The Surgical Workforce 2005

Based on the 2005 Census of the Surgical Workforce

Published 7th March 2005
Background:

Sustainability of the health workforce is a central concern for the Australian population. At the 2004 Australian Health Ministers’ Conference a National strategic framework for managing the Australian Health Workforce was laid out\(^1\). The overarching mission for this framework was that:

“Australia will have a sustainable health workforce that is knowledgeable, skilled and adaptable. The workforce will be distributed to achieve equitable health outcomes, suitably trained and competent. The workforce will be valued and able to work within a supportive environment and culture. It will provide safe, quality, preventative, curative and supportive care that is population and health consumer focussed and capable of meeting the health needs of the Australian community.”

The College considers that there is a critical role in supporting this mission by developing a comprehensive understanding of complex workforce dynamics in play today within the surgical sector. This will enable the College to strengthen its capacity to support and respond to the information needs of the wider community.

To begin the process of building this comprehensive picture, a survey of the Australian RACS Surgical Workforce was undertaken by the College from October to December 2005. The RACS Surgical Workforce survey was sent to all Active Fellows in Australia and a response rate of 80% was achieved.

The survey results therefore represent the most robust collection of information relating to surgical work practises and patterns, current gaps, and future supply issues currently available in Australia.

Throughout 2006 Workforce Assessment will continue this agenda by further interrogating the data and conducting complementary qualitative and quantitative research and creating tailored workforce projections. The forecast period will be from 2006 to 2010 and will initially focus on Australian based Fellows and will later include New Zealand, following the completion of their Surgical Needs Analysis Project\(^2\).

Method:

In October 2005, all Active Australian Fellows (3,343 Fellows) were invited to participate in the Surgical Workforce Questionnaire either by completing a paper-based survey or online survey. Three follow-up emails and two follow-up phone calls were made to non-respondents.

There were 2,665 respondents to the survey and 61 Fellows who were non-practising during the census period. An overall response rate of 79.7% was achieved, representing a statistically significant sample for estimating the total Active Australian Fellowship population with a ±3% level of statistical accuracy at the 95% confidence level.

Throughout the report, statistics shown are based on the total Active Australian Fellowship which is estimated from the sample of Fellows who responded to the census. Sample mean, proportions and ratios from the RACS Census of the Surgical Workforce 2005 are therefore been used to estimate the trends for the total Active Fellowship. The response rate and sampling error have been calculated and incorporated into the analysis.

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\(^1\) Australian Health Ministers’ Conference (2004) National Health Workforce Strategic Framework

\(^2\) The Surgical Needs Analysis Project seeks to estimate the number of surgeons New Zealand is likely to require in the future, at the level of DHB area and surgical subspecialty, by considering the current load and the community’s need for surgical service. It is anticipated that the SNAP analysis will be completed by mid 2006, following initial delays due to funding.
Key Findings:

- On average, the Active Australian Fellowship worked 51 hours per week in 2005. The highest number of hours per week (52.3 hours) occurred in the 45 to 49 year old age group.
- The number of hours worked in a week by Australian Fellows is expected to decline over the next 5 years by 7.3%, from an average of 51 hours per week to 47 hours per week.
- 3 out of every 5 hours worked in 2005 occurred in the private sector. Close to two-thirds of work carried out by Plastic and Reconstructive surgeons took place in the private sector (69%). Cardiotoracic surgeons however worked a greater proportion of their time in the public sector (53%). The proportion of private hours worked to total hours worked for Australian surgeons is expected to increase in the next 5 years from 61.5% in 2005 to 62.9% in 2010.
- The on-call cycle for RACS surgeons practicing in Australia was highly diverse. The average number of days on call per year was 108 days (or 30% of the year). In the private sector on-call duties were higher with 161 on-call days per year (or 44% of the year).
- Ninety-one percent of the Fellowship are involved in some form of training supervision, providing on average, 10.2 hours of supervision per week. The range of hours of supervision is between 6.8 and 13.6 hours per week.
- The average workload of Fellows who considered that their surgical practice was “too heavy” was 47 consulting and operating sessions per month, with an average working week of 52.9 hours. Nearly one in five Fellows however stated that their workload was “heavy” to “extreme”.
- Issues of sustainable work patterns for Australian Fellows have been an ongoing discussion within the Fellowship. As part of this dialogue, the Divisional Group of Rural Surgery have released a position paper proposing a standard for rural surgeons’ working hours. The paper states that standards for rural surgeons’ maximum working hours need to be realistic, safe and flexible.
- The surgical workforce is ageing. Forty-two percent of the Fellowship in Australia are aged 55 years and over. The average age of the Fellowship is 55.6 years.
- Nearly 1 in 7 Active Fellows are not participating in the surgical workforce or have reduced participation due to phasing into “semi-retirement”. The average hours worked by Fellows who consider themselves “Semi-retired” is 32.4 hours per week. Fellows who state that they are phasing into “retirement”, work on average 14.4 hours per week, and are largely involved with providing consulting services.
- Approximately, one in seven Fellows work on a part-time basis. Three-quarter of these Fellows are aged 55 years and over (74.2% or 368 Fellows).
- One third of the current Active Fellowship expected to retire in the next five years from emergency call work (1,120 Fellows). Seventy-six percent of this group are also intending to retire from operative practice in the next five years (852 Fellows).

Key Future Questions to be Addressed:

1. What will be the impact of reduced working hours of surgeons in the Australian context in the future – workforce requirements, patient care and training opportunities?
2. What is the impact of more hours worked in the private sector compared to the public sector?
3. What factors may influence working hours in the future?
4. What is considered an unacceptable on-call cycle? - What are the implications for the number of surgeons needed in the future?
5. Should / How can working pattern guidelines for surgeons be supported in the Australian context?
6. How do you maximise opportunities to retain surgeons in the workforce? – What factors influence the retention of older surgeons?
7. What are the implications of retirement on current succession planning and supervision requirements? – Are systems in place to support training requirements in the future?
8. How will mal-distribution be impacted by increasing retirements?
Introduction

The 2005 Survey of the Australian Surgical Workforce has provided a wealth of information on current and future in the work practices of Australian Fellows. This paper provides a summary of some of the key findings that have emerged from the data relating to working patterns (Part 1) and ageing and retirement (Part 2). Information is presented by specialty, jurisdiction and region. Supplementary national and international information has also been included where it provides a context to these issues.

Snapshot of the Australian RACS Fellowship 2005

The Surgical Workforce Survey studied 3,401 Active Australian Fellows based on the average number of Australian College Fellows for 2005. The largest specialty groups in 2005 were General Surgeons (1,180 Fellows or 36%) and Orthopaedic Surgeons (883 Fellows or 26%). The smallest specialty group was Paediatric Surgeons (84 Fellows or 2%). New South Wales and Victoria Fellows collectively represented 3 out of every 5 Fellows in Australia (2,065 Fellows).

One fifth of the Fellowship in Australia practised in non-metropolitan areas (634 Fellows) based on College Area Classifications. The RRMA remoteness indicator highlights that 3 in 4 surgeons practised in capital cities. Sixteen percent of the Fellowship are considered to operate and/or reside in rural and remote zones.

Table 1: 2005 RACS Active Australian Fellowship by RRMA Remoteness Indicator, Australia.

