Royal Australasian
College of Surgeons

Surgical workforce

2022 census report

Royal Australasian College of Surgeons
2022 Surgical Workforce Census Summary Report

This summary, and other Workforce Reports, are available at the Royal Australasian College of Surgeons website: www.surgeons.org

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ABBREVIATIONS

~	Not Applicable
%	Percentage of respondents
AoNZ	Aotearoa New Zealand
AMA	Australian Medical Association
ACT	Australian Capital Territory
AUS	Australia
CAR	Cardiothoracic surgery
CPD	Continuing Professional Development
F	Female
GEN	General surgery
IQR	Interquartile range
M	Male
N	Number of Fellows that responded to the Census question
NEU	Neurosurgery
NSW	New South Wales
NT	Northern Territory
ORT	Orthopaedic surgery
OTO	Otolaryngology Head and Neck surgery
PAE	Paediatric surgery
PLA	Plastic and Reconstructive surgery
QLD	Queensland
RACS	Royal Australasian College of Surgeons
SA	South Australia
SD	Standard deviation
SET	Surgical Education and Training Program
TAS	Tasmania
URO	Urology
VAS	Vascular surgery
VIC	Victoria
WA	Western Australia

INTRODUCTION

The Royal Australasian College of Surgeons (RACS), formed in 1927, is a non-profit organisation that is responsible for training surgeons and maintaining surgical standards across Australia and Aotearoa New Zealand. RACS' purpose is to be the unifying force for surgery in Australia and Aotearoa New Zealand, with FRACS standing for excellence in surgical care.

The Surgical Workforce Census commenced in 2005 and is conducted every two years. The Census is an important tool to assist RACS in its workforce planning and advocacy. It also provides additional information regarding a range of factors that affect surgeons in their day-to-day work. This allows RACS to build a picture of the challenges facing the surgical workforce and to help identify those areas in which RACS needs to advocate and find solutions.

This is the eighth Surgical Workforce Census conducted by RACS. Reports on our previous Censuses can be found on our website (www.surgeons.org).

KEY FINDINGS

Work Patterns

- Full time Fellows worked an average of 45.9 hours per week in 2022, compared to 47.1 hours in 2020, 50 hours in 2018 and 51 hours in 2016. This is a small but consistent decrease in average hours worked per week reported over the past six years.
- Fellows who work full time reported a preference to work 2.1 hours less than their current average of 45.9 hours per week.
- Part time Fellows reported a preference to work 2.1 hours more when comparing weekly hours worked and preferred hours. Locums preferred to work on average 2.6 hours less than they currently work.
- Fellows in the private sector reported working longer hours in consulting work than their public sector counterparts. Time spent on procedural work was similar in private and public sectors, however Fellows in the public sector spent more time on administration.
- Almost a quarter of Fellows were involved in other forms of paid employment such as clinical education/ assessment and medico legal work.

Rural and Regional Practice

- Almost 16% of Australian Fellows reported working exclusively in a regional, rural or remote location. For Aotearoa New Zealand Fellows, 14.3% reported working exclusively in a regional, rural or remote location.
- Of the Fellows who worked in regional or rural locations only, almost 80% were full time and reported working on average 39.9 hours per week. This is slightly less than the overall average hours per week recorded for all full time respondents (45.9 hours).
- Approximately 21% of Fellows engaged in outreach services monthly and 6% reported working in outreach services weekly, including both metropolitan and rural based Fellows.
- The majority of Fellows indicated no intention to change their future work hours in rural or regional settings.

Pro Bono Work

- Over 65% of Fellows participated in pro bono or volunteer work in 2022.
- Fellows reported working on average 10.5 hours per month on pro bono activities.
- The most frequently reported pro bono activities were contributions to RACS, including the SET Program, followed by clinical education not related to RACS.
- For RACS focused activities, contributing as an educational instructor/ presenter, SET Program supervisor and surgical mortality audit assessor were the most frequently reported pro bono contributions by Fellows.

Wellbeing

- Administrative regulation and processes continue to rate as a high to extreme source of stress for Fellows, rating higher than workplace culture and COVID-19.
- Almost three quarters of Fellows monitored their health in the last two years, visiting a medical doctor for a health check-up or at regular intervals as dictated by existing medical conditions (72%).
- Almost one in ten Fellows reported seeking professional assistance for stress or mental health issues in the last two years.

Future Work Intentions

- Fellows across all ages intend on reducing their preferred weekly work hours gradually over the next 10 years.
- Two thirds of Fellows aged 50 years and over plan to retire from all forms of paid work within the next ten years.
- Most Fellows aged 65 years or older who intend to continue in paid employment will maintain work predominately because they are doing work that they enjoy.

METHOD

Surgeon Eligibility Criteria

All surgeons who are Fellows of RACS and whose usual workplace was in Australia and Aotearoa New Zealand were eligible to participate in the 2022 Surgical Workforce Census via an online survey. RACS Fellows are surgeons who have passed the Fellowship Examination in one of the following specialties: Cardiothoracic surgery (CAR), General surgery (GEN), Neurosurgery (NEU), Orthopaedic surgery (ORT), Otolaryngology Head and Neck (OTO), Paediatric surgery (PAE), Plastic surgery (PLA), Urology (URO) or Vascular surgery (VAS). Surgeons that trained in the specialties of Ophthalmology or Obstetrics and gynaecology and RACS Fellows working outside Australia or Aotearoa New Zealand were not eligible to participate in the Census.

A Fellow may be defined as 'Active', 'Semi-retired' or 'Retired' (i.e., no longer registered to practise medicine). At the time of the Census commencement, there were 7291 Fellows in Australia and Aotearoa New Zealand eligible to participate. Of those, 574 opted out of communication or did not have an email address registered with RACS. As a result the final survey was issued to 6717 Fellows.

Table 1.1: 2022 Surgical Workforce Census target population

	Total
All Active and Retired Fellows eligible	7291
No email/ no communication request	574
Total no. of Census invitations	6717

Census Questionnaire

The Census consists of a set of core questions that were considered relevant to the Fellows' day-to-day work, future work intentions and wellbeing. More specifically, Fellows were asked to reflect upon their workforce status, weekly hours of work at present and as intended in the future, frequency of emergency on-call work, private billing practices (where applicable), retirement intentions, leave taken, stressors, health monitoring, and pro bono roles, including contributions to RACS.

Data Analysis

When a question elicited a "not applicable" answer, the response was excluded from the total. Respondents that did not answer a question were excluded from analysis of that question. At the time of survey, a small proportion of valid responses (1.7%) were from Fellows reporting that they currently live outside of Australia or Aotearoa New Zealand; these were also excluded from further analysis.

Table 1.2: Summary of respondents excluded from analysis

Total no. of respondents	1793	
No. of respondents overseas (excluded)	30	1.7%
No. unusable, partially complete respondents (excluded)	153	8.6%
Final no. of valid respondents	1608	

Data were analysed (where applicable) by segments including sex (male/ female/unspecificed), age (≤39, 40-49, 50-59, 60-69, 70-79, ≥80), location (8 Australian states/ territories/ Aotearoa New Zealand), country (Australia, Aotearoa New Zealand), specialty (CAR, GEN, NEU, ORT, OTO, PAE, PLA, URO, VAS) and workforce status (full time, part time, locum). Unless otherwise stated, descriptive statistics presented in this report are based on results of the respondent population, imputation or weighting methods have not been applied.

Chapter 1 – Descriptive Statistics

RACS achieved a 24.0% response rate (n=1608) for the 2022 Surgical Workforce Census, the same response rate recorded for the 2020 Surgical Workforce Census.[1] The country-specific response rate was 20.4% of Australian Fellows and 32.4% of Aotearoa New Zealand Fellows. For 946 Fellows, the online survey response status was recorded as 'unopened'. As a result, the response rate could be between 24.0% (from 6717 invitations) and 27.9% (from 5771 invitations).

Out of 1608 respondents, 1375 were in Active practice, while 233 reported to be Retired.

To establish representativeness of the results, the Active respondents were compared with Active Fellows from the RACS 2022 Activities Report.[2] The respondents represent a consistent demographic profile to that of the RACS Active Fellowship population, with similar age group, sex and specialty profiles. In addition, all Australian states and territories and Aotearoa New Zealand were broadly represented in the Census data set when compared to the wider Fellowship (Figure 1.1 to Figure 1.4).

Figure 1.1: Sex profile of Active Census respondents and Active RACS Fellows

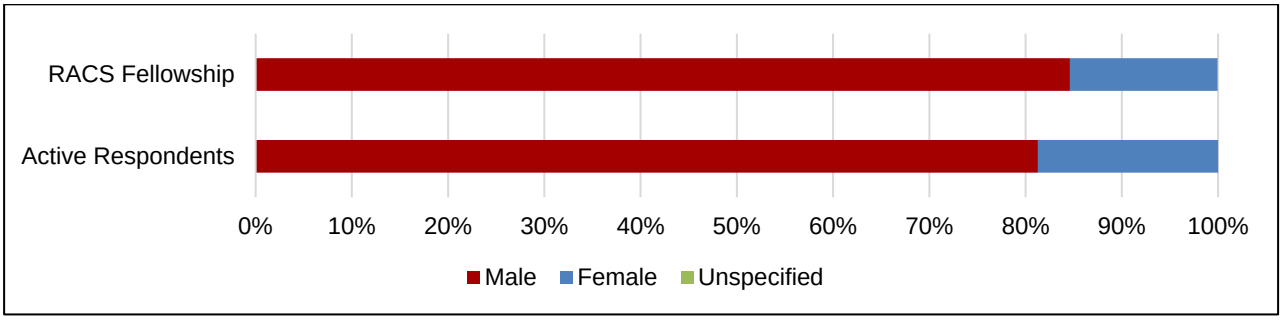


Figure 1.2: Age profile of Active Census respondents and Active RACS Fellows

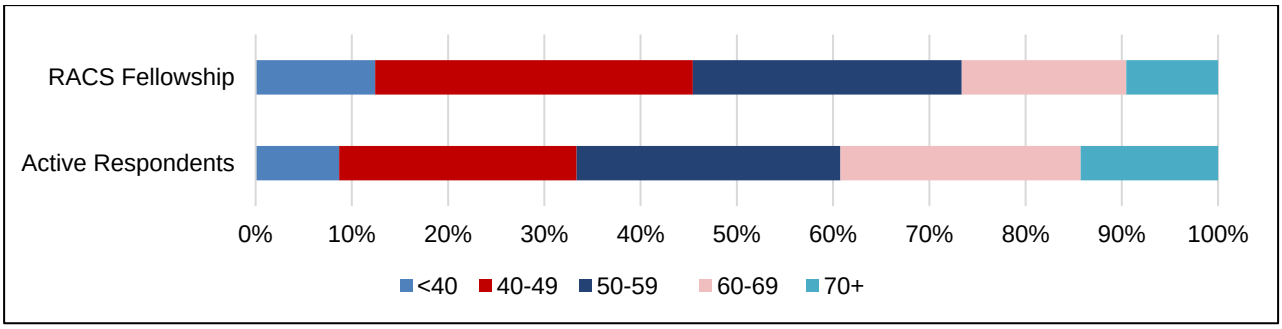
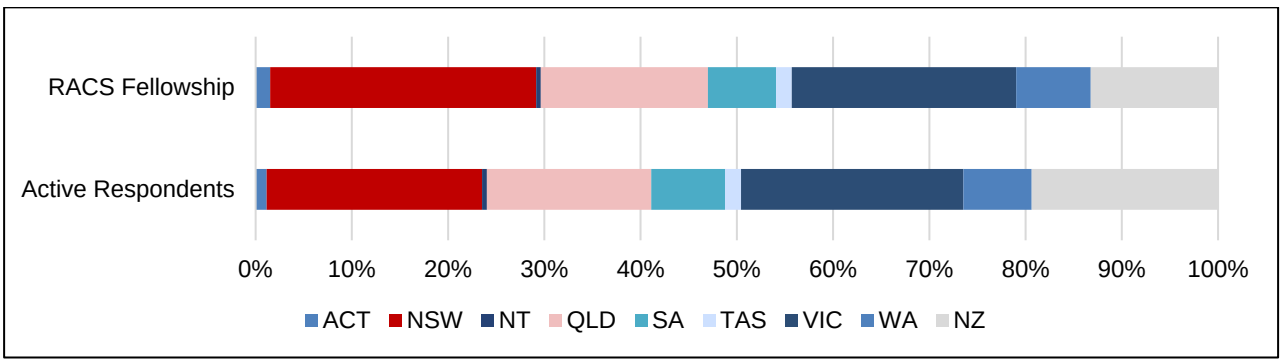
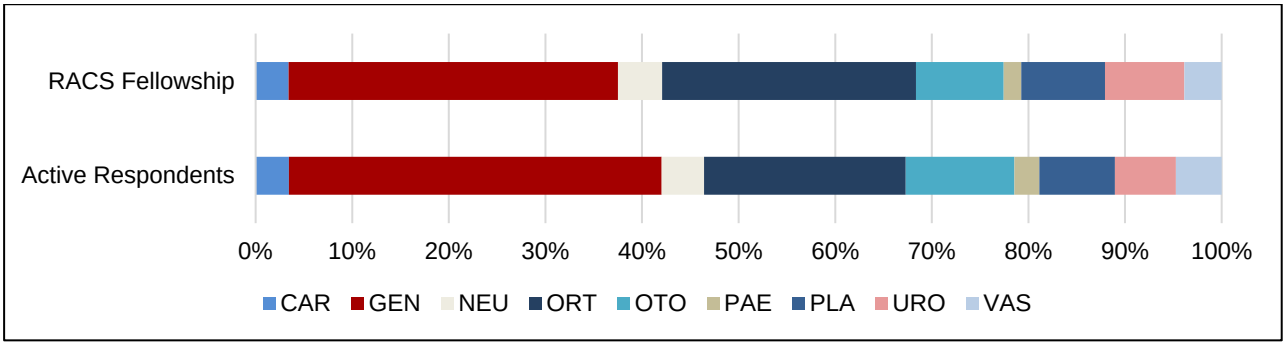


Figure 1.3: Location profile of Active Census respondents and Active RACS Fellows



Note: Refer to Table A1.1 to A1.3 in Appendix A for the tabulated data

Figure 1.4: Specialty profile of Active Census respondents and Active RACS Fellows

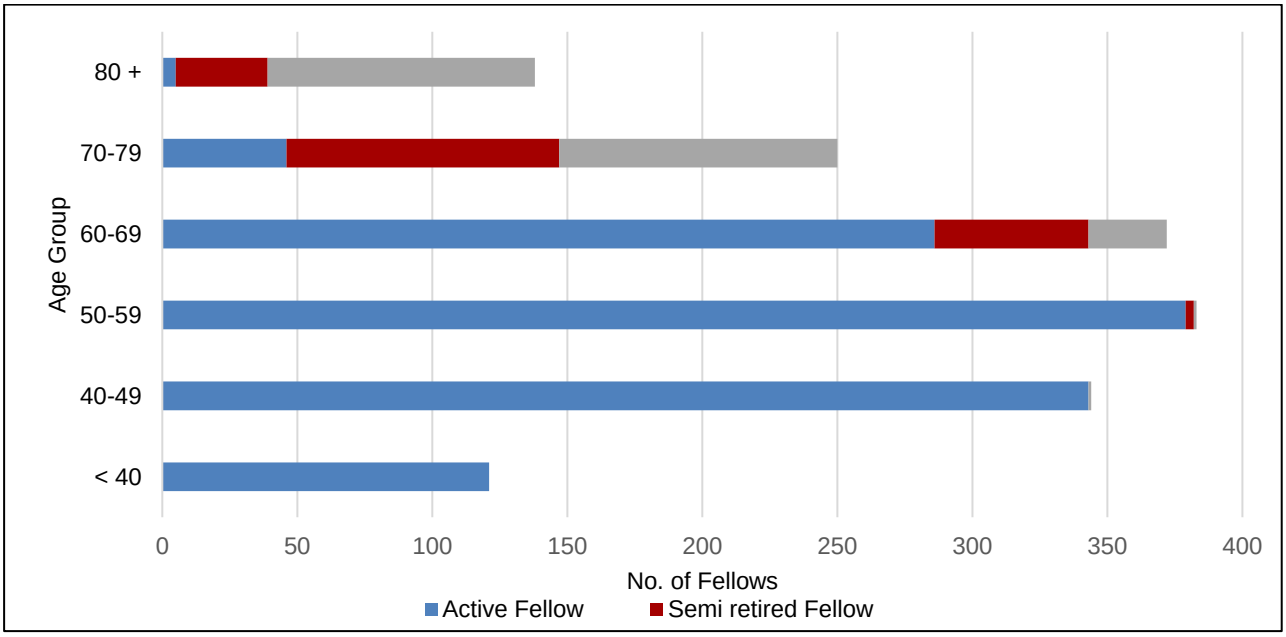


Note: Refer to Table A1.4 Appendix A for the tabulated data

In terms of Fellowship status, 73.4% of respondents identified as an Active Fellow, 12.1% as a Semi-retired Fellow and 14.5% a Retired Fellow (Figure 1.5).

