

EDITORIAL

Pro publica, pro bono, pro persona. The changing nature of surgical care—what happens when contributors retire?

Mark W Ashton MD, MBBS, FRACS (Plast)  0000-0002-5104-480X,^{1-3,a}

Mark Lee MBBS, FRACS (Plast)  0000-0002-5285-8266³⁻⁵

¹ Clinical Professor of Surgery, Department of Surgery, University of Melbourne, Parkville, Victoria, AUSTRALIA.

² Chairman, Professorial Plastic Unit, Epworth Freemasons Hospital, East Melbourne, Victoria, AUSTRALIA. ³ Editor-in-Chief, Australasian Journal of Plastic Surgery, St Leonards, New South Wales, AUSTRALIA. ⁴ Plastic and Reconstructive Surgery, St John of God, Subiaco, Western Australia, AUSTRALIA. ⁵ Plastic Surgery, Hollywood Private Hospital, Nedlands, Western Australia, AUSTRALIA.

Keywords: surgeons, work-life balance, workplace, attitudes, clinical competence

Submitted: September 04, 2024 AEST Accepted: September 04, 2024 AEST

DOI: 10.34239/ajops.123355

Australasian Journal of Plastic Surgery

Vol 7, Issue 2, 2024

Our society is changing. Rapidly. Many of the norms and embedded behaviours of our culture at the end of the last century are now being openly challenged by a new generation and a new appraisal of how we as a society function. One of these changes is to workplace involvement and our attitudes about work. Initially driven by a desire for a better work-life balance and a new focus on life outside of work, the forced lockdowns imposed upon us by COVID-19 and the subsequent change to working from home cemented a change in how society approaches work, how we perform that work and how many hours within a week we are prepared to devote to that work. Surgeons are not immune to this change. Indeed, many of the broader attitudinal changes encompassed in the so-called new ‘family-work-life balance’ in society are also reflected in the changing attitudes of surgeons toward their work—how many hours they are prepared to devote—and therefore their commitment to patients particularly in the provision of after-hours care. This new change directly impacts upon the health system’s capacity to provide for a community that depends upon medical practitioners as a whole, especially in rural and remote Australia and Aotearoa New Zealand, where many practitioners and surgeons were traditionally expected to provide a 24 hours a day, seven days a week service. This societal change consequently has major ramifications for the future provision of health care to all of society...the society that as medical practitioners and surgeons we traditionally have pledged to serve.

Every two years the Royal Australasian College of Surgeons (RACS) conducts a general workforce survey. This census collects data on work patterns and future work intentions of Fellows of RACS. The most recent survey has been analysed. In 2022, full-time Fellows worked an average of 45.9 hours per week, compared to 47.1 hours in 2020, 50 hours in

^a Corresponding author: Mark W Ashton MD MBBS FRACS (Plast); mwashton@icloud.com

2018 and 51 hours in 2016.¹ This incremental but consistent decrease in the number of hours worked is reflected in censuses over the last 15 years. Full-time surgeons are working less.

Additional questioning revealed that full time Fellows would prefer to work on average 2.1 hours (or half an afternoon) less per week. Reflecting societal change, where older age groups hold on to previous norms, in 2022 male surgeons aged 50–59 worked the most hours per week. This was followed by males aged 40–49. While most Fellows over the age of 65 intend to continue in paid work, two-thirds of Fellows aged 50–59, intend to retire completely from all forms of work within the next 10 years. All Fellows across all groups intend to gradually reduce their weekly work hours over the next 10 years.

This societal change is further exacerbated by a structural change within the public health system where almost all our junior surgeons are trained. At the end of the last century, most doctors were trained in an in-house model where exhausting constant service provision was integral to the overall training process. It was not uncommon for junior doctors to work continuously for three days at a time and for surgeons in training (registrars) to be available and work 24 hours a day for 12 days out of 14. Clearly this was not sustainable.

But the move to a shift-based training program has resulted in a significant change to the expectations of new surgeons toward work. We have invited Dr Aidan Fitzgerald to summarise his PhD about these changing attitudes as an invited editorial.² As Dr Fitzgerald highlights, the change to a shift-based training experience has had unintended consequences. Because the new trainee is at the workplace for less time, there is ‘a reduced ability to experience and nurture shared learning and working environments’² and to work as a team. Further:

it has significantly reduced the transference of professionalism through the hidden curriculum (the informal means by which professional behaviours are passed on to the next generation subliminally by the interaction of trainees with trainers).²

And we would submit there is less time to master the manual or physical attributes of being a surgeon. Older surgeons would say the younger trainee is book smart but lacks time on the tools.