<table>
<thead>
<tr>
<th>RRMA Remoteness Indicator</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan Zone</td>
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<td></td>
</tr>
<tr>
<td>Capital Cities</td>
<td>2546</td>
<td>74.9%</td>
</tr>
<tr>
<td>Other Metropolitan centres (&gt;100,000)</td>
<td>301</td>
<td>8.9%</td>
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<tr>
<td>Rural Zone</td>
<td></td>
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<tr>
<td>Large Rural Centre (25,000-99,999)</td>
<td>257</td>
<td>7.6%</td>
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<tr>
<td>Small Rural Centre (10,000-24,999)</td>
<td>133</td>
<td>3.9%</td>
</tr>
<tr>
<td>Other Rural Areas (&lt;10,000)</td>
<td>98</td>
<td>2.9%</td>
</tr>
<tr>
<td>Remote Zone</td>
<td></td>
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<tr>
<td>Remote Centre (&gt;5,000)</td>
<td>66</td>
<td>1.9%</td>
</tr>
<tr>
<td>Total</td>
<td>3401</td>
<td>100.0%</td>
</tr>
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</table>

3 The 2005 Surgical Workforce Study is based on an average of the number of Australian RACS Fellows for 2005 and includes all Fellows who joined in 2005 and excludes all Fellows who retired in 2005.
4 RACS Area Classifications extracted from the 2005 Surgical Workforce Survey: Q.A3: Best describe your location = 1: Metropolitan 2: Regional/Rural/Remote
5 Table 1 includes Fellows who may be semi-retired or retired and therefore have based their place of practice on their residential address.
Part 1: Working Patterns

Part 1 of this summary paper examines findings from the 2005 Surgical Workforce Survey that relate to working patterns. This section will describe and discuss working hours by specialty, jurisdiction and region; the comparative hours worked in the private and public sector; future trends in working hours; on-call requirements; as well as training supervision.

Current Hours of Work

The Active Australian Fellowship worked an average of 51 hours per week in 2005, equating to 45.4 operating and consulting sessions per month. The hours worked by the surgical workforce were however above the average across other occupational groups, where an average of 40.4 hours is worked per week.\(^6\)

Hours worked differed by surgical specialty. The highest average hours worked per week across specialties were in Orthopaedic surgery (51.9 hours) and Otolaryngology (51.5 hours). Higher working hours were also noted in the smaller territories of Australia (Northern Territory; 60 hours per week and Australian Capital Territory; 56.6 hours per week) as well as non-metropolitan areas of Australia (53.5 hours per week).

The average hours worked by Fellows also varied by age. The highest number of hours per week (52.3 hours) occurred in the 45 to 49 year old age group. Consulting and operating practise progressively declined after the age of 50 years, yet hours across all age groups remained significantly higher when compared to other occupational groups.

Sixty-two percent of hours worked by Australian Fellows occurred in the private sector. By specialty, the hours worked by Plastic and Reconstructive surgeons were more concentrated in the private sector (69%), while Cardiothoracic surgeons tended to work a greater proportion of their time in the public sector (53%). The highest proportion of private working hours by state was in the Australian Capital Territory (70%) and Queensland (64%). Regionally metropolitan Fellows worked more hours in the private sector (62%).

### Table 2: 2005 Active Australian Fellowship by Consulting and Operating Hours per Week, Australia.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Consulting Hours</th>
<th></th>
<th>Consulting Mean</th>
<th></th>
<th>Consulting 95% Confidence Interval</th>
<th>Operating Hours</th>
<th></th>
<th>Operating Mean</th>
<th></th>
<th>Operating 95% Confidence Interval</th>
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<td>Public</td>
<td>Total</td>
<td>Hours</td>
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<td>Hours</td>
<td>Hours</td>
<td>Hours</td>
<td>Mean</td>
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<td>12.5</td>
<td>17.4</td>
<td>29.8</td>
<td>22.7</td>
<td>25.4</td>
<td>48.1</td>
<td>8.6</td>
<td>30.9-65.3</td>
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<td></td>
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<td>30.1</td>
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</table>


**Future Hours of Work**

The number of hours worked in a week by Australian Fellows is expected to decline over the next 5 years by 7.3%, from an average of 51 hours per week to 47 hours per week. The most noticeable declines in hours worked are expected in Orthopaedic (-14.6%) and Paediatric surgery (-12.7%). Significant declines in the number of hours worked will also occur in non-metropolitan regions (-9.9%), with average working hours shifting from 53.5 hours per week to 48.2 hours per week between 2005 and 2010.

A further visible trend is the increase in the proportion of private to public working hours between 2005 and 2010. The proportion of private hours worked to total hours worked for Australian surgeons is expected to be:

- 2005 – 61.5%
- 2007 – 62.7%
- 2010 – 62.9%
Table 3: 2005 Active Australian Fellowship by Expected Hours of Work per Week, Australia.  

<table>
<thead>
<tr>
<th>Specialty</th>
<th>2005</th>
<th>2007</th>
<th>2010</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
<td>Hours</td>
<td>Hours</td>
<td>Hours</td>
<td>% Change</td>
</tr>
<tr>
<td>Cardiothoracic</td>
<td>48.1</td>
<td>45.9</td>
<td>45.3</td>
<td>-5.8%</td>
</tr>
<tr>
<td>General</td>
<td>51.1</td>
<td>49.4</td>
<td>47.9</td>
<td>-6.3%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>49.8</td>
<td>46.8</td>
<td>45.2</td>
<td>-9.2%</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>51.9</td>
<td>46.1</td>
<td>44.3</td>
<td>-14.6%</td>
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<td>Otolaryngology</td>
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<td>47.7</td>
<td>47</td>
<td>-8.7%</td>
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<td>42.3</td>
<td>40.6</td>
<td>-12.7%</td>
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<td>Plastic &amp; Reconstructive</td>
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<td>46.6</td>
<td>-8.4%</td>
</tr>
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<td>Vascular</td>
<td>47.8</td>
<td>43.8</td>
<td>43.1</td>
<td>-9.8%</td>
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<th>State</th>
<th>Hours</th>
<th>Hours</th>
<th>Hours</th>
<th>% Change</th>
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</thead>
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<td>57.2</td>
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<td>-9.3%</td>
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<td>-10.0%</td>
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<td>TAS</td>
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<td>-9.4%</td>
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<td>VIC</td>
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<td>-8.0%</td>
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<td>WA</td>
<td>52.6</td>
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<td>-9.5%</td>
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<table>
<thead>
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<th>Region</th>
<th>Hours</th>
<th>Hours</th>
<th>Hours</th>
<th>% Change</th>
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<tr>
<td>Metro</td>
<td>50.3</td>
<td>48.9</td>
<td>47.1</td>
<td>-6.4%</td>
</tr>
<tr>
<td>Non-Metro</td>
<td>53.5</td>
<td>53.2</td>
<td>48.2</td>
<td>-9.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All</th>
<th>Hours</th>
<th>Hours</th>
<th>Hours</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>51</td>
<td>49.9</td>
<td>47.3</td>
<td>-7.3%</td>
</tr>
</tbody>
</table>

Source: RACS (2005) RACS Management Report; RACS (2005) Surgical Workforce Survey (Refer to Appendix One for a Full Breakdown of hours including Standard Deviation and 95% Confidence Interval)

On-call Cycle

Ninety-one percent of the Active Fellowship in Australia have on-call duties. Sixty percent have on-call duties in the private and public sector, while a further 17% have on-call duties only in the public sector.