The mean age of respondents (Active and Retired) was 59 years compared to 57 years in 2020[1] and 2018.[3] With the mean age of 48 years, female Fellows were 13 years younger on average than their male counterparts.

Figure 1.5: Age distribution and Fellowship status of Census respondents



Note: Refer to Table A1.5 and A1.6 in Appendix A for the tabulated data

Chapter 2 – Work Patterns

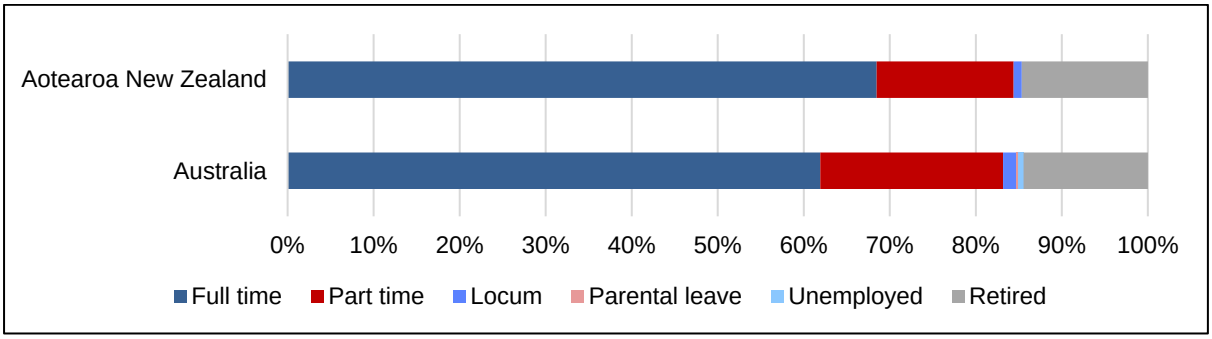
Summary

- Fellows employed full time worked an average of 45.9 per week compared to 47.1 hours in 2020 and 50 hours in 2018.
- Fellows who work full time reported a preference to work 2.1 hours less than their current average of 45.9 hours per week.
- Fellows who work part time reported a preference to work 2.1 hours more when comparing weekly hours worked and preferred hours (18.7 and 20.8 respectively).
- Locums preferred to work on average 2.6 hours less than they are currently working.
- Fellows in the private sector reported working longer hours in consulting work than their public sector counterparts. Time spent on procedural work was similar in private and public sectors, however, Fellows in the public sector spent more time on administration.
- In the public sector, one in ten Fellows worked more than the recommended emergency on-call period of 1:4.
- Almost a quarter of Fellows were involved in other forms of paid employment such as clinical education/ assessment and medico legal work.

Employment Status

Just over 63% of Active Fellows reported that they were working full time (Figure 2.1). Only two respondents aged 59 years or less reported that they were unemployed at the time of the Census.

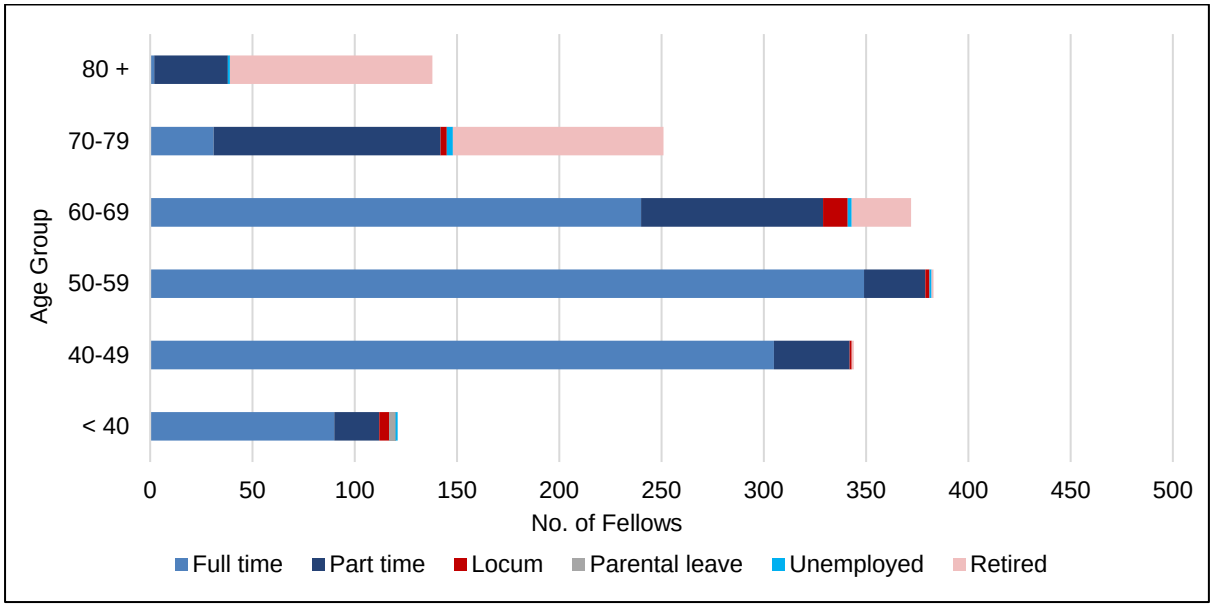
Figure 2.1: Employment status of Fellows by country



Note: Refer to Table A2.1 in Appendix A for the tabulated data

Twenty percent of Fellows reported they were working in a part time capacity, with the majority of these part time Fellows (n=325) aged 60 years and over, reflecting a career transition into retirement. Locum work was undertaken by a very small proportion of Fellows, 1.4% of respondents (Figure 2.2).

Figure 2.2: Employment status of Fellows by age group



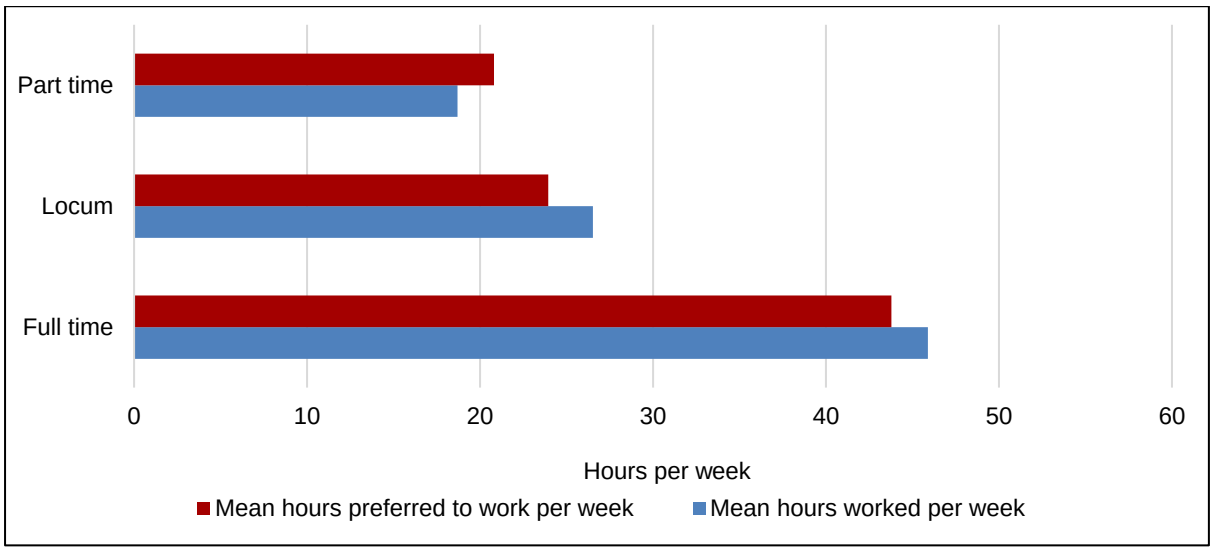
Note: Refer to Table A2.2 in Appendix A for the tabulated data

Work Hours

Fellows employed full time reported working an average of 45.9 hours per week, although they preferred to work 2.1 hours less a week (Figure 2.3). The reported average hours of full time work per week was 47.1 hours in 2020, 50 hours in 2018 and 51 hours in 2016.[4]

Part time Fellows worked on average 18.7 hours per week compared to 20.9 hours per week reported in 2020 and 19.6 hours in 2018. Locums reported working 26.5 hours per week compared to 20.6 hours per week in 2020 and 25 hours per week in 2018. Part time Fellows reported a preference to work 2.1 hours more than currently worked and locums reported a preference to work an average of 2.6 hours less per week.

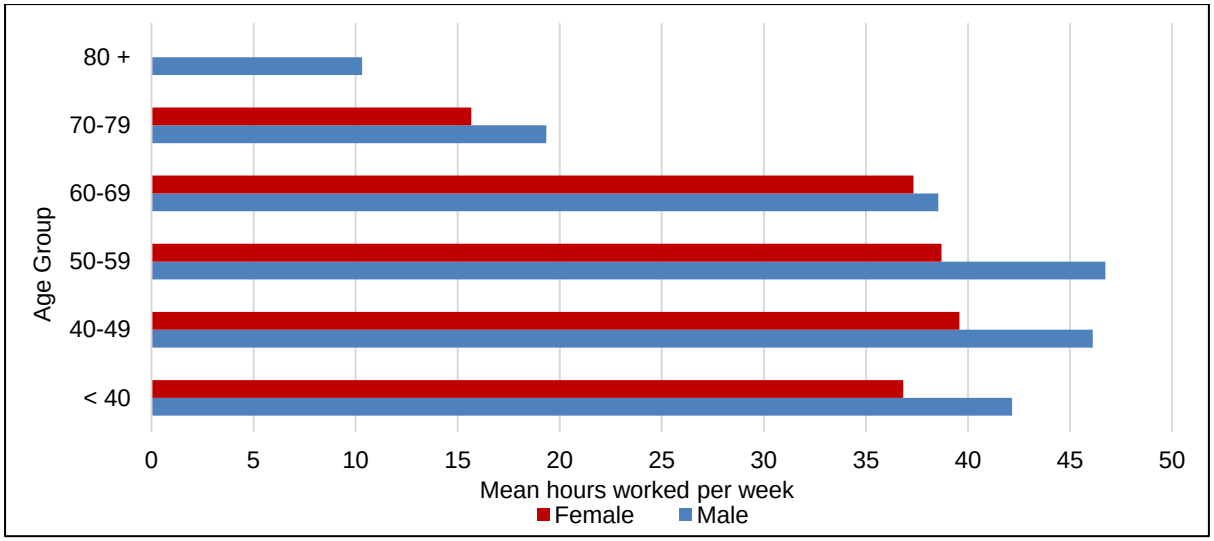
Figure 2.3: Mean hours worked per week and preferred weekly work hours by workforce status



Note: Refer to Table A2.3 in Appendix A for the tabulated data

Until the age of 60 years, female Fellows worked on average 38.4 hours a week, while male Fellows reported working on average 45 hours a week. Compared to other female age groups, female Fellows aged 40-49 worked the longest average hours per week (39.6 hours), while male Fellows in the 50-59 years age bracket reported working the longest hours on average (46.7 hours) when compared to other male age groups. Fellows aged 70-80+ years (male and female) had the lowest average hours worked per week (15.1 hours, compared to 27.6 hours in 2020), an indicator of transitioning into retirement (Figure 2.4).

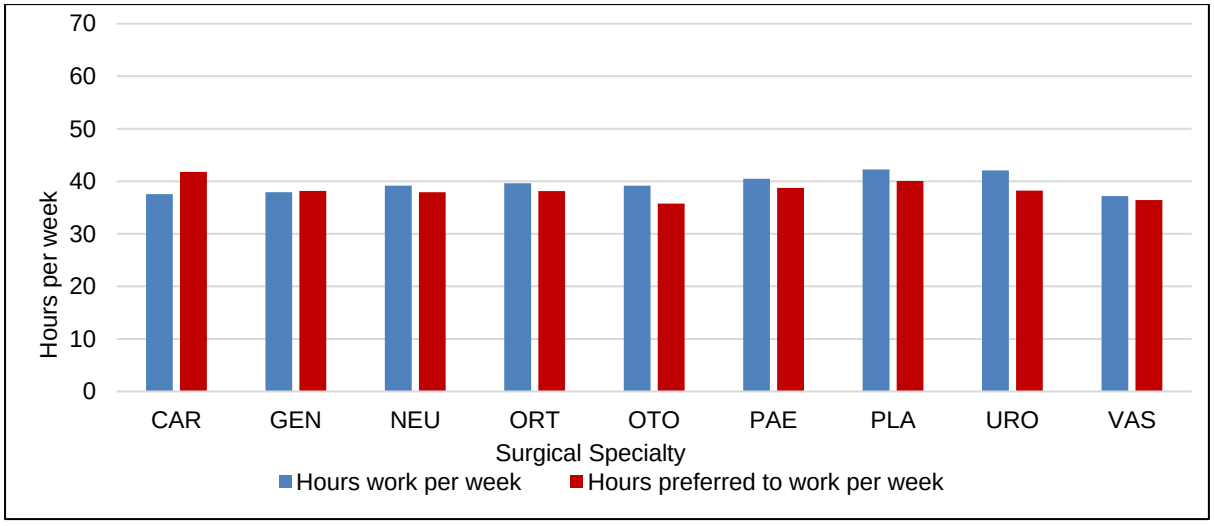
Figure 2.4: Mean hours worked per week by age group



Note: Refer to Table A2.4 in Appendix A for the tabulated data

For all Active Fellows (full time, part time and locum combined), Plastic surgeons reported the longest average hours worked per week (42.3 hours) and Vascular surgeons reported the shortest average hours worked per week (37.2 hours) (Figure 2.5). General surgeons and Vascular surgeons reported working on average similar hours to their preferred working hours. The biggest difference between hours worked and preferred hours was reported by Cardiothoracic surgeons, preferring to work on average 4.2 hours more per week than the 37.2 hours average reported.

Figure 2.5: Mean hours worked per week and preferred weekly work hours of Fellows by specialty



Note: Refer to Table A2.5 in Appendix A for the tabulated data

Public and Private Sector Employment

Fifty-two percent of respondents reported working in public and private practice, compared to 53% in 2020. Paediatric surgery had the highest percentage of respondents who only worked in public practice (60%). Conversely, Plastic and Reconstructive surgery had the highest percentage of respondents who only worked in private practice (41.1 %). The highest percentage of reported mixed practice was Urology (66.7%) (Figure 2.6).

