



ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA

What's really behind Canada's **unemployed specialists?**

Too many,
too few doctors?

Findings from the Royal College's
employment study - 2013

Executive Summary



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Executive summary

A first in health system research

In 2010, several of Canada's national medical specialty societies reported to the Royal College that a growing number of specialist physicians were unemployed or under-employed. The Royal College undertook research into this highly complex problem, seeking to determine if unemployment and under-employment are the simple and inevitable byproducts of an oversupply of physicians — or if other, more subtle factors come into play.

This report presents the findings of our research to date — most notably the state of employment of new specialists and subspecialists certified in 2011 and 2012 and the key drivers and influencers behind their employment challenges. (The report delves into the employment issues of specialist physicians only and does not delve into any employment issue that may affect family physicians.)

The Royal College has unique access to specialist physicians in Canada and, as such, was able to collect a unique set of data to inform this report. The Royal College surveyed newly certified specialists and subspecialists online for this study, and interviewed more than 50 persons with first-hand, in-depth knowledge of the issues who provided important new insights. It is our hope that this study will spark additional research and data collection into the phenomenon of specialist unemployment and under-employment so that health care stakeholders can work together to identify and address the countless factors that contribute to this growing challenge.

What our research revealed

Sixteen percent of new specialist and subspecialist physicians said they cannot find work; 31 percent pursue further training to become more employable.

Data from the Royal College's 2011 and 2012 employment surveys reveal that employment issues extend across multiple medical specialties. Among those who responded to the surveys of new specialists and subspecialists, 208 (16%) reported being unable to secure employment, compared to 7.1% of all Canadians as of August 2013. Of these, 122 stated they were or would be pursuing further training and 86 reported that they were unemployed and without a training post. Also of note is the significant number of new specialists and subspecialists — 414 (31.2%) — who chose not to enter the job market but instead pursued further subspecialty or fellowship training because they believed such training would make them more employable.

Employment challenges are increasing.

Comparison by year shows that employment challenges increased in 2012 over 2011. Those reporting employment issues increased by four percentage points (from 13% to 17%) for specialists and by six percentage points (from 15% to 21%) for subspecialists. Findings also show potential provincial variances, which merit further investigation.

Locum and part-time positions are often a default option to unemployment.

Almost 22% of new graduates reported they are staying employed by combining multiple locum positions (assuming another physician's duties temporarily) or various part-time positions. Forty percent stated they were not satisfied with their locum placement.

Employment issues are most pronounced in resource-intensive disciplines.

The survey revealed that a substantial proportion of new physicians experiencing employment issues were from surgical and resource-intensive disciplines, including but not limited to: critical care, gastroenterology, general surgery, hematology, medical microbiology, neurosurgery, nuclear medicine, ophthalmology, radiation oncology and urology.

Three key drivers contribute to employment issues.

The online surveys and interviews revealed new findings and confirmed hearsay. We have clustered our findings under the following three drivers: the economy, the health system, and personal factors.

1. The economy is the main factor driving new medical and surgical specialist under- and unemployment in Canada.

More physicians are competing for fewer resources

Much of specialty medical care depends on institutional health care facilities such as hospitals, and their resources, including operating rooms and hospital beds. Access to these resources directly impacts physician employment. While the health care needs of patients increase and the number of physicians and surgeons continues to grow, hospital funding growth continues to slow. To control costs, resources such as operating room time are cut. Physicians are competing for fewer resources.

Weak stock markets delay retirements

The stock market's relatively weak performance in recent years means many medical specialists are delaying their retirements. Long-held positions are not freeing up as expected and will not likely free up until markets improve.

2. The way in which the health care system is organized contributes to under- and unemployment of new medical and surgical specialists.

The role of interprofessional care models

Interprofessional collaborative practice—in which multiple health workers from different professional backgrounds provide care to patients—is increasingly taking root in Canadian healthcare. With this development comes a new range of health professional roles and responsibilities that affect how Canadians interact with medical services and physicians. Here is what we learned:

- **Interprofessional models reduce reliance on physicians, slow job growth.**

These new roles associated with interprofessional care models complement and in some cases substitute physician services, making it possible to increase the amount of specialty medical care that physicians and surgeons provide without increasing the number of jobs.