Figure 3: Active Fellowship by On-call Duties by Sector, Australia.

On-call Duties by Sector

95% Confidence Interval:
- 2005 = 41.0 to 61.0
- 2007 = 42.1 to 57.7
- 2010 = 40.7 to 55.1

Refer to Appendix 1 for a full breakdown.
The on-call cycle for College surgeons practicing in Australia was highly diverse, with rosters based on days in days, weeks in weeks, days in a month and/or weekends in weekends. On-call duties were also significantly different between the public and private sector. In the public sector the most common on-call cycles were:
- 1 week in 4 weeks
- 1 week in 3 weeks
- 1 day in 7 days
- And 1 in 4 weekends

For the private sector the most common on-call cycles were:
- 1 day in 1 day (at all times)
- 1 week in 3 weeks
- And 1 weekend in 4 weekends

Refer to Appendix 2: On-call cycles, for a full breakdown of on-call cycles in the private and public sector.

Three-quarter of the Australian Fellowship agree however that a ‘1 in 4’ on call roster is the maximum from a safe performance perspective in their specialty and practice location. (Refer to Appendix Six). Other on-call rosters that were considered suitable from a safe performance perspective were 1 in 3, 1 in 2 and 1 in 6.

Table 4: 2005 RACS Active Australian Fellowship, Suitable On-call Rosters from a safe performance perspective (Other)

<table>
<thead>
<tr>
<th>Consider a suitable On-call Roster from a safe performance perspective (Other)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 in 3</td>
<td>22.9%</td>
</tr>
<tr>
<td>1 in 2</td>
<td>14.3%</td>
</tr>
<tr>
<td>1 in 6</td>
<td>11.7%</td>
</tr>
<tr>
<td>1 in 5</td>
<td>10.0%</td>
</tr>
<tr>
<td>1 in 7</td>
<td>8.6%</td>
</tr>
<tr>
<td>1 in 1</td>
<td>4.1%</td>
</tr>
<tr>
<td>1 in 8</td>
<td>4.3%</td>
</tr>
<tr>
<td>1 in 10</td>
<td>2.9%</td>
</tr>
<tr>
<td>1 in 14</td>
<td>2.3%</td>
</tr>
<tr>
<td>1 in 14</td>
<td>1.8%</td>
</tr>
<tr>
<td>2 in 14</td>
<td>1.5%</td>
</tr>
<tr>
<td>3 in 4</td>
<td>1.4%</td>
</tr>
<tr>
<td>Other</td>
<td>14.3%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>


Surgeons comments on on-call rosters are as follows:

"A one in three roster may be acceptable if the load is light and there is support from good quality trainees; when my role is advisory and supervisory rather than constantly hands-on."

"The maximum safe on-call roster depends on how often one is called; the workload and duration."

"1 in 6 is more civil as it allows for time to recover and provides for relief during leave."

"Need to balance work with family commitments and lifestyle"

-RACS Surgical Workforce Survey 2005
For all College surgeons the average number of days on call per year was 108 days (or 30% of the year). In the private sector on-call duties were higher with 161 on-call days per year (or 44% of the year). Across specialties Paediatric surgeons (mean = 120 days) and Neurosurgeons (mean = 111 days) had the highest number of on-call days per year in the public sector. Cardiothoracic surgeons (mean = 227 days) and Otolaryngologists (mean = 199 days) on-call in the private sector. On-call duties were considerably higher in non-metropolitan areas in both the private and public sector.

Table 5: 2005 Active Australian Fellowship by Average On-call Days per year, Australia.

<table>
<thead>
<tr>
<th>Group</th>
<th>Average On-call Days per Year: Public Sector</th>
<th>Average On-call Days per Year: Private Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiothoracic</td>
<td>101.1</td>
<td>86.7</td>
</tr>
<tr>
<td>General</td>
<td>75.7</td>
<td>60.7</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>111.5</td>
<td>88.2</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>79</td>
<td>60.1</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>84.9</td>
<td>65.0</td>
</tr>
<tr>
<td>Paediatric</td>
<td>120.3</td>
<td>86.9</td>
</tr>
<tr>
<td>Plastic &amp; Reconstructive</td>
<td>90.1</td>
<td>85.0</td>
</tr>
<tr>
<td>Urology</td>
<td>91.1</td>
<td>87.3</td>
</tr>
<tr>
<td>Vascular</td>
<td>111.1</td>
<td>100.3</td>
</tr>
<tr>
<td>State</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td>76.6</td>
<td>57.6</td>
</tr>
<tr>
<td>NSW</td>
<td>79.2</td>
<td>65.0</td>
</tr>
<tr>
<td>NT</td>
<td>120.3</td>
<td>107.2</td>
</tr>
<tr>
<td>QLD</td>
<td>87.9</td>
<td>65.4</td>
</tr>
<tr>
<td>SA</td>
<td>91.5</td>
<td>65.0</td>
</tr>
<tr>
<td>TAS</td>
<td>90</td>
<td>77.7</td>
</tr>
<tr>
<td>VIC</td>
<td>84.3</td>
<td>65.0</td>
</tr>
<tr>
<td>WA</td>
<td>88.7</td>
<td>67.0</td>
</tr>
<tr>
<td>Region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metro</td>
<td>83</td>
<td>65.0</td>
</tr>
<tr>
<td>Non-Metro</td>
<td>98.6</td>
<td>78.0</td>
</tr>
<tr>
<td>All</td>
<td>86</td>
<td>65.0</td>
</tr>
</tbody>
</table>

*Refer to Appendix Three for a Full Breakdown of on-call days per year

The average number of day’s on-call per year is calculated by mean and median of days per year in the private sector, public sector and sector undefined.
Training Supervision

The commitment by the Fellowship to training excellence is demonstrated by their level of engagement with training and supervision. Ninety-one percent of the Fellowship are involved in some form of training supervision, providing on average, 10.2 hours of supervision per week. The range of hours of supervision is between 6.8 and 13.6 hours per week (95% Confidence Interval.)

The time spent supervising trainees is considerable, particularly for Cardiothoracic surgeons (15.4 hours per week); Neurosurgeons (14.6 hours per week) and Paediatric surgeons (13.7 hours per week). Hours spent by surgeons supervising training are also substantial in the Northern Territory (18.3 hours per week) and the Australian Capital Territory (14.2 hours per week). Likewise training supervision is higher in metropolitan areas compared to non-metropolitan areas.

Table 6: 2005 RACS Active Australian Fellowship by On-call Days per year, Australia.