Figure 2.6: Fellows working in public or private practice by surgical specialty

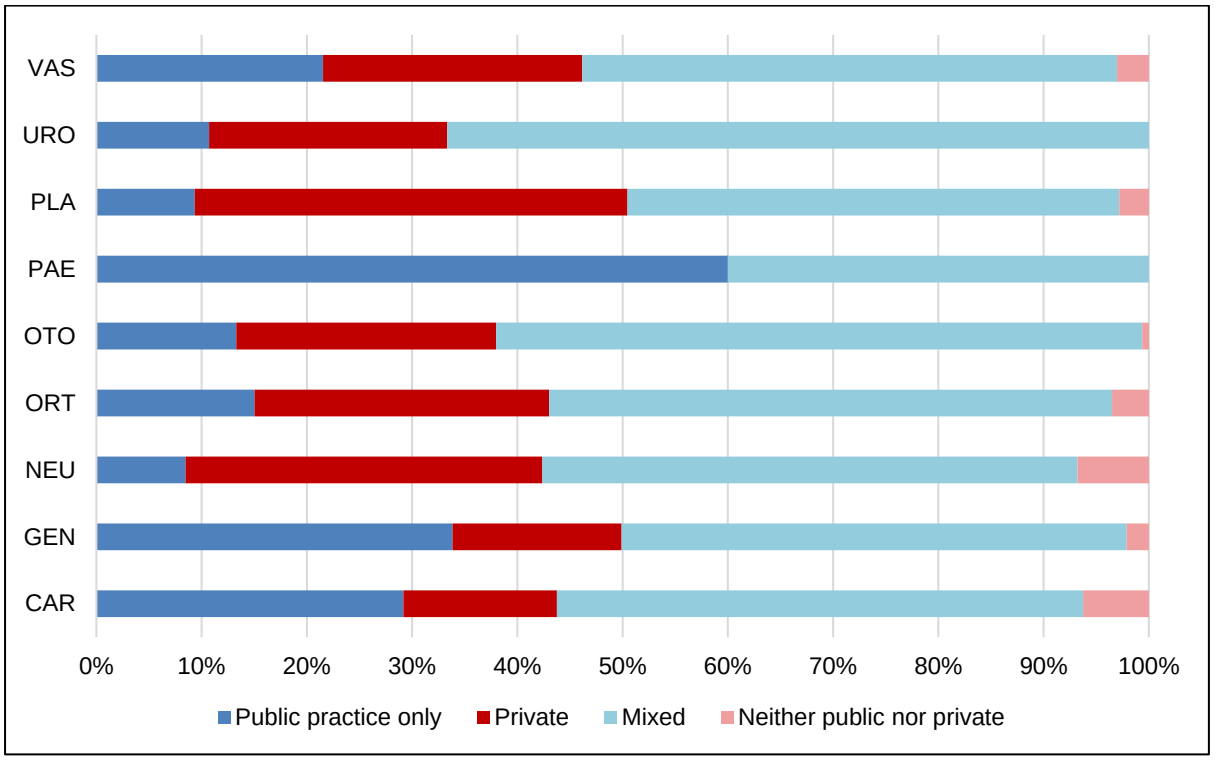
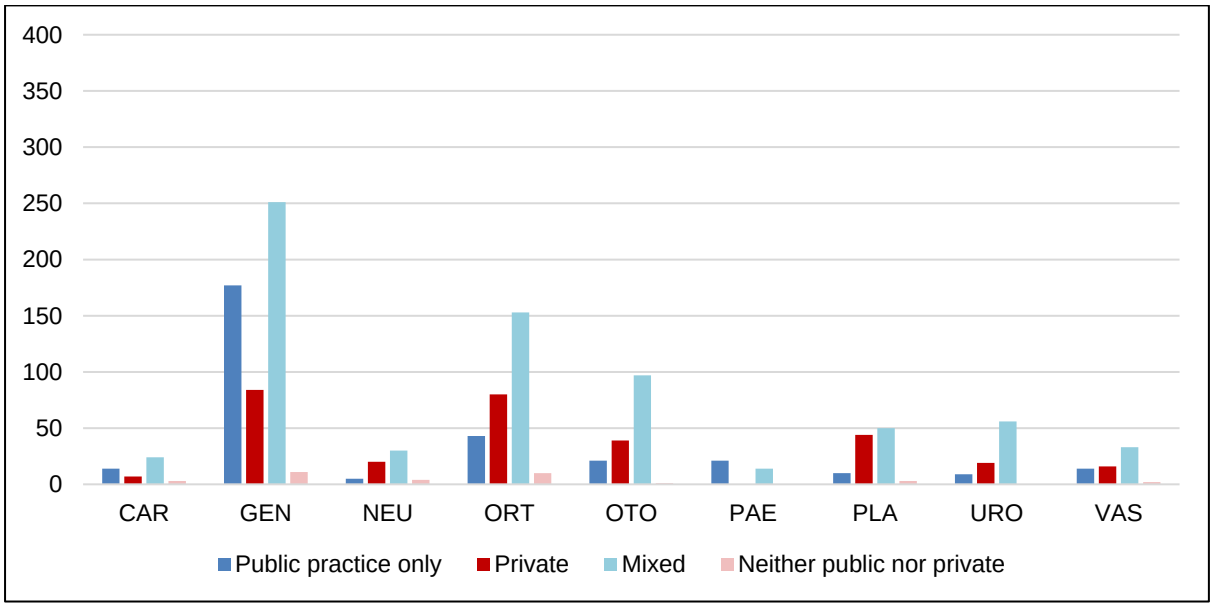


Figure 2.7: Number of Fellows working in public or private practice by surgical specialty



Note: Refer to Table A2.6 and A2.7 in Appendix A for the tabulated data

Fellows were asked to report on their average number of hours worked per week for consulting, procedural and administrative work (Table 2.1 and 2.2).

Fellows in the private sector reported working more hours per week consulting than their public sector counterparts, with a median of 13 hours per week, compared to seven hours a week consulting in the public sector. The median weekly hours spent on consulting work were higher in the private sector for most specialties. For some specialties like Neurosurgery, Orthopaedic surgery and Otolaryngology and Urology, the median hours spent on consulting in the private sector was double or more for the time spent on consulting in the public sector.

Fellows in the public sector reported spending more time on administrative work, reporting a median of four hours on average per week, compared to two hours per week in private practice.

Table 2.1: Median hours per week with interquartile range (IQR) Fellows spent on consulting, procedural work and administrative work in the public sector by surgical specialty

	Consulting (IQR)	Procedural work (IQR)	Administration (IQR)
CAR	6 (4 - 10)	8 (5 - 16)	1 (1 – 2)
GEN	8 (4 - 12)	9 (5 - 14)	2 (1 - 4)
NEU	7 (4 – 10.25)	10 (8 - 16)	4 (1 - 5)
ORT	7 (4 - 10)	12 (8 - 16)	2 (1 - 5)
OTO	5 (4 - 12)	9 (5 - 12)	2 (1 - 4)
PAE	10 (7.25 – 16)	5 (2 - 8)	1.5 (1 – 2.5)
PLA	6 (4- 10)	18 (12 - 24)	2 (1 - 5)
URO	5 (3 – 10)	11 (5 – 20)	2 (1.75 – 4.25)
VAS	6 (4 - 10)	10 (6 – 13.75)	2 (1 - 4)
TOTAL	7 (4 - 10)	10 (6 - 16)	2 (1 - 4)

Table 2.2: Median hours per week with interquartile range (IQR) Fellows spent on consulting, procedural work and administration in the private sector by surgical specialty

	Consulting (IQR)	Procedural work (IQR)	Administration (IQR)
CAR	4 (3 - 8)	8 (5 - 16)	1 (1 - 2)
GEN	10 (6 - 15.5)	9 (5 - 14)	2 (1- 4)
NEU	15 (10 - 25)	10 (8 - 16)	4 (1 - 5)
ORT	16 (10 - 20)	12 (8 - 16)	2 (1 - 5)
OTO	20 (14 - 25)	9 (5 - 12)	2 (1 - 4)
PAE	5 (3.5 - 8)	5 (2 - 8)	1.5 (1 - 2.5)
PLA	15 (10 - 20)	18 (12 - 24)	2 (1 - 5)
URO	16 (11 - 23.5)	11 (5 - 20)	2 (1.75 – 4.25)
VAS	10 (7 - 16)	10 (6 – 13.75)	2 (1 - 4)
TOTAL	13 (8 - 20)	10 (6 - 16)	2 (1 - 4)

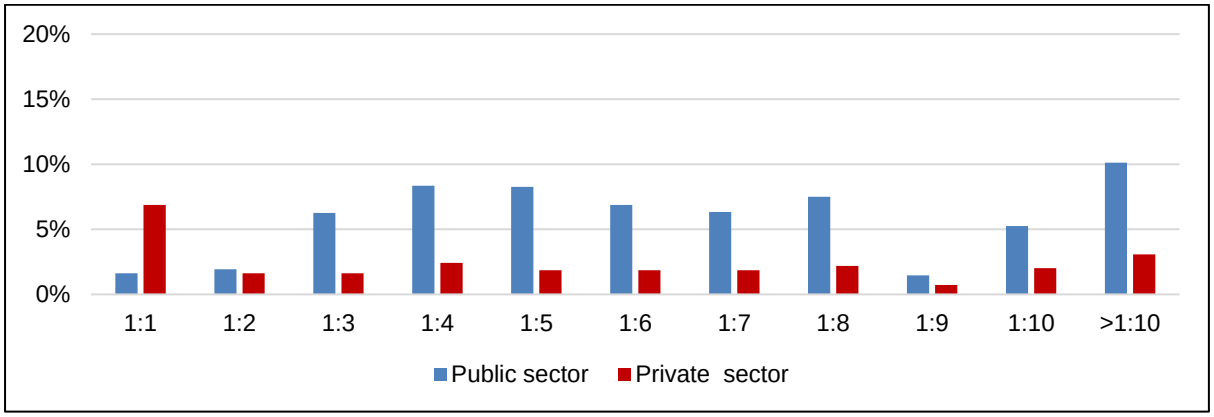
Compared to 2020 and 2018 Census results, the median hours spent on consulting and procedural work remains stable for both public and private sectors. The median time spent on administration in the public sector has decreased (two hours per week on average in 2022, compared to five hours per week in 2020). The private sector median hours spent on administration also remains stable, with 2 hours on average per week reported in 2022 and 2020).

Fewer Fellows in the private sector reported undertaking emergency on-call work compared to the public sector. Almost 74% of Fellows in the private sector reported they do not undertake emergency on call work, compared to 36% of Fellows working in the public sector. Of those doing on-call work in

the public sector, one in ten Fellows undertook emergency on-call more frequently than the recommended 1:4 rotation [5] (Figure 2.8). This is the same result recorded in 2020.

Almost 7% of respondents who undertook emergency on-call work in the private sector did so at 1:1 frequency, the same result recorded in 2020. This is likely to reflect the permanent 'on-call' state Fellows maintain for their patients in private hospitals.

Figure 2.8: Frequency of emergency on-call Fellows took by work sector

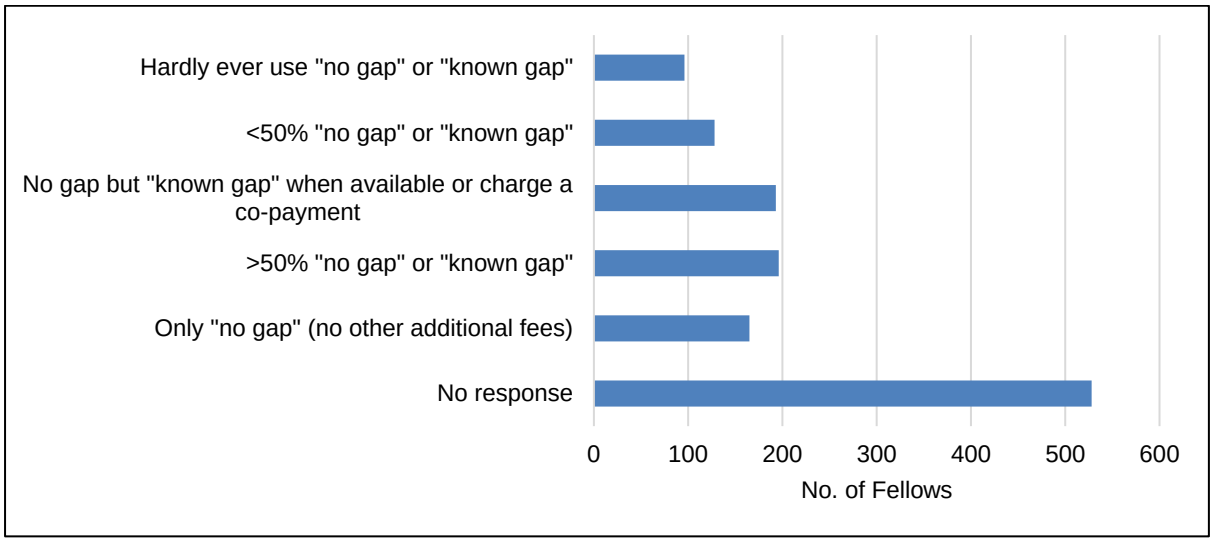


Note: Refer to Table A2.8 in Appendix A for the tabulated data

Private Billing Practices in Australia

The Surgical Workforce Census collects data on private billing practices. Australian Fellows who work in the private sector were asked to describe how their procedural billing is obtained, considering their total private procedural income. Responses were spread across the range of options, with 15.0% of Fellows selecting >50% "no gap" or "known gap", 14.8% selecting "no gap" but "known gap" when available or charge a co-payment and 12.6% selecting only "now gap" (no other additional fees). Almost 10% reported <50% "no gap" or "known gap" and a further 7% advised they hardly ever use "no gap" or "known gap" (Figure 2.9). These results are similar to the 2020 Census.

Figure 2.9: Method used to obtain private billing income, considering total private procedural income, Australia

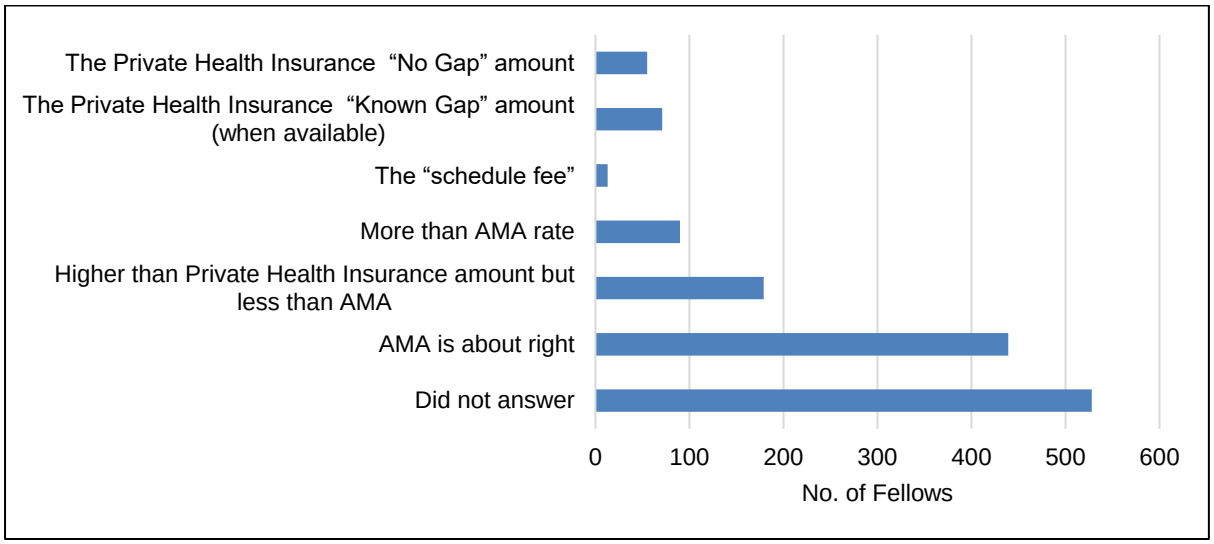


Note: Refer to Table A2.9 in Appendix A for the tabulated data

Fellows were also asked what they consider to be a fair professional fee, ignoring their current billing practice (Figure 2.10).

Almost 32% of respondents reported that the Australian Medical Associating (AMA) fee is about right as a fair professional fee (n=439). The second most frequently selected option was higher than the private health insurance amount, but less that the AMA (13%). This reflects private billing results recorded in 2020 and 2018.

Figure 2.10: Consideration of fair professional fee, ignoring current private billing practices, Australia



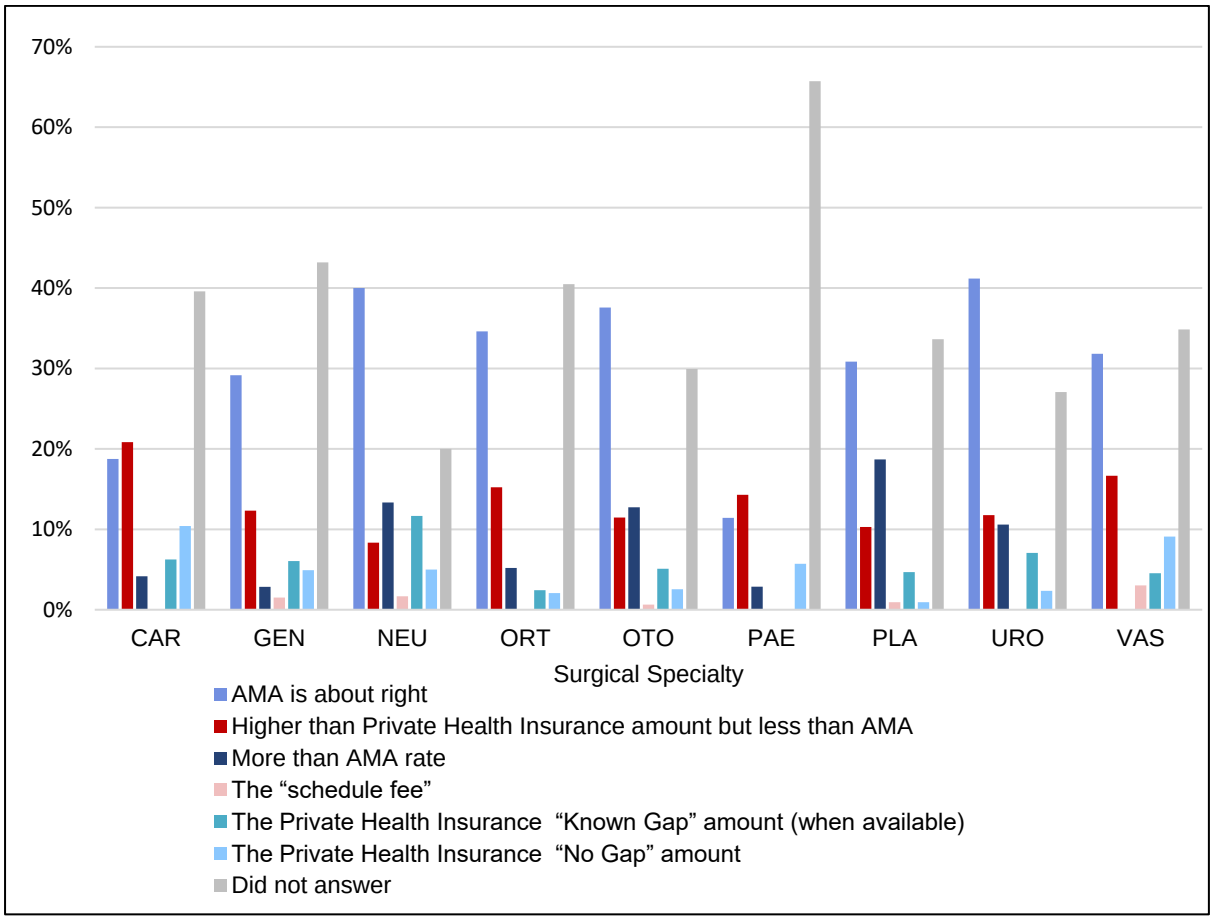
Note: Refer to Table A2.10 in Appendix A for the tabulated data

Of the 439 Fellows who reported that they consider the AMA to be about right in terms of a fair professional fee, the most frequently selected options for obtaining private billing income were >50% no gap" or "known gap" (n=106) and "no gap" but "known gap" when available or charge a co-payment (n=97). For a crosstabulation of the results for how private billing is obtained and what Fellows considered to be a fair professional fee, refer to Table 2.10a in Appendix A.