That is true, but no one would propose a return to the previous training model.

As a society we are therefore confronting a conundrum. We need to train our surgeons, and we know that this takes time. As previously published in this journal³ the ‘10,000 hours rule’ applies to surgery—just as it does to a violin virtuoso. Our trainees must have access to surgical training time. It is integral to mastering the manual skills of being a surgeon, but also to learning the hidden or unspoken competencies that are fundamental to what we as a society perceives is a ‘good’ surgeon.

And therein is the dilemma facing society. No one would wish a return to the horrendous working hours of the late twentieth century, but equally we need to train our new surgeons completely. Our recent change to a competency-based program is intended to encompass these new demands for maintenance of skill set, while still accommodating the new ethos of work ethic and work hours.

But we should be clear, the new surgical community will be very different to the current providers of care. The RACS census provides a hint of the future direction.

Surgeons in the future will want to work less, not more. The provision of after-hours care will be impacted by the now entrenched work-life balance that is afforded to all other parts of society and, as a consequence, after-hours care by surgeons will be harder to obtain.

The more worrying statistic is that 65 per cent of all RACS surgeons in the last census¹ provided pro bono or volunteer work. This was primarily in teaching and education. If societal norms change in the way they have elsewhere in society, it is foreseeable that this provision of service—which is currently provided for free and is unrecognised by government and funding bodies—is also under threat. It is not unreasonable to expect that surgeons wanting to improve their work-life balance will reduce unpaid work, putting at risk teaching, examining, hospital medical advisory committees, governance boards, research and additional professional development. The question for society is, who will provide this unpaid work when the older generation of ‘contributors’ retires?

Added to this trend is the currently underestimated impact of fertility and family. We have seen encouraging rises in the number of female surgeons in all specialties. This is to be welcomed. Surgical training however now coincides with the biological reality of peak

opportunity to have children. Balancing these two opposing roles can result in extended training time and, given evidence that even in dual income households women consistently bear the greater domestic and childrearing burden,⁴ this will further influence the number of surgeons working full-time. Society therefore must enable female trainees to not only care for a young family and train in surgery, but also to then establish a surgical practice following graduation.

At a time when healthcare is already deemed to be expensive and access to specialist surgical care difficult to obtain (particularly after-hours service and care in rural and remote Australasia), the recent trends in the surgical workforce combined with the attitudinal changes to after-hours work and volunteer teaching and education mean that the future cost of surgical care must rise. Far beyond what is currently planned. And access to that care will be harder to obtain.

References

- 1 Royal Australasian College of Surgeons. *Surgical workforce 2022 census report* [PDF on Internet]. Sydney: RACS. [Published 2023; cited 2 September 2024]. Available from: <https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/reports-guidelines-publications/workforce-activities-census-reports/PUB-2022-Surgical-Workforce-Census-Report---final.pdf?rev=4df8fb5add5949109776b0b0c5bd0d4e&hash=92EBAD7C555D97E8834EF3A36A4F05B5>.
- 2 Fitzgerald A. The changing face of professionalism. *Australas J Plast Surg.* 2024;7(2):122348. <https://doi.org/10.34239/ajops.122348>
- 3 Ashton M, Lee M. Cosmetic surgery—why training matters. *Australas J Plast Surg.* 2022;5(2):1–4. <https://doi.org/10.34239/ajops.v5n2.413>
- 4 Australian Bureau of Statistics. Females do more unpaid work, males do more paid work [media release]. Canberra: ABS. [Released 7 October 2022; cited 2 September 2024]. Available from: <https://www.abs.gov.au/media-centre/media-releases/females-do-more-unpaid-work-males-do-more-paid-work>.



CC-BY-4. This is an open access article distributed under the Creative Commons Attribution 4.0 International License (CC-BY-4) which permits unrestricted use, distribution and reproduction in any medium, provided the original work is properly cited. View this license's legal deed at <http://creativecommons.org/licenses/by/4.0> and legal code at <http://creativecommons.org/licenses/by/4.0/legalcode> for more information.