<table>
<thead>
<tr>
<th>Provision of supervision</th>
<th>Average Number of Hours of Supervision that is provided per week in hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic</td>
<td>127</td>
<td>100.0%</td>
<td>-</td>
<td>-</td>
<td>127</td>
<td>100.0%</td>
<td>15.4</td>
<td>2.6</td>
<td>10.3-20.5</td>
</tr>
<tr>
<td>General</td>
<td>1073</td>
<td>90.9%</td>
<td>107</td>
<td>9.1%</td>
<td>1180</td>
<td>100.0%</td>
<td>10.3</td>
<td>2.6</td>
<td>5.1-15.5</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>124</td>
<td>86.9%</td>
<td>19</td>
<td>13.1%</td>
<td>143</td>
<td>100.0%</td>
<td>14.6</td>
<td>2.7</td>
<td>9.2-20.0</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>794</td>
<td>90.0%</td>
<td>89</td>
<td>10.0%</td>
<td>883</td>
<td>100.0%</td>
<td>9.9</td>
<td>1.4</td>
<td>7.1-12.7</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>285</td>
<td>89.5%</td>
<td>33</td>
<td>10.5%</td>
<td>318</td>
<td>100.0%</td>
<td>7.8</td>
<td>2.5</td>
<td>2.8-12.8</td>
</tr>
<tr>
<td>Paediatric</td>
<td>81</td>
<td>96.8%</td>
<td>3</td>
<td>2.2%</td>
<td>84</td>
<td>100.0%</td>
<td>13.7</td>
<td>2.5</td>
<td>8.8-18.6</td>
</tr>
<tr>
<td>Plastic &amp; Reconstructive</td>
<td>263</td>
<td>92.2%</td>
<td>22</td>
<td>7.8%</td>
<td>285</td>
<td>100.0%</td>
<td>8.5</td>
<td>2.6</td>
<td>3.2-13.8</td>
</tr>
<tr>
<td>Urology</td>
<td>246</td>
<td>91.5%</td>
<td>23</td>
<td>8.5%</td>
<td>269</td>
<td>100.0%</td>
<td>8.6</td>
<td>2.0</td>
<td>4.5-12.7</td>
</tr>
<tr>
<td>Vascular</td>
<td>112</td>
<td>100.0%</td>
<td>-</td>
<td>-</td>
<td>112</td>
<td>100.0%</td>
<td>10.1</td>
<td>2.0</td>
<td>6.2-14.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>56</td>
<td>100.0%</td>
<td>-</td>
<td>-</td>
<td>56</td>
<td>100.0%</td>
<td>14.2</td>
<td>2.0</td>
<td>10.2-18.2</td>
</tr>
<tr>
<td>NSW</td>
<td>983</td>
<td>100.0%</td>
<td>179</td>
<td>15.4%</td>
<td>1162</td>
<td>100.0%</td>
<td>10.4</td>
<td>1.2</td>
<td>8.1-12.7</td>
</tr>
<tr>
<td>NT</td>
<td>21</td>
<td>100.0%</td>
<td>-</td>
<td>-</td>
<td>21</td>
<td>100.0%</td>
<td>18.3</td>
<td>2.7</td>
<td>12.8-23.8</td>
</tr>
<tr>
<td>QLD</td>
<td>574</td>
<td>94.8%</td>
<td>32</td>
<td>5.2%</td>
<td>606</td>
<td>100.0%</td>
<td>10.9</td>
<td>2.8</td>
<td>5.3-16.5</td>
</tr>
<tr>
<td>SA</td>
<td>293</td>
<td>94.4%</td>
<td>17</td>
<td>5.6%</td>
<td>310</td>
<td>100.0%</td>
<td>10.4</td>
<td>2.9</td>
<td>4.7-16.1</td>
</tr>
<tr>
<td>TAS</td>
<td>54</td>
<td>85.0%</td>
<td>10</td>
<td>15.0%</td>
<td>64</td>
<td>100.0%</td>
<td>11.3</td>
<td>2.9</td>
<td>5.4-17.2</td>
</tr>
<tr>
<td>VIC</td>
<td>856</td>
<td>94.8%</td>
<td>47</td>
<td>5.2%</td>
<td>903</td>
<td>100.0%</td>
<td>9.4</td>
<td>3.0</td>
<td>3.4-15.4</td>
</tr>
<tr>
<td>WA</td>
<td>269</td>
<td>96.3%</td>
<td>10</td>
<td>3.7%</td>
<td>279</td>
<td>100.0%</td>
<td>8</td>
<td>2.1</td>
<td>3.9-12.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metro</td>
<td>2536</td>
<td>91.5%</td>
<td>235</td>
<td>8.5%</td>
<td>2767</td>
<td>100.0%</td>
<td>10.5</td>
<td>1.5</td>
<td>7.6-13.4</td>
</tr>
<tr>
<td>Non-metro</td>
<td>573</td>
<td>90.4%</td>
<td>61</td>
<td>9.6%</td>
<td>634</td>
<td>100.0%</td>
<td>8.9</td>
<td>1.8</td>
<td>5.2-12.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>3105</td>
<td>91.3%</td>
<td>296</td>
<td>8.7%</td>
<td>3401</td>
<td>100.0%</td>
<td>10.2</td>
<td>1.7</td>
<td>6.8-13.6</td>
</tr>
</tbody>
</table>

**Fellowship Perceptions of their Current Workload**

Fellows were asked to consider how manageable their current workload and on-call duties were. Over half of the Fellowship (52.5% or 1,786 Fellows) considered that their surgery workload was “too heavy”. A considerably higher proportion of Plastic and Reconstructive surgeons (70.3% or 200 Fellows) and Vascular surgeons (60% or 67 Fellows) considered their surgical workload was “too heavy”. Three out of five Fellows aged 40 to 59 years expressed this concern.

The Northern Territory (80%) and the Australian Capital Territory (74%) had a higher proportion of Fellows who considered that their workload was “too heavy”. New South Wales, on the other hand had a smaller proportion of Fellows who regarded their surgical workload in this way (39%).

The average workload of Fellows who considered that their surgical practice was “too heavy” was 47 consulting and operating sessions per month, with an average working week of 52.9 hours.

**Figure 3-6: Active Fellowship by Proportion who consider their surgery workload is “too heavy”, Australia**
The level at which the Fellowship considers their workload to be “too heavy” is described in the table below. For the Fellowship to have a balanced workload, it is suggested from the table that they would need to work 41.7 hours per week$^9$.

Table 7: 2005 RACS Active Fellowship by Proportion of the workload that is “too heavy”, Australia.

<table>
<thead>
<tr>
<th>Proportion of the workload that is “too heavy”</th>
<th>Average Sessions per Month</th>
<th>Average Hours Worked per Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>45.1</td>
<td>50.7</td>
</tr>
<tr>
<td>20%</td>
<td>47.7</td>
<td>53.7</td>
</tr>
<tr>
<td>30%</td>
<td>48.6</td>
<td>54.7</td>
</tr>
<tr>
<td>40%</td>
<td>54.7</td>
<td>61.6</td>
</tr>
</tbody>
</table>


One third of surgeons described their workload on an average on-call day as “light”. A further 49% stated that there on-call duties were moderate. Nearly one in five Fellows however stated that their workload was “heavy” to “extreme”. A higher proportion of Neurosurgeons (28%); Orthopaedic surgeons (24%); and Paediatric surgeons (24%) regarded their workload to be “heavy” to “extreme”. There was no significant difference between metropolitan and non-metropolitan regions. Refer to Appendix Three for a breakdown of the full description of the workload on an average on-call day.