The results for consideration of fair professional fee were reviewed by each surgical specialty (Figure 2.11).

Just over 29% of General surgeons reported the AMA is about right, compared to 18.8% of Cardiothoracic surgeons. The lack of support for the "schedule fee" as a fair professional fee was consistent across the surgical specialties and mirrors Census results from 2020 and 2018.

Figure 2.11: Consideration of fair professional fee, ignoring current private billing practices by specialty, Australia

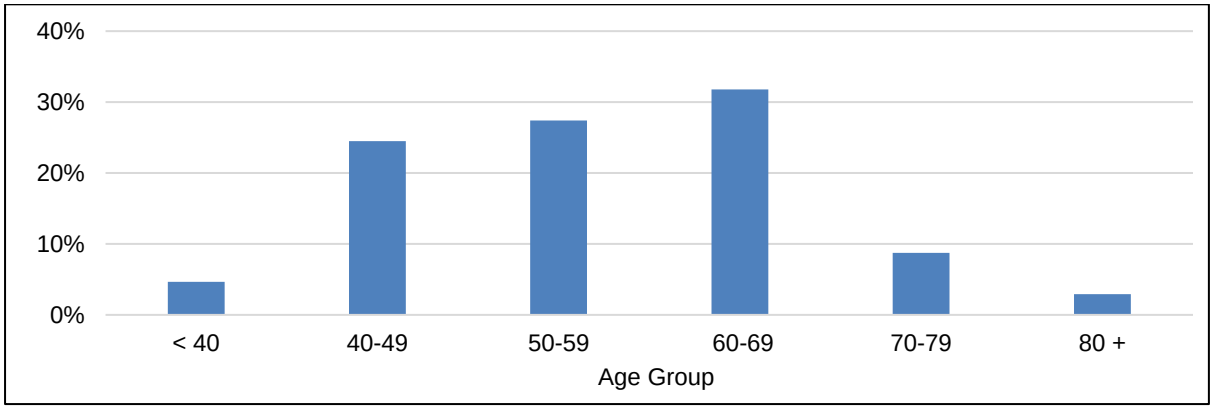


Note: Refer to Table A2.11 in Appendix A for the tabulated data

Other Paid Employment

A quarter of Active Fellows reported that they are involved in other forms of paid employment (Figure 2.12). This is the same result reported in 2020. Fellows aged 60 – 69 reported the highest rate of involvement in other forms paid employment, contrasting with 2020 Census results, where Fellows aged 40 – 49 years old reported undertaking the most other paid employment.

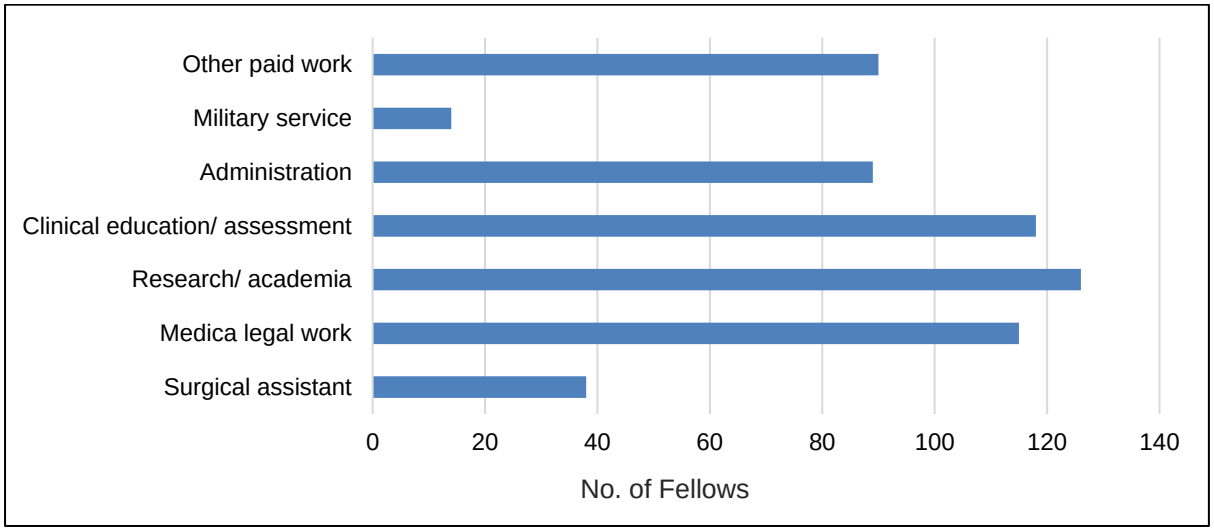
Figure 2.12: Active Fellows involved in other forms of paid employment by age group



Note: Refer to Table A2.12 in Appendix A for the tabulated data

The most common forms of other employment Fellows are engaged in research/ academia, clinical education/ assessment and medical legal work (Figure 2.13).

Figure 2.13: Other forms of paid employment for Fellows



Note: Refer to Table A2.13 in Appendix A for the tabulated data

Chapter 3 – Rural and Regional Practice in Australia and Aotearoa New Zealand

Summary

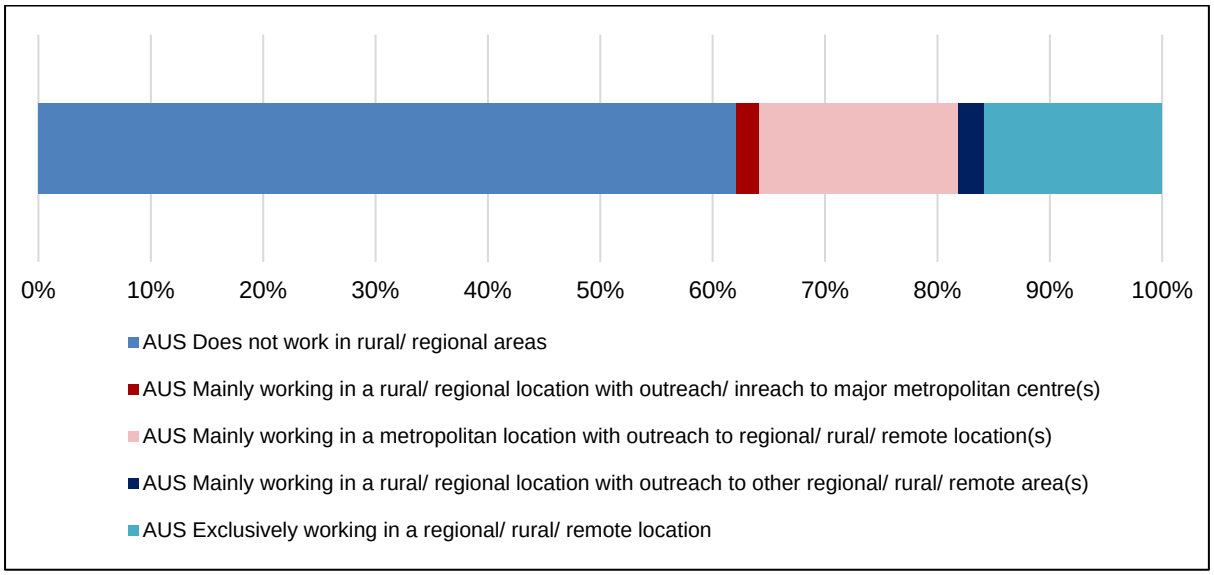
- Almost 16% of Australian Fellows reported working exclusively in a regional, rural or remote location. For Aotearoa New Zealand Fellows, 14.3% reported working exclusively in a regional, rural or remote location.
- Of the Fellows who worked in regional or rural locations only, almost 80% were full time and reported working on average 39.9 hours per week. This is slightly less than the overall average hours per week recorded for all full time respondents (45.9 hours).
- Approximately 21% of Fellows engaged in outreach services monthly and 6% reported working in outreach services weekly, including both metropolitan and rural based Fellows.
- The majority of Fellows indicated no intention to change their future work hours in rural or regional settings.

Characteristics of the Rural and Regional Workforce

Approximately 38% of Australian and 35% of Aotearoa New Zealand respondents reported that they worked in a regional/ rural/ remote location; this includes those practising in both metropolitan locations and regional/ rural/ remote locations. Examples of metropolitan locations in Australia are Melbourne, Geelong, Canberra, Sydney, Newcastle, Wollongong, Brisbane, Gold Coast, Sunshine Coast, Adelaide, Perth. For Aotearoa, New Zealand metropolitan locations are Auckland, Hamilton, Wellington, Christchurch, Dunedin and Tauranga.

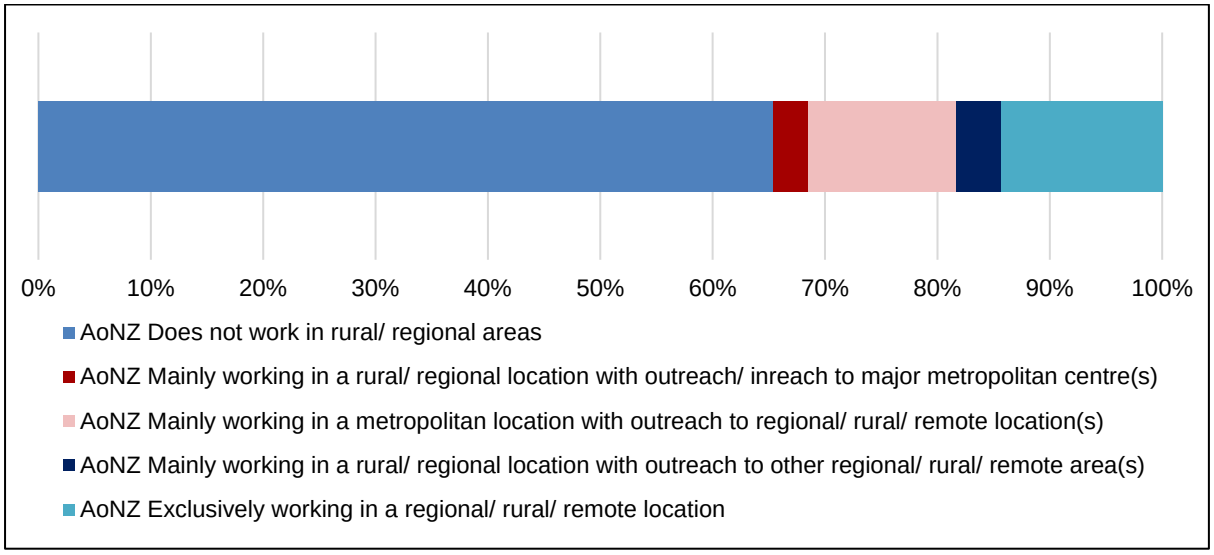
For Australia, the proportion of Fellows reporting that they worked exclusively in a regional, rural or remote location was 15.8%. This increases to 18.2% when including those Fellows who mainly work in a regional/ rural location with outreach to other regional/ rural/ remote area(s). For Aotearoa New Zealand, the proportion of Fellows reporting they worked exclusively in a regional or rural location was 14.3%. This increases to 18.3% when including those Fellows who mainly work in a regional/ rural location with outreach to other regional/ rural/ remote area(s).

Figure 3.1a: Location of work for Active Fellows, Australia



Note: Refer to Table A3.1 in Appendix A for the tabulated data

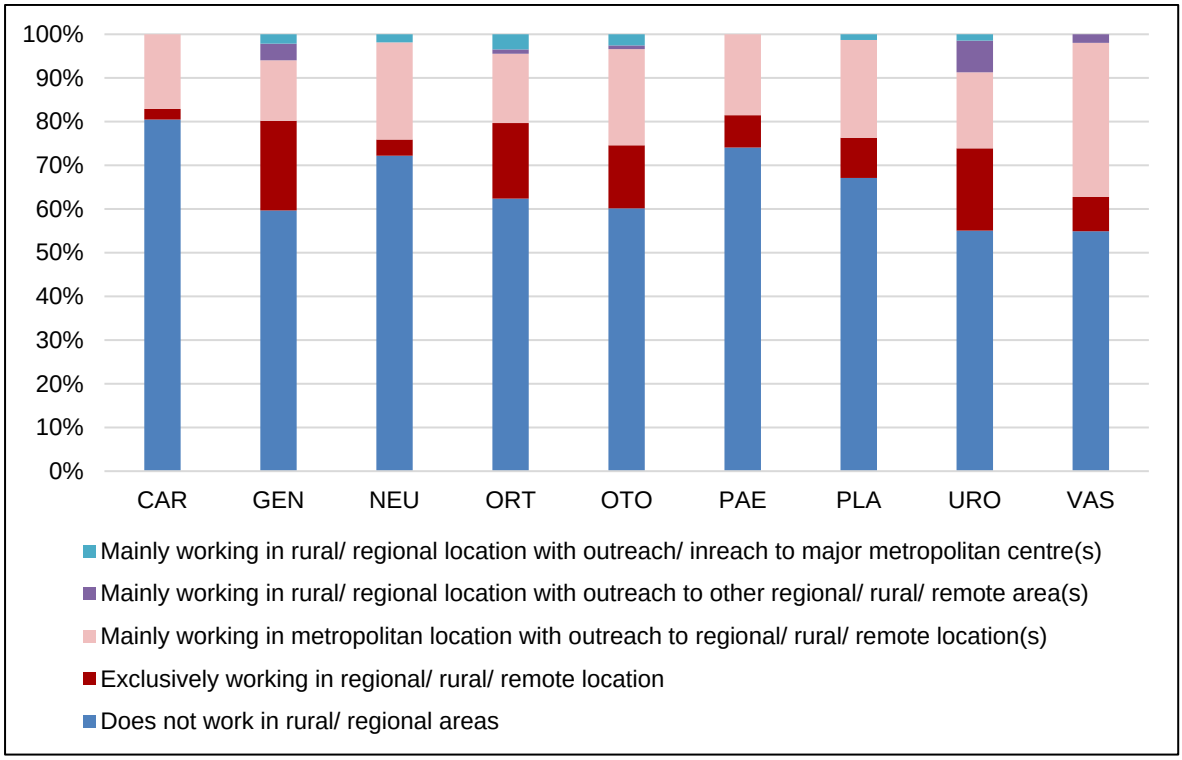
Figure 3.1b: Location of work for Active Fellows, Aotearoa New Zealand



Note: Refer to Table A3.1 in Appendix A for the tabulated data

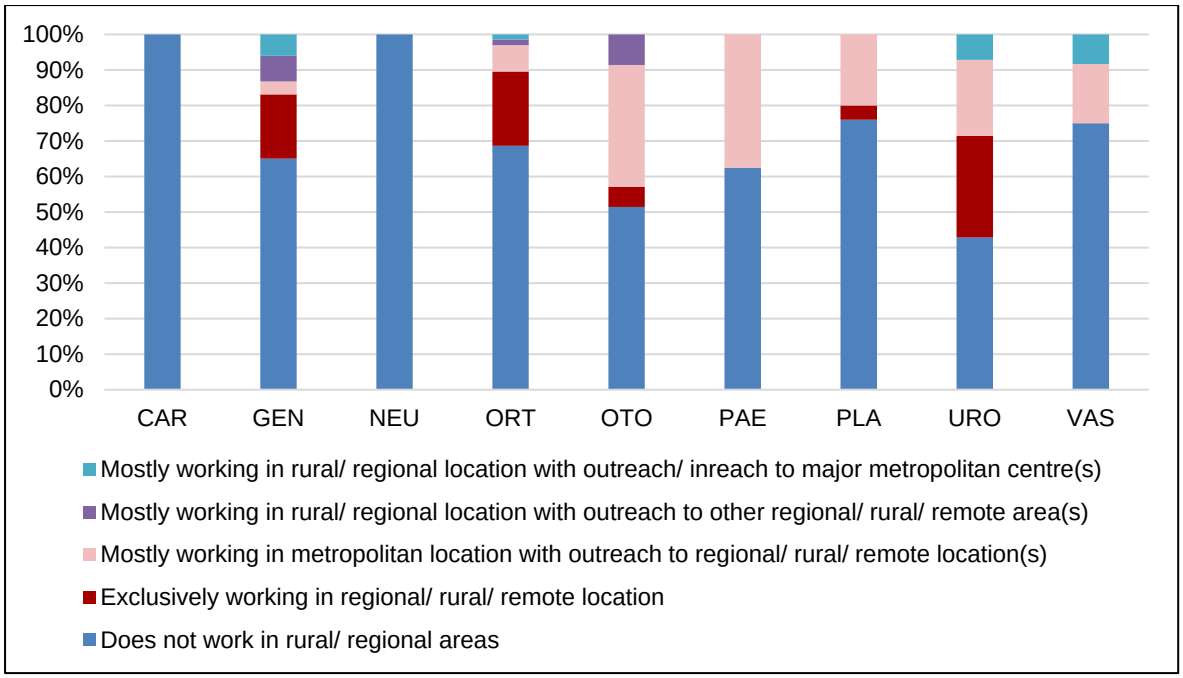
For respondents residing in Australia, the highest proportion of Fellows who worked exclusively in a regional/ rural/ remote location were General surgeons (20.5%), Urology (18.8%) and Orthopaedic surgeons (17.3%). For respondents residing in Aotearoa New Zealand, the highest proportion of Fellows who worked exclusively in a regional or rural location were Urology (28.6%), followed by Orthopaedic surgery (20.9%) and General surgery (18.1%). (Figure 3.2a and 3.2b)