- **Interprofessional models are reducing reliance on residents for service, enabling the potential to better align supply of new physicians with longer-term patient needs.**

Our research reveals a promising trend that some teaching facilities are adapting models of care to include health professionals that complement or substitute for physicians. Residency programs in these locales are therefore relying less on residents to fill service gaps and not taking in as many residents. They are adjusting resident intake with what they believe will be future needs. This is good news because the educational system will be more likely to produce the number of specialist physicians needed rather than taking in additional residents as “boots on the ground”. Unfortunately, this is not yet the case everywhere. This is an area that requires further research.

Workforce planning

- **Determining and allocating the number of residency positions is complex and may not always take into account societal health needs and available resources.**

Approaches for allocating residency positions can vary greatly among the provinces and territories and decisions are broadly based on scant information about longer-term societal health needs and health care resources. In addition, new medical graduates may not remain in the jurisdiction where they trained, creating further imbalances in the medical supply.

- **Increasing reliance on residents can lead to overproduction.**

Academic health facilities must often balance their immediate service requirements (which are often met by residents) with the number of physicians they will need in the future. Put another way, when additional residency positions are created to meet immediate needs, the number of new specialists and subspecialists eventually certified may exceed the number of positions needed and available over the long term. This can happen despite the potential of better balancing service needs through interprofessional care models (see above).

Culture of practice influences physicians' willingness to share resources.

Most health professions develop a personal culture of practice, which is motivated by both altruism and self-interest. Given that the availability of clinical and practice resources is generally fixed (this is especially true of operating room time) established specialists can be reluctant to share resources. This is because they wish to protect their access to clinical resources for their patients and their incomes. Income protection is especially important for those whose retirement portfolios have been negatively affected by the recent economic downturn.

3. Personal and context-specific factors drive employment challenges among new graduates.

Residents report a lack of adequate career counseling and information about jobs.

The importance of career counseling for specialists cannot be overemphasized; career choices are key to these physicians' futures and to how they are distributed across the country. More than half of new specialists in our study said they had not received any career counseling and more than one third without jobs and who were not continuing training in 2012 reported that poor access to job postings hampered their ability find a job. Lack of transparency about available jobs also hindered their ability to find suitable work.

Research findings reveal that a more systematic and comprehensive approach to career counseling and job advertising than currently exists in Canada is needed to meet the needs and objectives of individual physicians as well as the system.

Personal preferences influence choices.

Personal factors influence the choices that physicians make about the type and location of practice they will pursue. This is a byproduct of many influencers, including:

- the relatively late age at which new medical specialist graduates enter independent practice. Many new graduates have family responsibilities that might make it harder to move to available job opportunities (sandwich generation, spousal employment, etc.)
- individual career preferences such as practice location or type.

Employment challenges are creating a new type of specialist, and contributing to “brain waste” and “brain drain”.

New specialists who lack access to hospital suitable resources, or who cannot find jobs in the settings they require, are developing ‘tailored’ or ‘morphed’ practices that allow them to work within the resources available to them. These new practices do not embrace the full spectrum of specialists’ abilities, resulting in skill loss and under-employment (such as when a surgeon cannot operate) This condition is called “brain waste.”

Just under 20% of recently certified medical and surgical specialists who have not found positions reported they would look for work outside Canada. The predicted physician shortages in the US may become a market for Canada’s unemployed specialists, prompting a “brain drain”.

We need to think in new ways about medical workforce planning.

While our research has revealed many specific factors that contribute to specialist unemployment and under-employment, a single, overarching message has also emerged: that a significant gap appears to exist in medical workforce planning in Canada. Most planning approaches attempt to produce the right mix and number of physicians based on society’s health needs. But that is only part of the picture. Many specialty medical and surgical disciplines require specific resources such as operating room time and hospital beds to function efficiently. With health care spending on the decline, specialists often have limited access to such resources, which affects the number able to practice as well as how much work each specialist can undertake.

It has become clear that medical workforce planning must consider the availability of practice resources as well as the health needs of the population. Such an approach will help physicians do the work they have been trained to do; to do otherwise will perpetuate physician unemployment. It will also worsen physician brain waste and under-employment since physicians will be able to apply only a portion of their knowledge and skills based on the resources available to them.