The level of acceptance of on-call commitments by Fellows was closely correlated with the number of days they were required for on-call duties per year. For surgeons who were required to be on-call for under 236 days per year, a negative relationship existed, whereby the more cycles they were required to be on-call for, the less acceptable their commitment was. In contrast however, for Fellows who were on-call for more than 236 days per year, a positive relationship emerged, with increasing acceptance of on-call requirements the heavier the duties became. Further investigation into this trend may reveal some important insights into how Fellows manage on-call requirements.

Figure 7: RACS Active Fellowship by Acceptance of On-call Commitments by On-call Days, Australia

$^9$ 41.7 hours = Average hours worked per week less proportion of the workload that is “too heavy” – 10% to 40%
Discussion on Working Patterns

Issues of sustainable work patterns for Australian Fellows have been an ongoing discussion within the Fellowship. As part of this dialogue, the Divisional Group of Rural Surgery have released a position paper focusing on standard for rural surgeons’ working hours. The paper states that standards for rural surgeons’ maximum working hours need to be realistic, safe and flexible. Recommendations for standard of staffing and practice in rural departments of surgery are provided and consider the following key points on rosters, on-call duties and leave allowances:

Rosters: “Roster and work planning must take into account that performance will be impaired by: continuous work shifts greater than 4 hours; starting a full work shift without at least 9 hours rest in the preceding 24 hours; not taking at least 36 consecutive hours off-duty per week; and sleep deprivation.”

On-call: “Experienced rural surgeons consider that the on-call roster should be no more frequent than 1 in 4 if fatigue is to be avoided.”

Leave: “Recommended leave is 6 weeks recreation leave; 2 weeks study leave and up to 1 week administrative leave.”

The Divisional Group of Rural Surgery position paper reflects the increasing focus externally on the issue of working hours, particularly by the Australian Medical Association (AMA). The AMA have developed a National Code of Conduct into the working patterns in the health sector. The Code responded to research showing that long working hours have a substantial impacts on the capacity to consistently deliver high quality patient care, the effectiveness of their training regime and overall negative consequences on surgeons’ health, social life and family responsibilities.

The Code does not necessarily require a shorter working week but seeks increased attention to ensuring that risk from working extended hours is assessed and minimised. They have developed a Risk Assessment Audit Tool to support this mission. The core measures of the audit included:

- Hours Worked: Each hour over 14 hours per day; no 30 minute break in 8 hours; Less than 10 hours until the next shift; Hours over 50 hours
- Night shifts
- Sleep taken during the day
- On-call rostering
- No full day free in the period

In 2005 a Code of Conduct a Risk Assessment Audit was undertaken. Results from the audit are displayed in table below by clinical discipline. It shows that half of the surgical clinicians assessed had a higher risk rating, with 12% showing a low risk rating. Across all disciplines surgery had the greatest proportion assessed at a higher risk.

---

12 AMA’s National Code of Practice - Hours of Work, Shiftwork and Rostering for Hospital Doctors, 1999

Sleep and Fatigue: Both lack of sleep and fatigue, individually and in combination, can adversely affect task performance levels, individual health and safety and the safety of others.

Disruption to Social and Family Life

Effects on Health: Continued exposure to the disruptions and dislocations created by work scheduling may have deleterious effects on the health of individuals. The most common short term effect is gastro-intestinal problems that arise from night shift related sleep disruptions.

The research on long term health effects is equivocal but the following areas have been highlighted in research findings: increased risk of cardiovascular disease; effects on women including irregular menstrual cycles; and a diverse range of complaints sometimes overlaid by stress created by social and family dislocation.
Table 8: Risk Rating for Clinical Disciplines 2005

<table>
<thead>
<tr>
<th>Clinical Discipline</th>
<th>Low (%)</th>
<th>Significant (%)</th>
<th>Higher (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>12</td>
<td>38</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Medicine / Physicians</td>
<td>11</td>
<td>68</td>
<td>21</td>
<td>100</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>33</td>
<td>54</td>
<td>13</td>
<td>100</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>21</td>
<td>71</td>
<td>8</td>
<td>100</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>17</td>
<td>66</td>
<td>17</td>
<td>100</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>9</td>
<td>73</td>
<td>18</td>
<td>100</td>
</tr>
<tr>
<td>Other</td>
<td>22</td>
<td>52</td>
<td>26</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: ASMOFQ/AMA Queensland (2005) Safe Hours Report

Key concerns for practitioners surrounding changes to the level of work undertaken in a week is the impact it could have in on training requirements and training opportunities; as well as the capacity for continuity of care.

A US study into the effect on hospital outcomes of a 12 hour reduction in doctors’ workweek by Mayo Clinic researchers, found that with effective communication no statistical difference was witnessed when outcomes for patients’ hospital stays, mortality or residents’ educational opportunities were studied. An Australian based controlled study of the impact of reduced hours has not been carried out to date.

Key questions on Working Patterns

1. What will be the impact of reduced working hours of surgeons in the Australian context in the future – patient care and training opportunities?
2. What is the impact of more hours worked in the private sector compared to the public sector?
3. What factors may influence working hours in the future?
4. What is considered an unacceptable on-call cycle? - What are the implications for the number of surgeons needed in the future?
5. Should / How can working pattern guidelines for surgeons be supported in the Australian context?

Part 2: Ageing and Retirement

Introduction

Part 2 of this paper provides a summary of ageing and retirement patterns in the Australian Fellowship. This section will show an age breakdown of the Fellowship by specialty, state and jurisdiction. It will also explain the working status and working arrangements of Fellows by age. Actual and expected retirement patterns are analysed and an outline of broader retirement trends is highlighted.

Age Profile

The surgical workforce is ageing. Forty-two percent of the Fellowship in Australia is aged 55 years and over. The average age of the Fellowship is 55.6 years. Table Nine and Ten show a considerably aged workforce, with 42% of the Active Fellowship aged 55 years or over and 16.1% are aged under 40 years. Overall, the average age of the Active Fellowship in Australia is 55.6 years. The average age of new Fellows has also increased 4% from 2000 to 2005, with the average age of new Fellows now at 36.6 years. Across specialties Paediatric surgeons (average age = 61.4 years) and General surgeons (average age = 59.2 years) are the most aged group of surgeons.

Table 9: 2005 RACS Active Fellowship by Age, Australia.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Proportion of the Workforce Aged 55+</th>
<th>Average Age (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic</td>
<td>33%</td>
<td>55.6</td>
</tr>
<tr>
<td>General</td>
<td>50%</td>
<td>59.2</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>35%</td>
<td>52.6</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>36%</td>
<td>52.6</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>44%</td>
<td>54.8</td>
</tr>
<tr>
<td>Paediatric</td>
<td>52%</td>
<td>61.4</td>
</tr>
<tr>
<td>Plastic &amp; Reconstructive</td>
<td>38%</td>
<td>52.5</td>
</tr>
<tr>
<td>Urology</td>
<td>35%</td>
<td>53.1</td>
</tr>
<tr>
<td>Vascular</td>
<td>47%</td>
<td>55.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State</th>
<th>Proportion of the Workforce Aged 55+</th>
<th>Average Age (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>38%</td>
<td>54.0</td>
</tr>
<tr>
<td>NSW</td>
<td>44%</td>
<td>55.3</td>
</tr>
<tr>
<td>NT</td>
<td>38%</td>
<td>53.7</td>
</tr>
<tr>
<td>QLD</td>
<td>36%</td>
<td>53.5</td>
</tr>
<tr>
<td>SA</td>
<td>45%</td>
<td>56.3</td>
</tr>
<tr>
<td>TAS</td>
<td>39%</td>
<td>55.6</td>
</tr>
<tr>
<td>VIC</td>
<td>47%</td>
<td>56.0</td>
</tr>
<tr>
<td>WA</td>
<td>37%</td>
<td>54.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th>Proportion of the Workforce Aged 55+</th>
<th>Average Age (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metro</td>
<td>42%</td>
<td>55.5</td>
</tr>
<tr>
<td>Non-Metro</td>
<td>43%</td>
<td>55.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All</th>
<th>Proportion of the Workforce Aged 55+</th>
<th>Average Age (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>42%</td>
<td>55.6</td>
</tr>
</tbody>
</table>