Figure 3.2a: Fellows working in a regional/ rural/ remote location by surgical specialty, Australia



Note: Refer to Table A3.2a in Appendix A for the tabulated data

Figure 3.2b: Fellows working in a regional/ rural/ remote area by surgical specialty, Aotearoa New Zealand



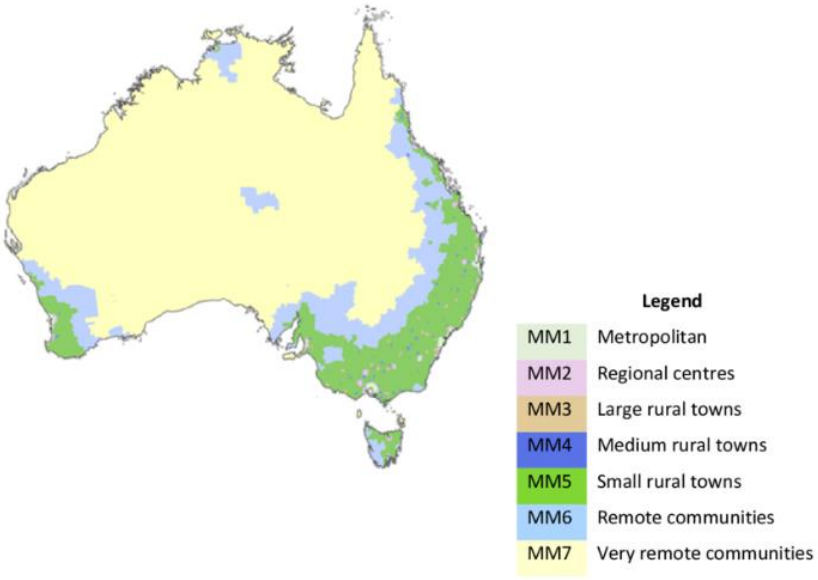
Note: Refer to Table A3.2b in Appendix A for the tabulated data

Rural Location Classifications

To further investigate the number of surgeons that provide care outside major metropolitan centres, Fellows were asked to provide the postcode of their main practice location and other practice location(s) in order of FTE (full time equivalent). Postcodes were mapped to national location classifications.

Australia uses the Modified Monash Model (MMM) 2019 to classify metropolitan, regional, rural and remote areas according to geographical remoteness, as defined by the Australian Bureau of Statistics and town size.[6] The model measures remoteness and population size on a scale of Modified Monash (MM) categories MM 1 to MM 7. MM 1 is a major city and MM 7 is very remote.

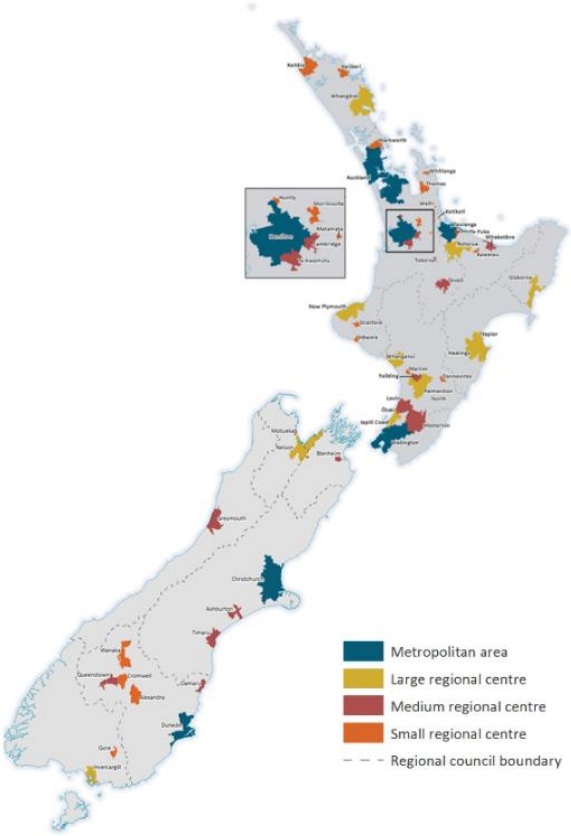
Australian Modified Monash Model (2019)



Source: Australian Department of Health and Aged Care

Aotearoa New Zealand uses the Functional Urban Areas (FUA) classification (2022) developed by Stats NZ to identify small urban areas and rural areas that are integrated with major, large, and medium urban areas to create Functional Urban Areas.[7] FUA types are categorised as metropolitan area, large regional centre, medium regional centre and small regional centre.

Aotearoa New Zealand Functional Urban Areas (2022)



Source: Stats New Zealand

Using the Monash Modified Model (2019) to establish regional, rural and remoteness, of the Australian Fellows who reported working a regional/ rural/ remote location, 43.5% of respondents recorded their main practice location in a metropolitan setting (MM1) and just over 25% in a regional centre (MM2). Almost 15% of Fellows had their main practice location in a small rural town (MM5) and almost 12% in large rural town (MM3). Almost 3% of Australian Fellows had a main practice in a medium rural town (MM4) and a further 2% of Fellows in either a remote or very remote community (MM6 – 7). (Figure 3.3a)

Using the Functional Urban Areas (2022) classification to establish rural and regionality, of the Aotearoa New Zealand Fellows who reported working in a regional/ rural/ remote location, 48.3% of respondents recorded their main practice location in a large regional centre and almost 45% in a metropolitan area. A further 7% had their main practice location in a medium regional centre. (Figure 3.3b)

Of the 488 Australian and Aotearoa New Zealand Fellows who reported that they worked in a full time, part time, or locum capacity in a regional/ rural/ remote location, it should be noted that 16% of Fellows (n=78) provided postcodes for primary and/ or subsequent practice locations that were classified as metropolitan areas only (i.e. MM1 and FUA Metropolitan area). Therefore, the results differ when comparing location of work based on the four options for regional/ rural/ remote practice featured in Figures 3.1a and 3.1b and the location classification results using the Modified Monash Model and Functional Urban Areas (Figures 3.3a and 3.3b).

Figure 3.3a: Location of work using Monash Modified Model classification for Fellows in Australia

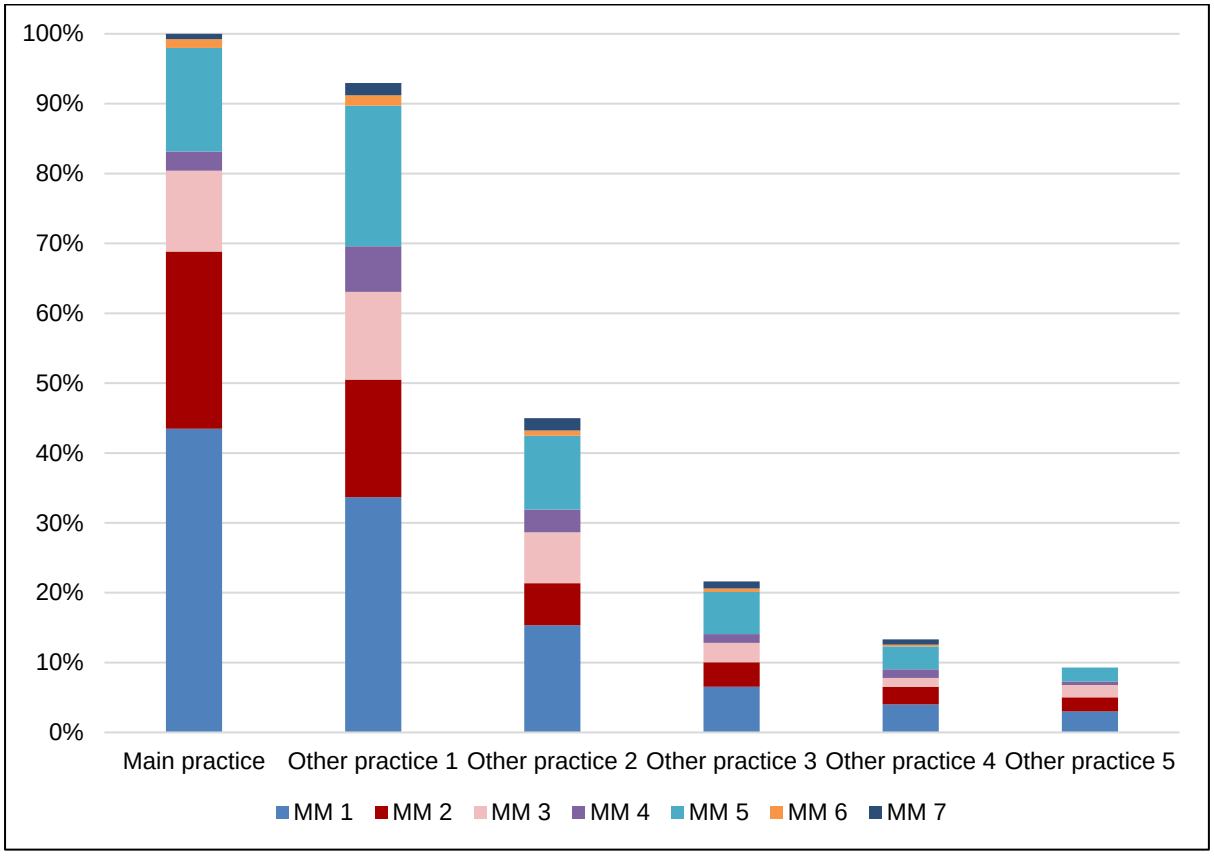
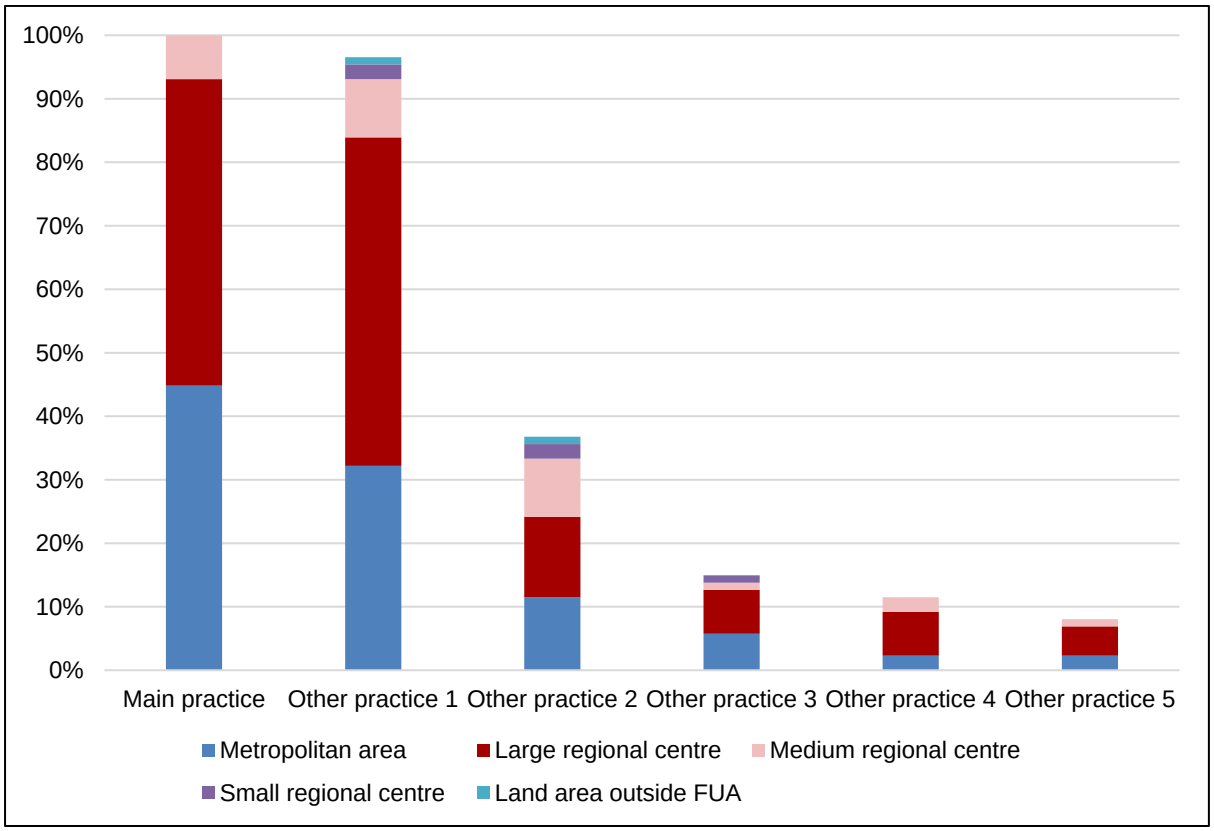


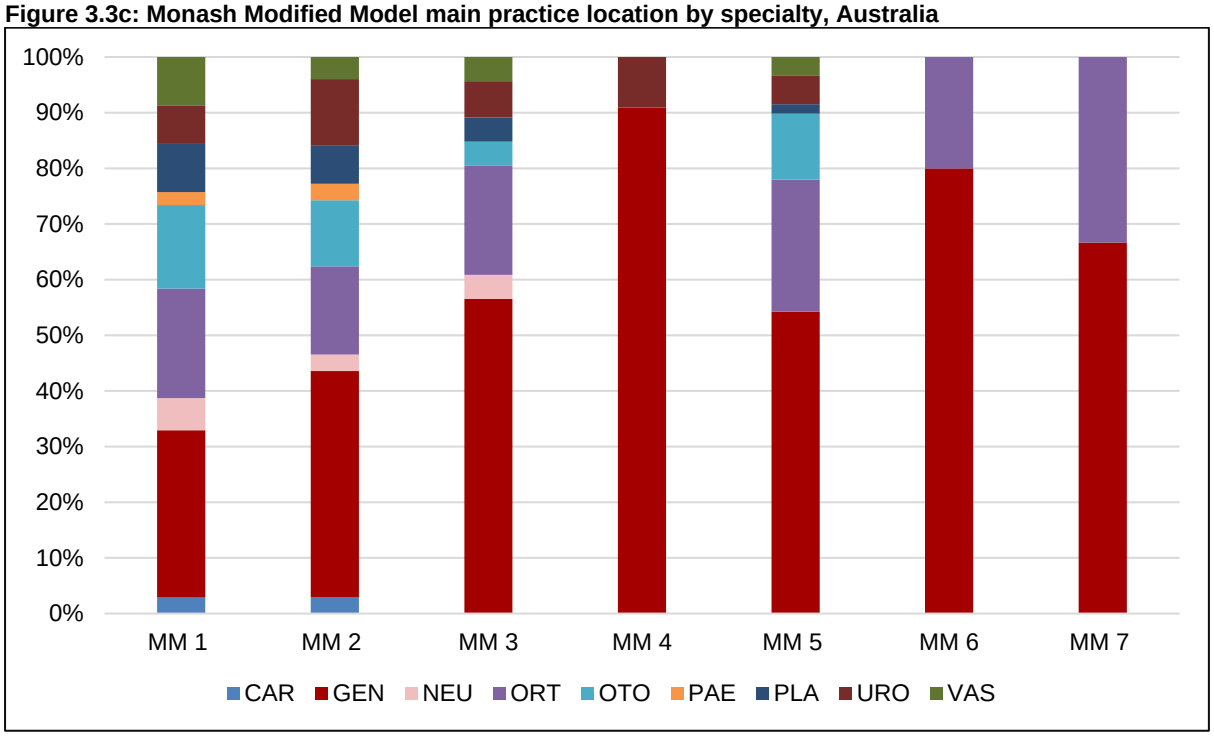
Figure 3.3b: Location of work using Functional Urban Areas classification for Fellows in Aotearoa New Zealand



Note: Refer to Table A3.3a and A3.3b in Appendix A for the tabulated data

For Australian Fellows who worked in a regional, rural or remote location, Monash Modified Model classifications for main practice location were reviewed by surgical specialty. All nine surgical specialties were featured for metropolitan (MM1) and regional centre (MM2) main practice locations, then number of specialties reduce for MM3 – MM7 (large rural towns to very remote communities).

