

THE FIVE TIER SURGICAL CAREER

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The Seven Ages of Man by S Harris (with Acknowledgement to New Yorker Magazine)

Introduction

The long established general surgical career model in the UK is crumbling. Training times for surgeons have been seriously curtailed, with loss of depth, and breadth, of experience on reaching consultant status. The emerging NHS service configuration, of district general hospitals feeding into specialist surgical centres, produces a requirement for a large number of generalist surgeons to service local routine and emergency workload, and a smaller number of specialist surgeons for complex elective caseload.

The extension of the mandated retiring age to 65 and beyond, places new demands upon the tired minds and bodies of surgeons, whose modern stovepipe careers have ensured that they have already lost much of the interest arising from the breadth of practice enjoyed by earlier generations. The contraction of economic activity is curtailing the volume of private practice in many areas, thus reducing the options for professional practice still further. The substantial reduction in retirement incomes, resulting from the inevitable ending of final salary pension schemes, will ensure that few surgeons will have the option of a comfortable opt-out clause from age 55 years onwards, with 66-68 being nearer to the norm.

The time has come to re-examine all of the assumptions around the surgical career structure, and to consider a wholly different evolutionary model which addresses these challenges in a logical way. This is, at least, in so far as it affects surgeons in the sub-specialities of general surgery, where safe provision of the emergency take in hospitals across the country remains a driving factor for providers. There is a general recognition of the benefits of separating elective and emergency surgical

services, and of distinguishing between them, as set out in a working document of the Royal College of Surgeons of England in 2007 [1].

Without the substantial increase in workforce, which now seems to be ruled out for the foreseeable future, we can take the following factors as given:

- Consultant surgeons will have to continue to take on a greater proportion of "out of hours" and emergency workload, with fewer experienced and capable trainees to share it.
- A two tier system of General Service Hospitals and Specialist Tertiary Centres is evolving. These are not necessarily synonymous with existing DGHs and University Teaching Hospitals, as tertiary units may develop in the former.
- An extended working life will produce heavy, and possibly intolerable, physical, fatigue and emotional burdens upon consultant surgeons who, until now, have had the comfortable financial and psychological option of retirement from 60 onwards.
- Mid and late career stress and burnout are significant and will increase [2].
- Any model which emerges will have to be evolutionary, rather than revolutionary, and flexible and adaptable to a wide variety of different circumstances.

The Five Decade Surgical Career

Surgery presently has a very limited career structure for most individuals. In the most general terms, from leaving school until around the age of 37, surgeons will be in extended higher education and a progressive supervised practical apprenticeship in general and specialist surgical practice. From then on, they will generally work for a monopolistic employer, in a fairly predictable and structured daily practice, until retirement, with the option of some variety in parallel employment, primarily in independent practice to a greater or lesser degree.

Some individuals will secure variety through academic career development, although this has been considerably curtailed in the past decade; others will take up parallel administrative and managerial commitments; others may occasionally move geographically from one hospital to another; and some will contribute to the work of the Surgical Royal Colleges, the Specialty Associations, the Defence Medical Services, and to national political life. Many will endure a growing sense of repetitive boredom, frustration and fatigue, which must be concealed in public, but which is often very real in private.

Based upon the racing certainty of a minimum national pensionable retirement age of 66, and possibly 68 within a few years, we can consider

what form a re-engineered surgical career might take over five decades, providing regular refreshment, countering fatigue, and securing employer satisfaction from a wholly engaged surgical workforce.

The First Surgical Decade: The Educational Years (17 to 26-ish)

These years, from the latter time at school, through undergraduate education, to the early postgraduate phase of junior doctor posts, may not require much change. The surgical persona will select itself for career progression. However, it will be necessary to build more "whole of life" coaching into the curriculum, to mould career planning and expectations.

The Second Surgical Decade: The General Training Years (27 to 36-ish)

Compared with a generation ago, when surgical training was estimated to have consumed some 30,000 professional hours, this Training Decade now offers around 8,000 professional hours. This is a relatively limited time to secure a broad general and emergency expertise, along with specialist expertise. The essence of this proposal is that the focus shifts to a greater emphasis on the development of skills for acute and emergency service provision, with a lesser emphasis on sub-speciality experience.

The Third Surgical Decade: The Emergency Surgical Service Years (37 to 46-ish)

The newly appointed consultant would expect a high intensity and frequency of acute and emergency workload, involving a significant proportion of professional time and focus "on-call". Elective time would be spent within multidisciplinary units, under mentorship, and attending specialist courses, in preparation for a later sub-speciality interest.

The balance of remuneration would have to shift significantly, such that nights spent on-call and at work were much better financially rewarded than at present, when compared to daytime elective practice. This would compensate and incentivise for less specialist public and independent practice at this phase in the surgical career, and *vis a vis* those who were unable, or unwilling, to make such an emergency commitment for domestic and family reasons.

The Fourth Surgical Decade: The Specialist Years (47 to 56-ish)

The fourth decade would see a significant shift from high intensity general and emergency practice to specialist practice, and a much less onerous on-call schedule. Loss of income from emergency work would be compensated by a growing specialist practice, and more quality downtime for other personal and professional interests.

The Fifth Surgical Decade: The Elder Statesperson Years (57 to 66-ish)

The final decade of surgical practice would complete the shift from emergency service commitments to specialist elective practice. It would provide the opportunity for a senior surgeon to move into hospital administration and management posts with the benefit of considerable life experience and institutional knowledge; or to make a greater commitment to other professional activities.

Summary

A fresh philosophical approach to the surgical career would recognise, and address, many of the problems of burnout and stagnation which affect the latter phase of many professional careers. It would institutionalise career migration and retraining for different career phases, and maintain momentum and sustain interest across a career. The driver to change would be a much greater financial weighting to emergency and on-call commitments, which, in turn, would induce hospital managements to look much more rigorously at efficient emergency service provision, to minimise out of hours workload and its associated costs.

Within the philosophical framework, change would occur at different rates, and in different forms, in different hospitals, according to professional age and skills mix. The proposed changes engage the profession, employers, the Colleges, the Deaneries and the Specialty Associations. They are intended to be evolutionary rather than revolutionary within the existing employment and training structures, although they will result in changes of emphasis for individuals at different ages and career stages. They may involve more career and age associated migration between General Service Hospitals and Specialist Centres.

A vigorous debate on whole-career management within the surgical profession is long overdue. This paper is merely a ranging shot in the debate.

*All the world's a stage,
And all the men and women merely players:
They have their exits and their entrances;
And one man in his time plays many parts,
His acts being seven ages....*

As You Like it
William Shakespeare

References

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- [2] **Sharma A, Sharp D M, Walker L G, Monson J R**
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