Source: RACS (2005) RACS Management Report – (Based on Actual Fellowship Age Breakdown)
Table 10: 2005 Royal Australasian College of Surgeons Active Fellowship by Age, Australia.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;39</td>
<td>545</td>
<td>16.1%</td>
</tr>
<tr>
<td>40-44</td>
<td>525</td>
<td>15.4%</td>
</tr>
<tr>
<td>45-49</td>
<td>486</td>
<td>14.3%</td>
</tr>
<tr>
<td>50-54</td>
<td>399</td>
<td>11.7%</td>
</tr>
<tr>
<td>55-59</td>
<td>435</td>
<td>12.7%</td>
</tr>
<tr>
<td>60-64</td>
<td>455</td>
<td>13.3%</td>
</tr>
<tr>
<td>65-69</td>
<td>280</td>
<td>8.2%</td>
</tr>
<tr>
<td>70+</td>
<td>276</td>
<td>8.2%</td>
</tr>
<tr>
<td>Total</td>
<td>3401</td>
<td>100.0%</td>
</tr>
</tbody>
</table>


Figure Eight, further demonstrates that the Fellowship is aged by comparing it to the wider health sector workforce and the general workforce across Australia.

Figure 8: RACS Active Australian Surgical Workforce by the Health Workforce and Australian Workforce.

Work Status

Table Eleven considers the number of surgeons who are registered with the College as Active Fellows, by their current working status in relation to operating and/or consulting practice\textsuperscript{14}. The table shows that approximately 466 (or 13.7\%) of the Active Fellowship are either “semi-retired”, “retired” or temporarily not in practice. This demonstrates that nearly 1 in 7 Active Fellows are not participating in the surgical workforce or have reduced participation due to “semi-retirement”. The average hours worked by Fellows who consider themselves “Semi-retired” is 32.4 hours per week. Fellows that state that they are retired work on average 14.4 hours per week, and are largely involved with providing consulting services.

Neurosurgery (16.2\%) and Orthopaedic surgery (14.9\%) have the highest proportion of Fellows who are considered “semi-retired” or “retired”. By state, Victoria has the largest group of “semi-retired” and “retired” Fellows (15\%). There is only a small difference between regions, with metropolitan areas having on average, 11.8\% of their Fellowship in this group, compared to 11.3\% in non-metropolitan areas.

<table>
<thead>
<tr>
<th>Workforce Status</th>
<th>No.</th>
<th>%</th>
<th>Average Hours per Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td>2935</td>
<td>86.3%</td>
<td>51.5</td>
</tr>
<tr>
<td>Semi-retired</td>
<td>291</td>
<td>8.6%</td>
<td>32.4</td>
</tr>
<tr>
<td>Retired</td>
<td>109</td>
<td>3.2%</td>
<td>14.4</td>
</tr>
<tr>
<td>Temporarily not in practice</td>
<td>66</td>
<td>1.9%</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>3401</td>
<td>100.0%</td>
<td>51.0</td>
</tr>
</tbody>
</table>

*Refer to Appendix Seven for a Full Breakdown of Work status

Working Arrangements

Approximately, one in seven Fellows work on a part-time basis. Three-quarter of these Fellows are aged 55 years and over (74.2\% or 368 Fellows). Part-time work is considerable in Orthopaedic surgery (17\% or 148 Fellows) and is noticeably higher in non-metropolitan regions of Australia (14.5\% or 93 non-metropolitan Fellows). (Refer to Appendix Four)

Retirement

Coupled with the ageing of the surgical workforce, is the intention, by a significant proportion of the Fellowship, to move into retirement in the near future.

Currently, the average age at retirement for Australian College fellows was 71.3 years\textsuperscript{15}. Twenty-four percent moved into retirement aged between 70 to 74 years, 23\% retired aged between 65 to 69 years, while over 1 in 5 surgeons retired before the age of 65 years. By specialty, the highest age at retirement was for Urologists (74.2 years) and Cardiothoracic surgeons (73.2 years). Neurosurgeons (66.3 years) and Plastics and reconstructive surgeons had the earliest age at retirement (67.5 years). Likewise, South Australia (76.4 years) and New South Wales (72.7 years) retain surgeons for the longest period.

There were distinct differences in the age of retirement in metropolitan and non-metropolitan areas of Australia. The average age at retirement for metropolitan surgeons is 71.1 years, whereas the average age at retirement for non-metropolitan surgeons is 72.8 years.

\textsuperscript{14} Fellows self-identified their current work status.
\textsuperscript{15} RACS (2005) Management Report, Based on 2005 Age At Retirement
Table 12: 2005 Active Fellowship by Actual and Intended retirement age, Australia.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Age at retirement (Actual)</th>
<th>Emergency Call Retirement (Expected)</th>
<th>Operative Practice Retirement (Expected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic</td>
<td>73.2</td>
<td>67.6</td>
<td>68.5</td>
</tr>
<tr>
<td>General Surgery</td>
<td>71.8</td>
<td>66.7</td>
<td>66.8</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>66.3</td>
<td>63.1</td>
<td>63.5</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>70.0</td>
<td>63.2</td>
<td>64.8</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>71.3</td>
<td>66.0</td>
<td>66.4</td>
</tr>
<tr>
<td>Paediatric</td>
<td>*</td>
<td>71.4</td>
<td>71.6</td>
</tr>
<tr>
<td>Plastic &amp; Reconstructive</td>
<td>67.5</td>
<td>61.9</td>
<td>64.0</td>
</tr>
<tr>
<td>Urology</td>
<td>74.2</td>
<td>64.0</td>
<td>65.1</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>70.2</td>
<td>68.4</td>
<td>70.6</td>
</tr>
<tr>
<td><strong>State</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td>*</td>
<td>61.4</td>
<td>62.4</td>
</tr>
<tr>
<td>NSW</td>
<td>72.7</td>
<td>64.1</td>
<td>66.7</td>
</tr>
<tr>
<td>NT</td>
<td>*</td>
<td>63.1</td>
<td>63.1</td>
</tr>
<tr>
<td>QLD</td>
<td>70.4</td>
<td>63.0</td>
<td>63.4</td>
</tr>
<tr>
<td>SA</td>
<td>76.4</td>
<td>63.2</td>
<td>64.5</td>
</tr>
<tr>
<td>TAS</td>
<td>69.3</td>
<td>61.8</td>
<td>64.2</td>
</tr>
<tr>
<td>VIC</td>
<td>68.7</td>
<td>65.6</td>
<td>66.5</td>
</tr>
<tr>
<td>WA</td>
<td>71.1</td>
<td>62.8</td>
<td>63.9</td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metro</td>
<td>71.1</td>
<td>64.1</td>
<td>66.7</td>
</tr>
<tr>
<td>Non-Metro</td>
<td>72.8</td>
<td>63.2</td>
<td>64.3</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td>71.3</td>
<td>65.2</td>
<td>66.6</td>
</tr>
</tbody>
</table>


*Data not available
**Refer to Appendix Eight and Nine for a Full Breakdown of Retirement Expectations

In the future, Fellows intend to enter into retirement earlier than they have previously, with an average expected retirement age of 66.6 years from operative practice. Further, Fellows generally expect to retire from emergency call duties, prior to their retirement from operative practice. One quarter of the Fellowship also intend to retire from emergency call and operative practice in the next five years (852 Fellows).