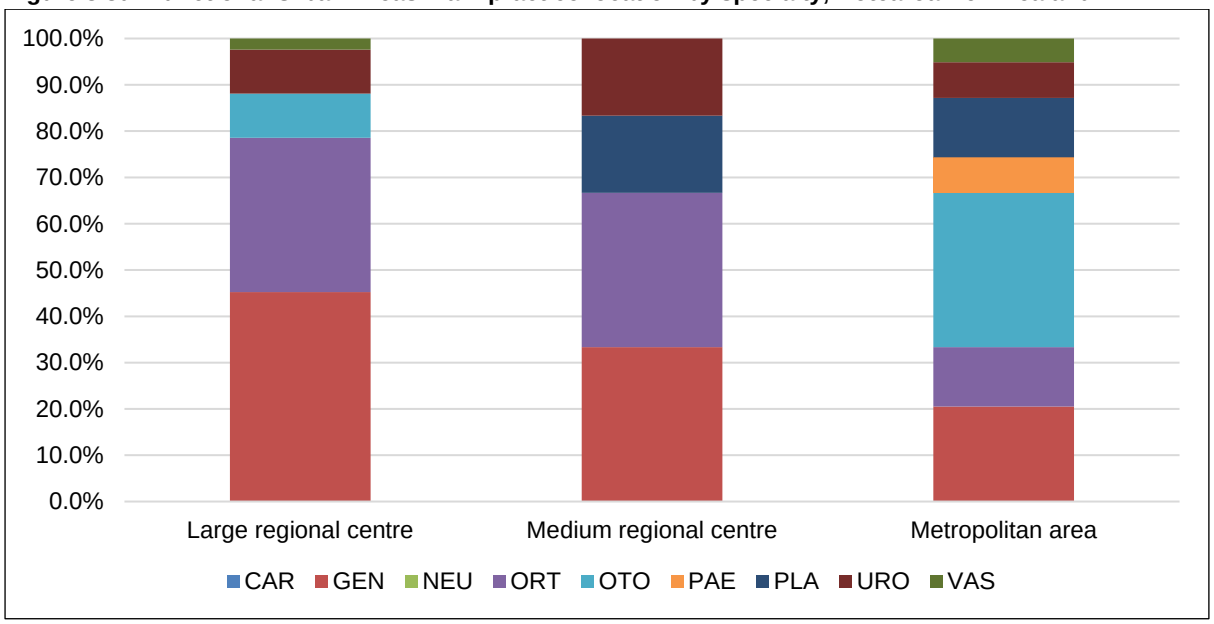
Figure 3.3c: Monash Modified Model main practice location by specialty, Australia



Note: Refer to Table A3.3c in Appendix A for the tabulated data

For Aotearoa New Zealand Fellows who worked in a regional, rural or remote location, Functional Urban Areas classifications for main practice location were also reviewed by surgical specialty. Not all specialities were represented for the Metropolitan area classification, due to the small number of respondents (n=87).

Figure 3.3d: Functional Urban Areas main practice location by specialty, Aotearoa New Zealand

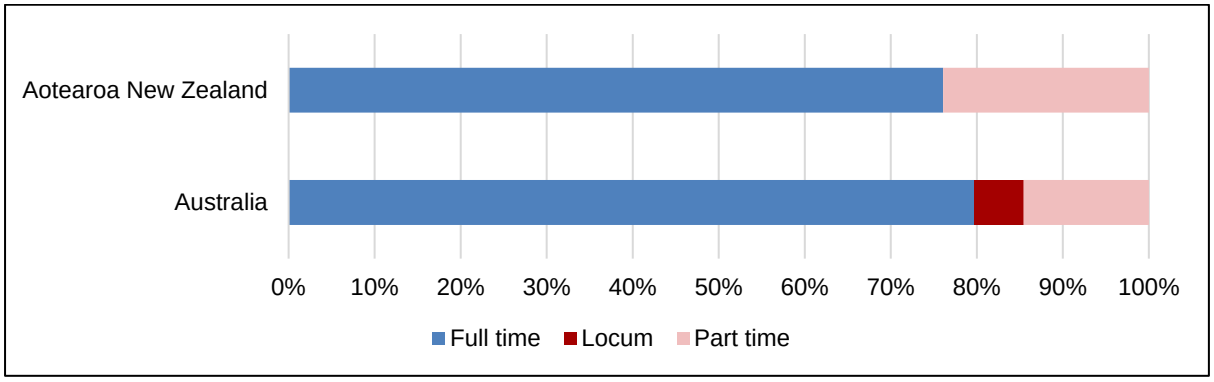


Note: Refer to Table A3.3d in Appendix A for the tabulated data

Rural Employment Status

For Fellows who reported working regional/ rural/ remote locations only, (n=192 Australia, n=46 Aotearoa New Zealand), almost 80% were working on a full time basis (Figure 3.4).

Figure 3.4a: Employment status of Fellows who work in a regional/ rural/ remote location only



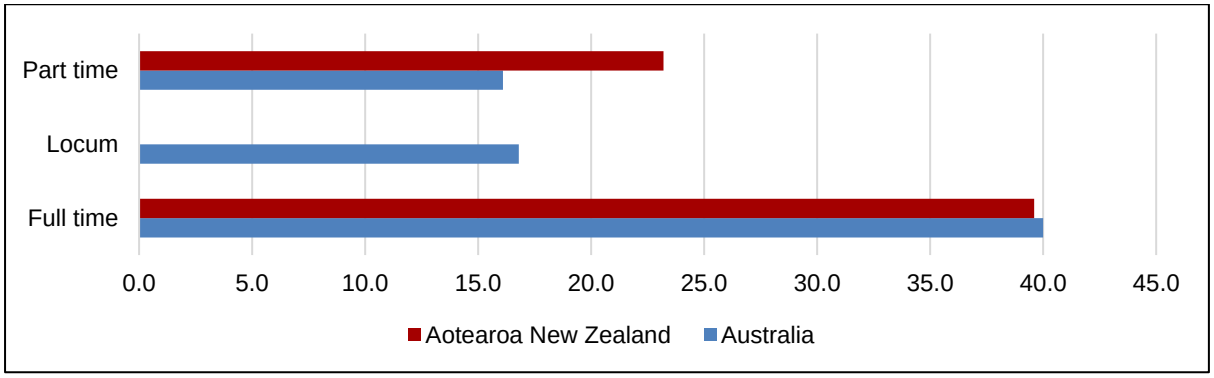
Note: Refer to Table A3.4a in Appendix A for the tabulated data

For this subset of Fellows who reported working in regional/ rural/ remote location only, their full time average hours worked per week was 39.9 hours (compared to 43.7 hours recorded in 2020). This is slightly less than the overall average hours per week for all full time Census respondents (45.9 hours on average per week) in 2022.

Locums who worked in regional/ rural/ remote settings only reported working on average approximately 16.8 hours per week (compared to 14 hours per week in 2020). This is less than the overall average hours per week for all locums in 2020, 26.5 hours.

Part time Fellows who worked in regional/ rural/ remote settings only reported working on average 19.1 hours per week (compared 19.5 hours per week in 2020) (Figure 3.4b). This is similar to the overall average hours worked per week for all part time respondents in 2020 (18.7 hours per week).

Figure 3.4b: Mean weekly hours worked for Fellows who work in a regional/ rural/ remote location only by employment status



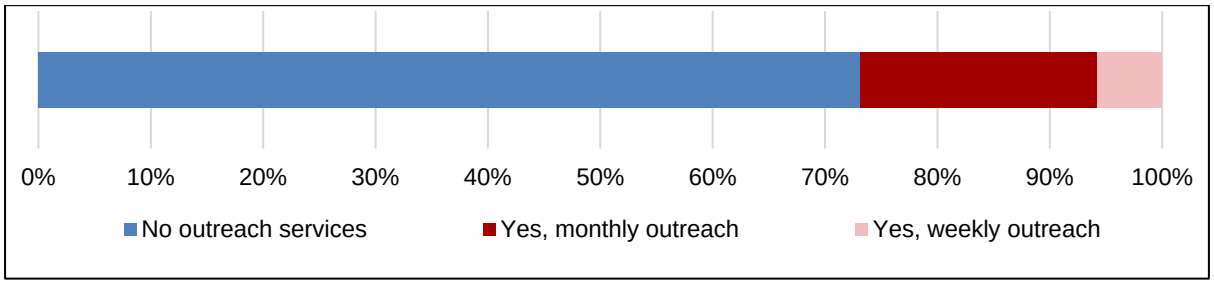
Note: Refer to Table A3.4b in Appendix A for the tabulated data

Outreach Surgery

Respondents who worked in regional/ rural/ remote locations in any capacity were asked about their outreach activities. Outreach surgery is defined as performing surgery in a town where the surgeon is not a resident and may not be available in person for ongoing post-operative care or follow up. Approximately 21% of Fellows reported engaging in outreach services on a monthly basis (working on average 9.3 hours a month) and 6% reported working in outreach services weekly basis (on average

7.8 hours a week) (Figure 3.5). Of the 21% engaged in monthly outreach, 83.5% of respondents (n=86) are from Australia and 16.5% (n=17) are from Aotearoa New Zealand.

Figure 3.5a: Outreach services for Fellows who work in regional/ rural only and rural and metropolitan locations



Note: Refer to Table A3.5a in Appendix A for the tabulated data

When reviewing frequency of outreach surgery by work location, the highest proportion of Fellows who provided per monthly outreach services were those who mainly working in a metropolitan location with outreach to regional/ rural/ remote location(s) (n=55). For a weekly frequency of outreach services, the work location of Fellow was more evenly spread (refer to A3.5b in Appendix A).

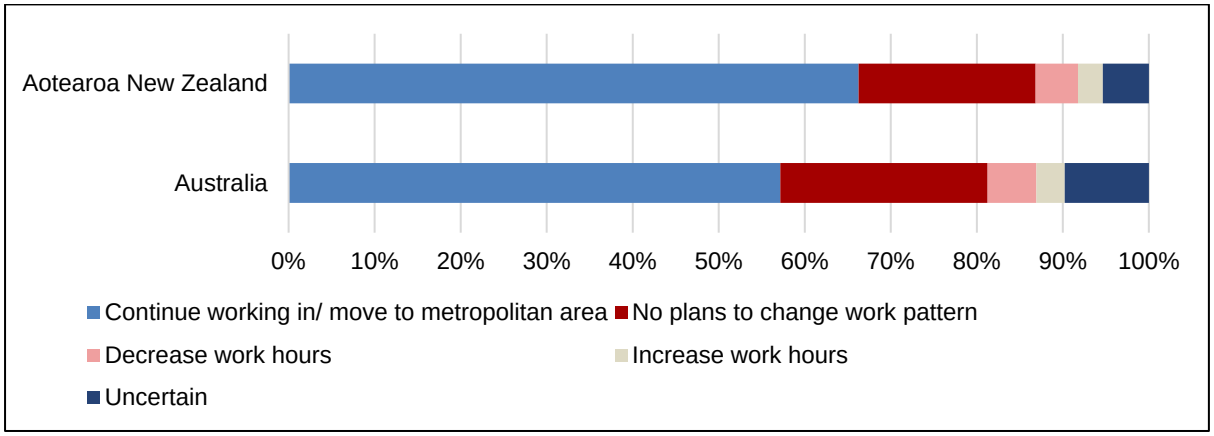
Future Regional and Rural Work Intentions

Fellows who work in regional/ rural/ remote location(s) were asked about their future work intentions in regional/ rural settings over the next five years, including those who work in both metropolitan and rural based locations.

The majority of Fellows reported no intentions to change their regional or rural workload over the next five years.

More than half of respondents (55%) reported they plan to remain practising in a metropolitan setting and 21.4% reported they will continue working in regional/ rural areas without change. Approximately 4% reported they intend on increasing their hours and 7.7% reporting they plan to decrease their working hours in regional and rural settings (Figure 3.6).

Figure 3.6: Future rural and regional work intentions over the next five years



Note: Refer to Table A3.6 in Appendix A for the tabulated data

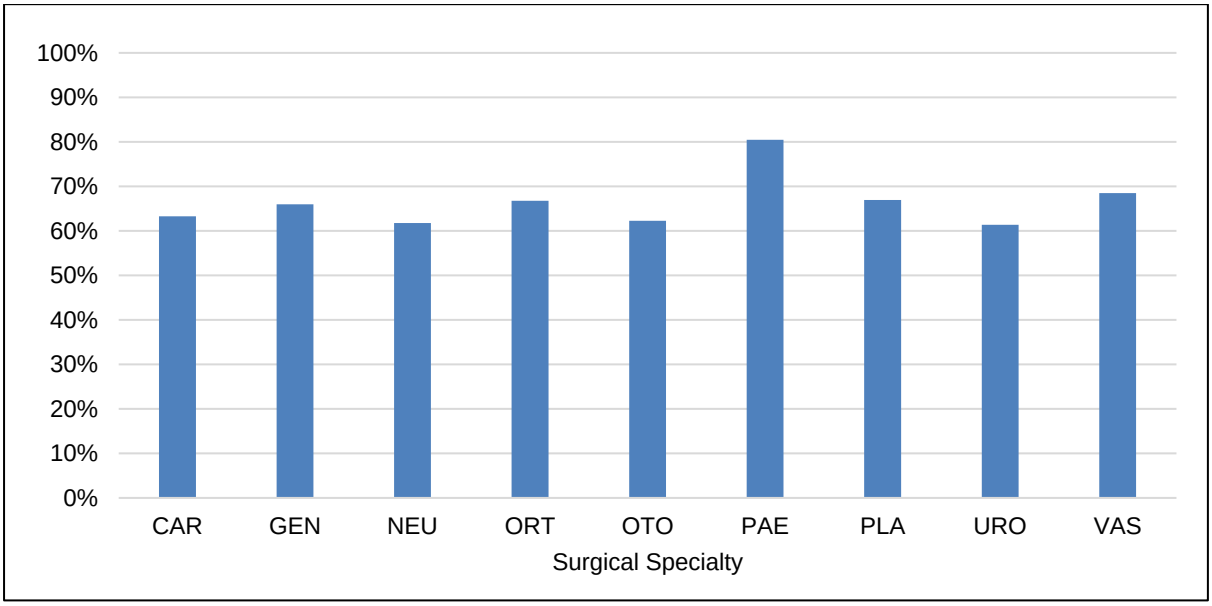
Chapter 4 – Pro Bono Work

Summary

- Over 65% of Fellows participated in pro bono or volunteer work in 2022.
- Fellows reported working on average 10.5 hours per month on pro bono activities.
- The most frequently reported pro bono activities were contributions to RACS, including the SET Program, followed by clinical education not related to RACS.
- For RACS focused activities, contributing as an educational instructor/ examiner, SET Program supervisor and surgical mortality assessor were the most frequently reported pro bono contributions made by Fellows.

In 2022, 65.7% of Active and Retired Fellows reported undertaking pro bono work or volunteer work. By specialty, the largest proportions were Paediatric surgeons (Figure 4.1).

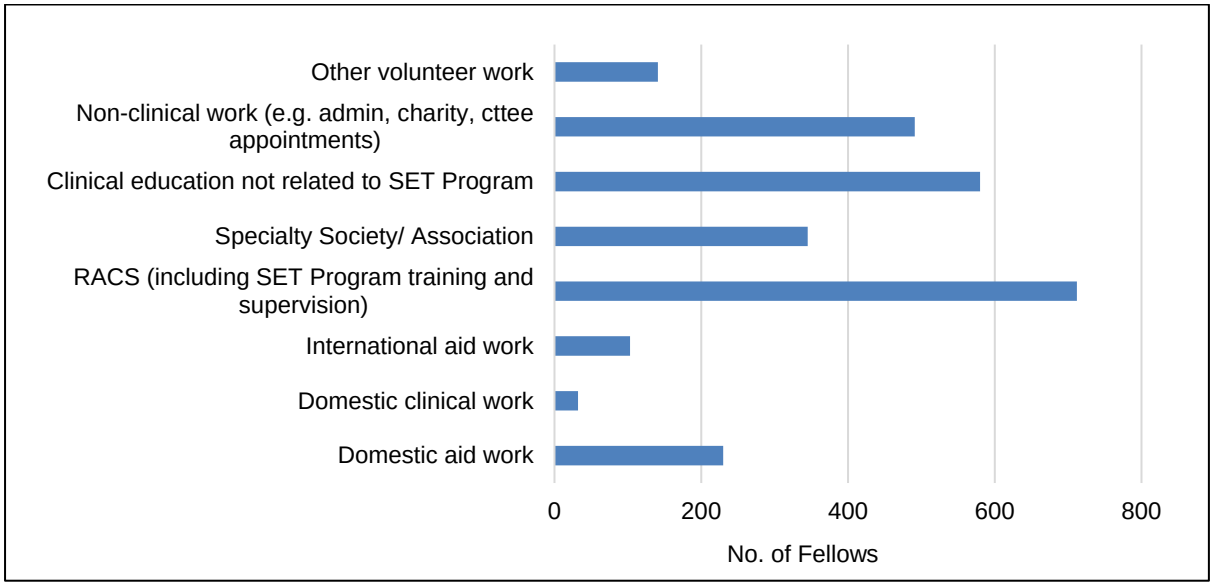
Figure 4.1: Percentage of Fellows who undertake volunteer or pro bono work by specialty



Note: Refer to Table A4.1 in Appendix A for the tabulated data

Almost three quarters of Fellows undertaking pro bono activities reported contributing to RACS, including the Surgical Education and Training (SET) Program (n=712). Just over fifty eight percent of Fellows undertook clinical education not related to SET (n=580) and almost half of the respondents are engaged in non-clinical work (e.g. administration, charity work and committee appointments) (n=491).

