it has largely gone unnoticed by the general public. Some surgeons have left the country — not for more lucrative jobs as in days past, but rather for any permanent job at all.

The overall feeling among trainees is that this lack of opportunity represents a major deficiency in our health care system, and many feel justifiably angry at a system that demanded so much of them during their training. Although none of these individuals are “owed” anything, including a job, the society that paid to train them certainly is. It is hard to quantify the wasted resources that are consumed by an unemployed surgeon — our tax dollars subsidized a decade of medical and residency training for each trainee, and that subsidized training must be added to the cost of future productivity lost. Further, unemployment wastes the talent and time of some of the most educated, skilled workers in the country.

Moreover, we owe it to our patients to address this issue. Day in and day out, patients allow residents to care for them with graduated levels of supervision. Undoubtedly, these patients accept the risk of being cared for by trainees in exchange for its equal benefit — doctors on hand during the night, for example — but they do this with a certain unstated understanding that this training yields expertise that will benefit society for decades to come. The eventual unemployment of these physicians not only wastes extraordinary amounts of money, resources and the time of clinical teachers, but also breaks this implicit social contract. All patients who are cared for by trainees should be concerned that these surgeons they are helping to train may not have a place to practise the skills they have acquired after they graduate.

Are there any solutions to this growing problem? One promising concept is that of practice sharing. That is, as senior surgeons begin to wind their practices down, they partner with young surgeons starting out. Operating times can be split, with the elder surgeons taking progressively less time going forward. This model has several advantages. First, in hospitals where resources are limited, the senior surgeons do not “tie up” positions until formal retirement, allowing the younger surgeons the prospect of some future stability. There is a huge benefit to providing a smooth transition to new staff members. As the work curve of the senior surgeons winds down, the younger colleagues wind up. One of the challenges for senior surgeons is the burden of call responsibilities as they age, which could be eased by practice sharing with junior colleagues. Many recently certified surgeons are in the early stages of starting a family, and another potential personal benefit of practice sharing for junior surgeons is that it would enable them to spend more time with their families during this crucial phase of family life.

Of critical importance is the role of mentoring. The practice sharing model builds in strong mentoring for junior surgeons. Many surgeons, as they look back on their first several years in practice, realize that they needed mentoring during this important phase, in which a great deal is learned about surgical judgment, patient selection and technical approaches to difficult cases. Practice sharing would provide a formal structure for mentoring these new surgeons, complementing the informal and ad hoc way in which senior mentors are identified and used at present. Ultimately, this may also lead to better patient outcomes, whereby better mentoring encourages better decision making in patient care.

So how can hospitals begin to use this new model? Certainly leadership at the hospital level is essential for the success of this new model. From an administration standpoint, arranging practice sharing should require little in the way of additional resources, as the senior and junior surgeons would be sharing operating time and potentially other secondary support staff as well.

Ultimately, leadership at the provincial and federal levels is critical to address the root cause of the employment crisis in surgery. Rigorous evaluation of the numbers and of the specialty requirements needed to provide adequate surgical care across the country is long overdue. If there are mismatches in demand, the numbers of trainees should be adjusted to fit the projected workforce needs. Traditionally, academic health centres have relied on resident house staff. However, as physician extenders like nurse practitioners and physician assistants become more common, academic centres may instead be able to reduce the service roles currently filled by superfluous trainees. This would allow educational centres to focus on trainee education and experience while at the same time reducing the numbers of eventual graduates who are unemployable given projected national and provincial needs.

Our government needs to make a serious effort to address unemployment. It is not ethical for the system to put highly talented individuals through 5–10 years of rigorous clinical and research training to have little prospect of permanent appointment at the end. It will erode morale and collegiality. Practice sharing presents a viable alternative that can benefit all involved. We all owe it to our patients to improve our health care system, and planning for the employment of young surgeons is an important part of this.

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Competing interests: None declared.

Contributors: Both authors contributed substantially to the conception, writing and revision of this commentary and approved the final version for publication.

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