New South Wales and South Australia have the largest groups of Fellows intending to move into retirement from emergency practice in the next five years (36.5% and 36.3% respectively). The General surgery (32%) and Otolaryngology (26%) specialties have the most significant group of Fellows considering retirement from operative practice in the next five years. A larger proportion of metropolitan surgeons are intending to retire from both emergency and operative practice in the next five years when compared to non-metropolitan surgeons.

Table 13: 2005 RACS Active Fellowship by Intention to cease availability for emergency call, Australia.

<table>
<thead>
<tr>
<th>Years to Retirement from Emergency Call</th>
<th>Active Fellows</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 yr</td>
<td>237</td>
<td>7%</td>
</tr>
<tr>
<td>2-3 yrs</td>
<td>372</td>
<td>11%</td>
</tr>
<tr>
<td>4-5 yrs</td>
<td>511</td>
<td>15%</td>
</tr>
<tr>
<td>6-10 yrs</td>
<td>690</td>
<td>20%</td>
</tr>
<tr>
<td>11-15 yrs</td>
<td>597</td>
<td>18%</td>
</tr>
<tr>
<td>16-20 yrs</td>
<td>522</td>
<td>15%</td>
</tr>
<tr>
<td>21+ yrs</td>
<td>473</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3401</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 14: 2005 RACS Active Fellowship by Intention to cease operative practice, Australia.

<table>
<thead>
<tr>
<th>Years to Retirement from operative practice</th>
<th>Active Fellows</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 yr</td>
<td>205</td>
<td>6%</td>
</tr>
<tr>
<td>2-3 yrs</td>
<td>275</td>
<td>8%</td>
</tr>
<tr>
<td>4-5 yrs</td>
<td>371</td>
<td>11%</td>
</tr>
<tr>
<td>6-10 yrs</td>
<td>628</td>
<td>18%</td>
</tr>
<tr>
<td>11-15 yrs</td>
<td>990</td>
<td>29%</td>
</tr>
<tr>
<td>16-20 yrs</td>
<td>223</td>
<td>7%</td>
</tr>
<tr>
<td>21+ yrs</td>
<td>708</td>
<td>21%</td>
</tr>
<tr>
<td>Total</td>
<td>3401</td>
<td>100%</td>
</tr>
</tbody>
</table>


Retirement intentions by age

On average, younger Fellows expect to retire earlier, than their older counterparts. Fellows aged under 55 years expect to retire on average at age 58 from emergency call and age 60 from operative practice. Fellows aged 55 years or over in contrast expect to retire at aged 70 from both operative practice and emergency call.

Intention to retire and current working hours

There is an interesting relationship between age, intention to phase into retire from operative work and current hours worked per week. For Fellows aged 54 years or younger, there is a strong intention to retire early when working hours are high. For example, the average hours worked by younger Fellows intending to move into retirement in the next 1 to 3 years is between 54 and 55 hours per week, when the average hours worked is between 48 to 50 hours per week, retirement is planned in 11 years or more. This significant trend may warrant further investigation.

For Fellows aged 55 years and over a reverse pattern is demonstrated the closer retirement is, the more likely the Fellows is to indicate an intention to reduce hours of work per week. This affirms the trend of Fellows entering part-time working arrangements or working less hours prior to retirement.

Intention to retire from Operative Practice by Hours of Work and Age Group

Correlation coefficient = -0.916
Correlation coefficient = 0.743
Discussion on Ageing and Retirement

The ageing of the surgical workforce and potential “mass” retirements is of central relevance. In Australia, as well as many other industrialised countries, population ageing and retirement has the potential to significantly affect future workforce supply. \(^{18}\)

Trends revealed by the workforce survey indicated that as many as one-quarter of the Fellowship intend to retire from emergency practice and operative practice in the next five years. Fellows also intend on phasing into retirement earlier than in the past.

While, these trends may appear alarming national and international studies show that there can be a considerable distinction between actual and intended retirement and that it is possible to retain older workers for longer by addressing factors that influence retention. A summary of some key studies in these areas are discussed below.

A University of New South Wales investigation into retirement intentions of mature aged workers found that for workers that have full control over when they retire (ie. financially independent) their actual retirement will most likely occur after intended retirement age. \(^{19}\)

A US study by Centre for Health Workforce Studies, University of North Carolina, found that a considerable proportion of doctors who expected to retire actually continued to work in either a full-time or part-time capacity:

- Aged 55-59 years – 45% continued to work full-time; 13% continued to work part-time
- Aged 60-64 years – 7% continued to work full-time; 26% continued to work part-time
- Aged 65-69 years – 8% continued to work full-time; 28% continued to work part-time
- Aged 70-74 years – 14% continued to work full-time; 29% continued to work part-time \(^{20}\)

Ongoing tracking of retirement patterns for the Fellowship, will be possible through the planned bi-annual Census of the Surgical Workforce.

Comparable trends were seen when the census data was analysed, revealing that Fellows phased into “retirement”, moving on average from 51.0 hours per week, to 32.4 hours per week, and then to 14.4 hours per week, before fully retiring.

A survey into early retirement intentions of doctors conducted by the Department of Public Health, University of Oxford, found that the key determinants for early retirement were a reduction in work-related pressure; increased leisure time; job dissatisfaction; disillusionment with the public health system; and wanting a healthy retirement \(^{21}\).

Factors that could encourage retention included more flexible working patterns, a reduction in workload with increasing age; improved staffing levelling; and preservation of pension rights for part-time working, and greater professional freedom.

Factors that influence retention of older Fellows is yet to be explored. Further analysis would assist the development of appropriate strategies.

---

\(^{18}\) Russell, A (2005) NHS facing surgeons shortfall, 15/02/05 – In the UK, a report by the Royal College of Surgeons of England found that up to 4,000 surgeons could retire by 2007, resulting in a shortfall of 2,760 surgeons by 2010. Coupled with retirement was the increased demands of training and education because of new technologies and new treatment opportunities. The report highlighted the need for extra training places to be funded to ensure patient safety.