Figure 4.2: Types of pro bono or volunteer activities Fellows participate in

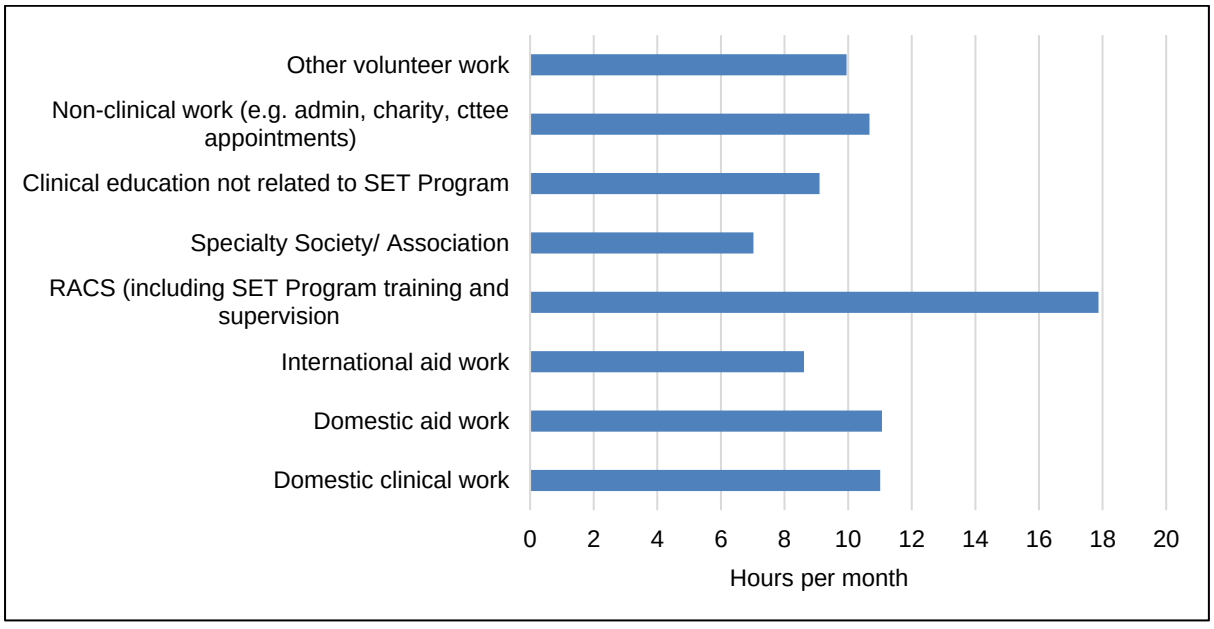


Note: Refer to Table A4.2 in Appendix A for the tabulated data

Fellows were asked about the number of hours they spent on various pro bono activities. Respondents reported spending on average 10.5 hours a month on pro bono services, an increase from 9.5 hours on average recorded in 2020.

Fellows contributed the largest amount of pro bono time to RACS, recording on average 17.9 hours per month. Fellows gave on average 11 hours a month to both domestic clinical work and domestic aid work, and contributed 10.7 hours on average a month towards non-clinical work (e.g. administration, charity work and/ or committee appointments) (Figure 4.3).

Figure 4.3: Mean hours worked per month on pro bono or volunteer activities

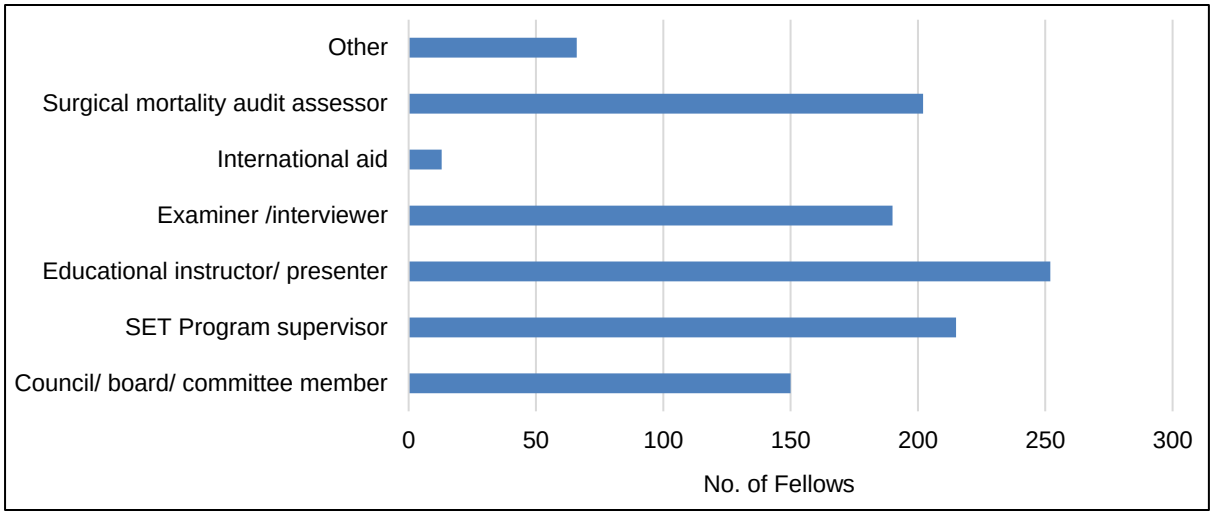


Note: Refer to Table A4.3 in Appendix A for the tabulated data

RACS Pro Bono Roles

Of the Fellows that reported they undertake pro bono work for RACS, the most frequently reported roles were educational instructor/ presenter (n=252) and SET Program supervisor (n=215), followed by surgical mortality audit assessor (n=202) (Figure 4.4).

Figure 4.4: Types of RACS pro bono roles Fellows participate in



Note: Refer to Table A4.4 in Appendix A for the tabulated data

There is strong support from Fellows across all specialties to engage in RACS pro bono activities. Paediatric surgery and General surgery had the highest proportion of representatives involved in RACS pro bono roles (refer to Table A4.5 in Appendix A).

Chapter 5 – Wellbeing

Summary

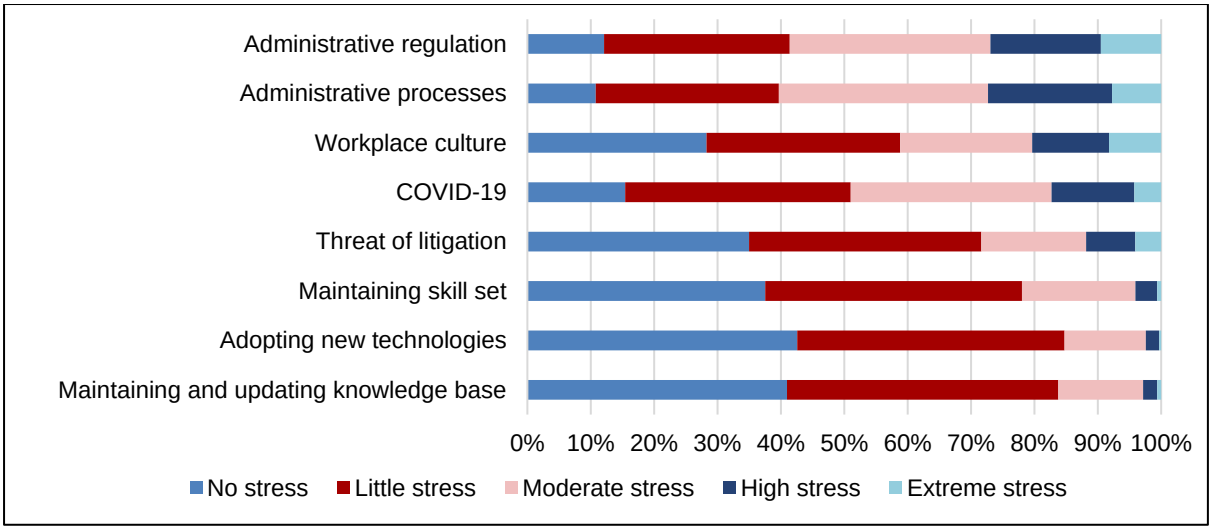
- Administrative regulation and processes continue to rate as a high to extreme source of stress for Fellows, rating higher than workplace culture and COVID-19.
- Almost three quarters of Fellows monitored their health in the last two years, visiting a medical doctor for a health check-up or at regular intervals as dictated by existing medical conditions (72%).
- Almost one in ten Fellows reported seeking professional assistance for stress or mental health issues in the last two years.

Stress

Australian and Aotearoa New Zealand Fellows were asked to rate their stress levels experienced for a range of sources and issues.

High or extreme stress was reported most frequently for administrative processes (27.3%) and administrative regulation (26.9%), consistent with previous Census results in 2020. This was followed by workplace culture (20.4%) and COVID-19 (17.3%). For sources of little or moderate stress, Fellows COVID-19 rated the highest (67.3%), followed by administrative processes (61.9%) and administrative regulation (61.0%) (Figure 5.1).

Figure 5.1: Workplace sources of Fellows' self-rated stress levels

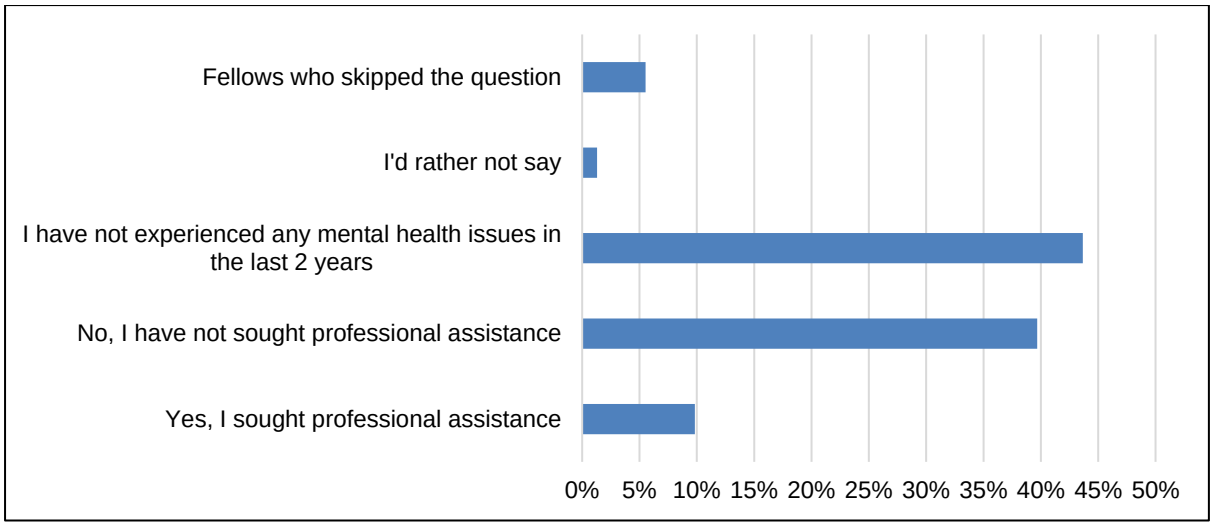


Note: Refer to Table A5.1 in Appendix A for the tabulated data

Health Monitoring and Support

Fellows were asked whether they have sought professional assistance to deal with stress or other mental health issues in the last two years. Forty three percent (n=702) reported that they have not experienced any mental health issues and almost 40% (n=638) reported that they had not sought professional assistance. Almost 10% of Fellows (n=158) reported that they had sought professional assistance, a similar result to 2020 and 2018, but an increase compared to 7.6% recorded in 2016 (Figure 5.2).

Figure 5.2: Proportion of Fellows who have sought professional assistance to deal with stress or a mental health issue in the last two years

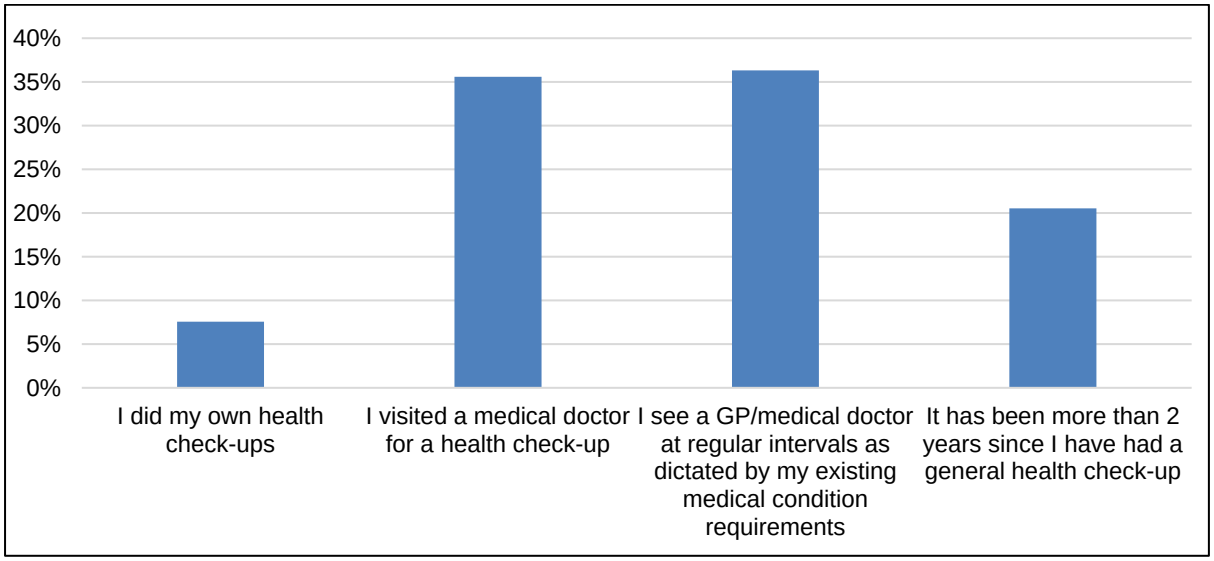


Note: Refer to Table A5.2 in Appendix A for the tabulated data

Most Fellows have had a physical health check-up in the last two years (Figure 5.3), with a total of 72.6% of Fellows either visiting a medical doctor for a check-up or reporting that they see a GP/ medical doctor at regular intervals.

Just over 18% of percent of Fellows reported that it has been more than two years since their last general health check-up. There continues to be a small percentage of Fellows reporting that they do their own health check-ups (8.6% compared to 7.6% in 2020, 8.5% in 2018 and 10% in 2016).

Figure 5.3: How Fellows monitored their general health in the last two years

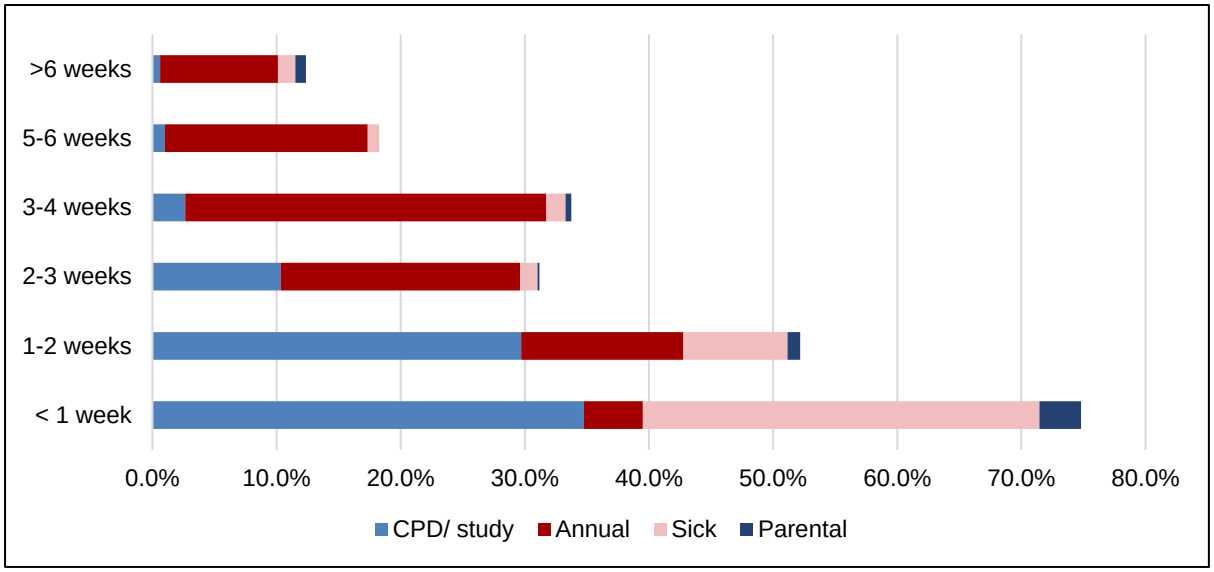


Note: Refer to Table A5.3 in Appendix A for the tabulated data

Leave

Nearly all respondents took either study leave or annual leave in the past 12 months. The common period of leave was up to one week for CPD/ study leave and four weeks for annual leave. This is similar to previous Census results. (Figure 5.4).