\(^{19}\) Knox, G (2003) Retirement intentions of mature age workers, Paper for the Australian Social Policy Conference to be held 9 – 11 July 2003 at the University of New South Wales


Key questions:

1. How do you maximise opportunities to retain surgeons in the workforce? – What influence retention of older surgeons?
2. What are the implications of retirement on current succession planning and supervision requirements? – Are systems in place to support training requirements in the future?
3. How will mal-distribution be impacted by increasing retirements?
### Appendix 1: Active Fellowship by Expected Hours of Work per Week

<table>
<thead>
<tr>
<th>Specialty</th>
<th>2005 Hours</th>
<th>Standard Deviation</th>
<th>95% Confidence Interval</th>
<th>2007 Hours</th>
<th>Standard Deviation</th>
<th>95% Confidence Interval</th>
<th>2010 Hours</th>
<th>Standard Deviation</th>
<th>95% Confidence Interval</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic</td>
<td>48.1</td>
<td>8.6</td>
<td>30.9-65.3</td>
<td>45.9</td>
<td>7.6</td>
<td>30.7-61.1</td>
<td>45.3</td>
<td>11.2</td>
<td>22.9-67.7</td>
<td>-5.80%</td>
</tr>
<tr>
<td>General</td>
<td>51.1</td>
<td>4.6</td>
<td>41.9-60.3</td>
<td>49.4</td>
<td>3.2</td>
<td>43-55.8</td>
<td>47.9</td>
<td>3.6</td>
<td>40.7-55.1</td>
<td>-6.30%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>49.8</td>
<td>4.4</td>
<td>41.0-58.6</td>
<td>46.8</td>
<td>4.6</td>
<td>37.6-56</td>
<td>45.2</td>
<td>4.6</td>
<td>36-54.4</td>
<td>-9.20%</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>51.9</td>
<td>5.3</td>
<td>41.3-62.5</td>
<td>46.1</td>
<td>4.1</td>
<td>37.9-54.3</td>
<td>44.3</td>
<td>2.6</td>
<td>39.1-49.5</td>
<td>-14.60%</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>51.5</td>
<td>4.8</td>
<td>41.9-61.1</td>
<td>47.7</td>
<td>4.4</td>
<td>38.9-56.5</td>
<td>47</td>
<td>6.7</td>
<td>33.6-60.4</td>
<td>-8.70%</td>
</tr>
<tr>
<td>Paediatric Plastic &amp; Reconstructive</td>
<td>46.5</td>
<td>2.8</td>
<td>40.9-52.1</td>
<td>42.3</td>
<td>1.3</td>
<td>39.7-44.9</td>
<td>40.6</td>
<td>2.8</td>
<td>35-46.2</td>
<td>-12.70%</td>
</tr>
<tr>
<td>Urology</td>
<td>48.7</td>
<td>5.3</td>
<td>38.1-59.3</td>
<td>46.2</td>
<td>2.1</td>
<td>42-50.4</td>
<td>44.3</td>
<td>3.1</td>
<td>38.1-50.5</td>
<td>-9.00%</td>
</tr>
<tr>
<td>Vascular</td>
<td>47.8</td>
<td>3.9</td>
<td>40-55.6</td>
<td>43.8</td>
<td>3.3</td>
<td>37.2-50.4</td>
<td>43.1</td>
<td>4.0</td>
<td>35.1-51.1</td>
<td>-9.80%</td>
</tr>
<tr>
<td>State</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td>56.6</td>
<td>3.9</td>
<td>48.8-64.4</td>
<td>51.9</td>
<td>1.1</td>
<td>49.7-54.1</td>
<td>44.6</td>
<td>2.2</td>
<td>40.2-49</td>
<td>-21.20%</td>
</tr>
<tr>
<td>NSW</td>
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<td>42.1-57.3</td>
<td>48</td>
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<td>41.8-54.2</td>
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Appendix 2: Active Fellowship by Public Sector On-Call Cycle

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<th>Days per month</th>
<th>Weekends per weekend</th>
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<td>7 in 21</td>
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<tr>
<td>7 in 28</td>
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*The on-call cycle can be read by row than by column. For example, 1 in 1 column Days per days means 1 days per day (or daily); 1 in 1 column Weeks per weeks means 1 week per 1 week (or daily); 1 in 1 column Days per month means 1 day in 1 month; 1 in 1 column Weekends per weekends means 1 weekend per 1 weekend (or every weekend).

Appendix 2 shows the diverse range of on-call cycles taken on by the Fellowship in the public sector. The most common on-call cycles include 1 day in 7 days (17.5% of the Fellowship) and 1 week in 3 weeks or 1 week in 4 weeks (18.1% and 20.9% respectively). Thirty-seven percent of Fellows are on-call every 1 weekend in 4 weekends or 1 weekend in 5 weekends.
Appendix 3: Active Fellowship by Description of workload on an average on-call day

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Light</th>
<th>Moderate</th>
<th>Heavy</th>
<th>Extreme</th>
<th>Total</th>
</tr>
</thead>
<tbody>
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<td>50</td>
<td>16</td>
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<td>127</td>
</tr>
<tr>
<td>General</td>
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<td>620</td>
<td>211</td>
<td>20</td>
<td>1180</td>
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<tr>
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<td>19</td>
<td>83</td>
<td>36</td>
<td>-</td>
<td>143</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>211</td>
<td>459</td>
<td>183</td>
<td>30</td>
<td>883</td>
</tr>
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<td>20</td>
<td>-</td>
<td>318</td>
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<td>-</td>
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<td>17</td>
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<td>-</td>
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</table>

<table>
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<th>State</th>
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<th>Heavy</th>
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<th>Total</th>
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<td>18</td>
<td>-</td>
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<td>12</td>
<td>-</td>
<td>21</td>
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<td>-</td>
<td>606</td>
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<td>17</td>
<td>-</td>
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<td>634</td>
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</table>

| All                            | 1129  | 1658     | 553   | 60      | 3401  |

* Cells with <5 Fellows have been confidentialised
## Appendix 3: Active Fellowship by Description of workload on an average on-call day

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Description of workload on an average on-call day</th>
<th>ACT</th>
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<th>NT</th>
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<th>TAS</th>
<th>VIC</th>
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* Cells with <5 Fellows have been confidentialised
### Appendix 4: Active Fellowship by On-Call Days per Year

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<th>TAS Mean</th>
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* Cells with <5 Fellows have been confidentialised
### Appendix 5: Active Fellowship by Working arrangements over the past year

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| All                     | 1877      | 64.6%     | 1027      | 35.4%     | 128   | 25.8% |

* Cells with <5 Fellows have been confidentialised
## Appendix 5: Active Fellowship by Working arrangements over the past year

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* Cells with <5 Fellows have been confidentialised
Appendix 6: Active Fellowship by Agree that a 1 in 4 on call roster is the max from a safe performance perspective

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* Cells with <5 Fellows have been confidentialised
## Appendix 7: Active Fellowship by Workforce Status over the last year

### Workforce Status over the last year

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<td>49.9</td>
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<td>53.5</td>
<td>117 9.9%</td>
<td>35.7</td>
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<tr>
<td>Neurosurgery</td>
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<td>83.1%</td>
<td>54.6</td>
<td>23 16.2%</td>
<td>32.4</td>
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<td>21 6.6%</td>
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<td>7  2.3%</td>
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### State

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<th>%</th>
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<th>%</th>
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* Cells with <5 Fellows have been confidentialised
## Appendix 8: Active Fellowship by Retirement from Emergency call

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