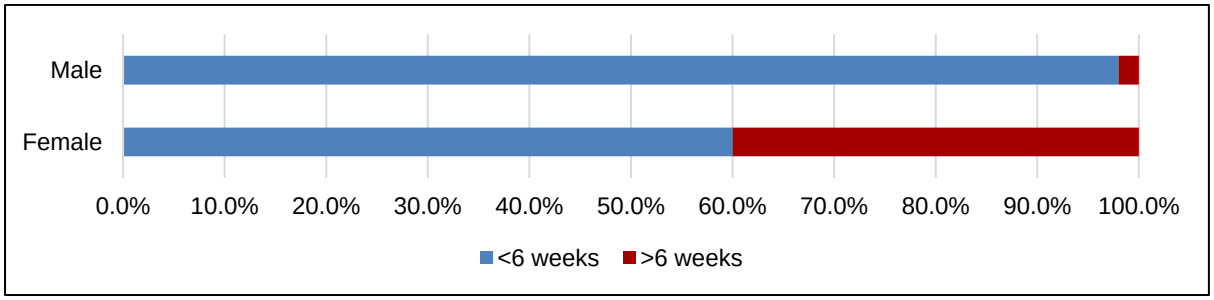
Figure 5.4: Distribution of leave Fellows took over the past 12 months



Note: Refer to Table A5.4 in Appendix A for the tabulated data

Sixty percent of female Fellows (n=15) who reported taking parental leave during 2022 took six weeks or less of leave. Over 98% of male Fellows (n=49) took less than six weeks (most taking one to two weeks). Approximately 40% of female Fellow (n=10) reported returning to work after more than six weeks of parental leave, compared to 2% of male (n=1).

Figure 5.5: Duration of parental leave Fellows took over the past 12 months



Note: Refer to Table A5.5 in Appendix A for the tabulated data

Chapter 6 – Future Work Intentions

Summary

- Fellows across all age ranges intend on reducing their preferred weekly work hours gradually over the next 10 years.
- Male Fellows reported a preference to work slightly more hours in future years than female Fellows across over all age groups reported.
- Two thirds of Fellows aged 50 years and over plan to retire from all forms of paid work within the next ten years.
- Most Fellows aged 65 years or older who intend to continue in paid employment will maintain work predominately because they are doing work that they enjoy.

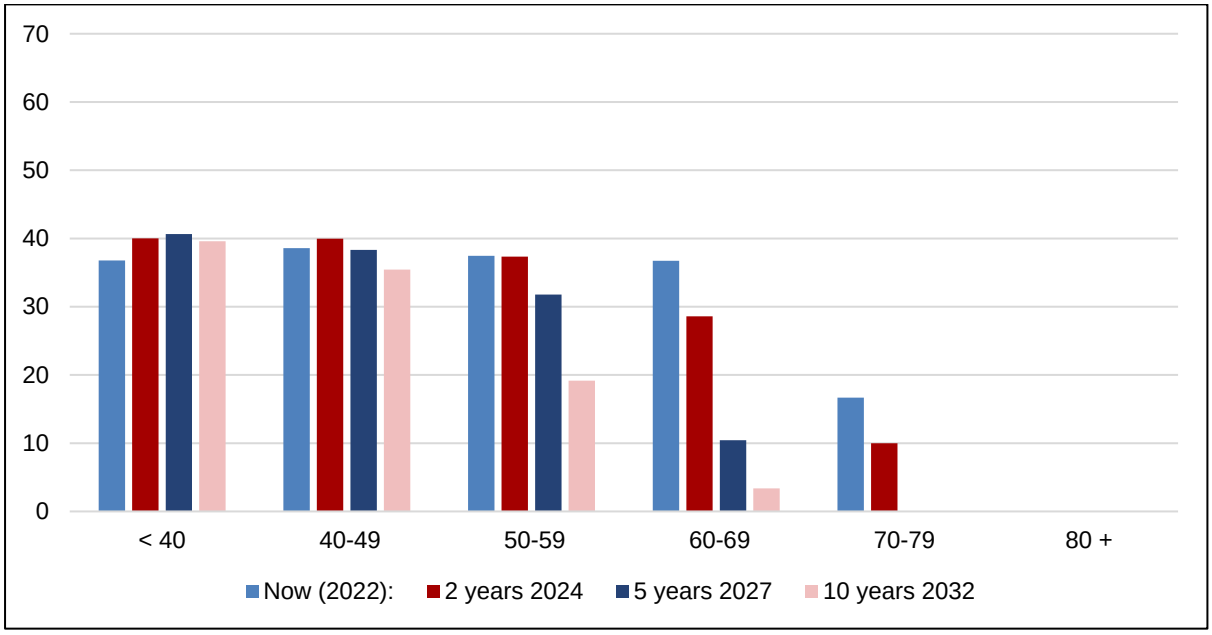
Future Work Hours

Australian and Aotearoa New Zealand Fellows were asked to nominate their preferred hours worked per week now and in the future, at two years, five years, and ten years (Figure 6.1a & b).

40 years or less

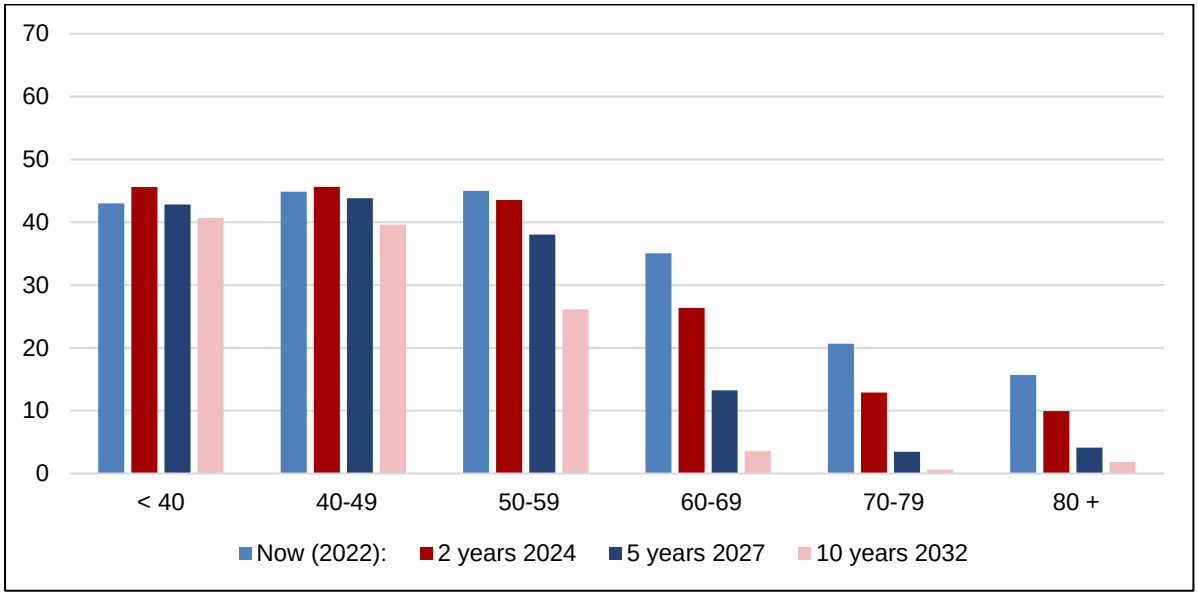
The 2022 preferred work hours of male Fellows below 40 years is more than their female counterparts, with males preferring to work on average 43.0 hours per week and females 36.8 hours on average per week. For both male and female Fellows in this age range, their plan for future weekly work hours for the next 10 years remains fairly consistent, with males planning to work on average 40.7 hours (three hours lower to current work hours) and females 39.6 hours (an increase of 3 hours to current work hours) per week by 2032.

Figure 6.1a: Female Fellows current and future work intentions over the next 10 years



Note: Refer to Table A6.1 in Appendix A for the tabulated data

Figure 6.1b: Male Fellows current and future work intentions over the next 10 years



Note: Refer to Table A6.1 in Appendix A for the tabulated data

40 – 49 years

The current preferred work hours of Fellows aged 40-49 years is also higher for male compared to female Fellows (44.9 and 38.6 hours respectively). Both male and female Fellows in this age group intend to reduce their working hours gradually over the next ten years. Female Fellows reported that they have a preference to work 35.4 hours on average a week and male Fellows on average 39.6 hours per week in 2032.

50 – 59 years

The 50 to 59 years age group also show similar trends with male Fellows reporting higher preferred work hours per week in 2022 (45.0 hours for males versus 37.5 hours for females). Both male and female Fellows intend on reducing hours in work hours gradually over the next ten years. Specifically, male Fellows recorded a preference to work 38.1 hours in 2027 (reducing further to 26.1 hours a week in 2032), compared to 31.8 hours for female Fellows in 2027 (reducing further to 19.2 hours a week on average in 2032).

60 – 69 years

Male and female Fellows reported a preference to work similar hours per week in 2022 (35.1 hours and 36.7 hours respectively) for the 60 – 69 years age range. As reported for all other age groups, both male and female Fellows plan to reduce their weekly working hours over time.

70 – 79 years

Among this age group, male Fellows reported higher average weekly work hours preference in 2022 (20.7 hours) compared to female Fellows (16.7 hours). Male Fellows intend to work more hours per week on average than female Fellows for the next five years as well. Similar to the other age groups, both male and female Fellows plan to continue the trend of gradually reducing their average hours worked over the next ten-year period.

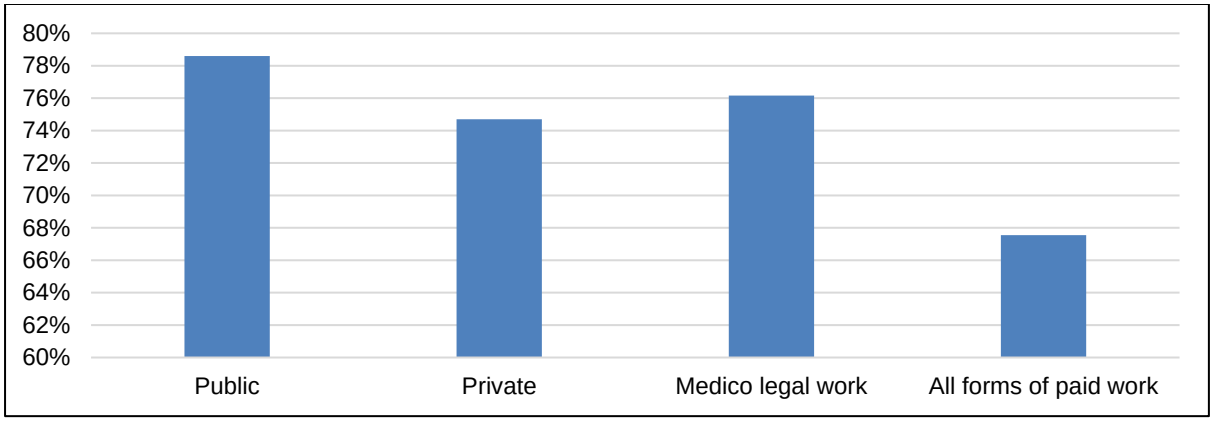
Retirement

Fellows were asked to indicate when they intend to retire from a surgical work within the next ten years, specifically for public work, private work, medico legal work and all forms of paid employment.

Three and a half percent of Fellows aged less than 50 years reported that they intend to retire from all forms of paid work within the next ten years. Regarding clinical practice in the public sector, 15.0% of Fellows in this age group plan to retire within the next 10 years (refer to Appendix A6.2).

For those respondents aged 50 and over, approximately 78.6% of Fellows reported that they intend to retire from public practice within the next ten years, with 74.7% intend to retire from private practice within the next ten years. In total, over 67.6% of Fellows aged over 50 years (n=792) plan to retire from all forms of paid work within the next ten years (Figure 6.2).

Figure 6.2: Proportion of Fellows aged 50 years or older who intend to retire within the next 10 years from clinical practice and all forms of paid work



Note: Refer to Table A6.2 in Appendix A for the tabulated data

Preparing for Retirement

Fellows were asked to reflect on how RACS can further support Fellows leading up to retirement. Analysis of qualitative responses resulted in 130 comments (refer to Table A6.3 in Appendix A).

The most frequent responses recorded were:

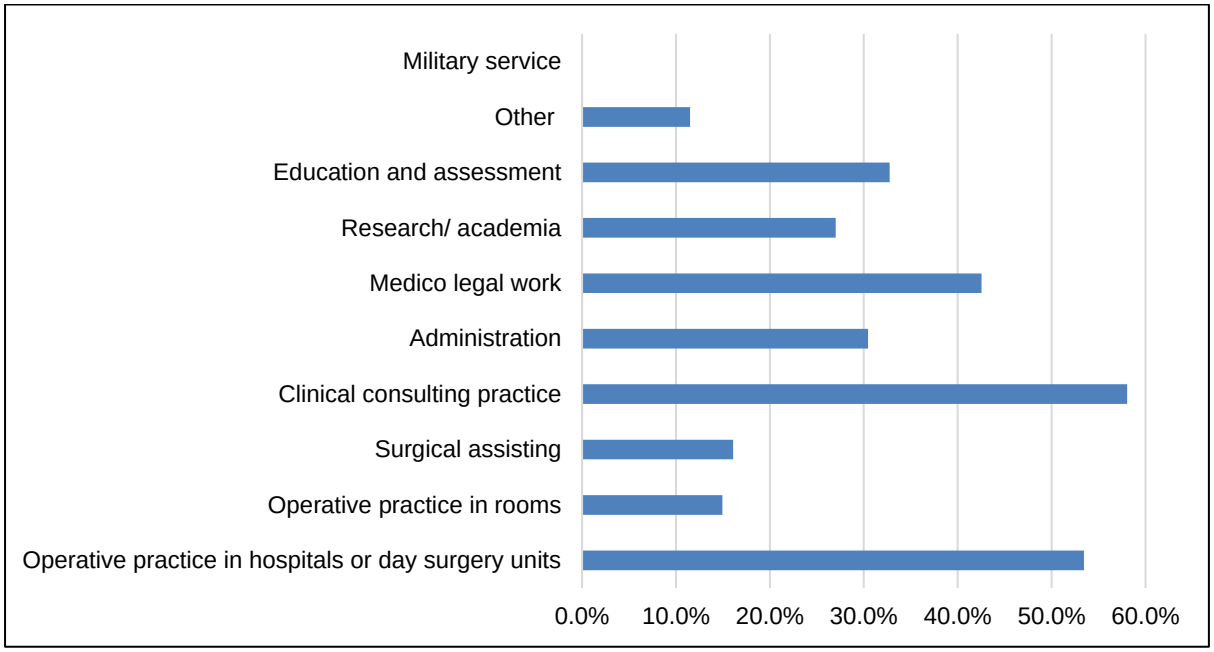
- reduce/ tailor CPD Program requirements for semi-retired Fellows
- offer supportive seminars/ webinars/ eLearning about transitioning to retirement
- utilise the expertise of senior Fellows (e.g. for teaching, mentoring, supporting colleagues transitioning into retirement)
- Provide resources, roadmaps and checklists to help manage the transition from active surgery to non-operative roles
- Advocate to remove barriers to continue to practice (e.g. cost of medical indemnity insurance, medical board registration).

Representative comments made by Fellows include:
“Retired surgeons have a lot to offer, and are very willing to do so, whether in teaching, mentoring etc. The College should be more actively involved in this space. It's a lost valuable resource to the profession and community.”
“Help clinicians close to retirement with ways to maintain registration as it becomes increasingly difficult to maintain CPD points required for ongoing registration. We still have a lot to give.”
“Provide some peer derived guides as to strategies for moving into the next phase of life.”

Future Work Plans for Fellows Aged 65 or Older

Just over 57% of Fellows (n=174) aged 65 years or older reported an intention to be engaged in paid employment for the next two years (refer to Table A6.4a in Appendix A). The most common types of employment these Fellows plan to be engaged in are clinical consulting practice, operative practice in hospitals or day surgery units, and medico legal work (Figure 6.3). This is a similar result to the 2020 Census.

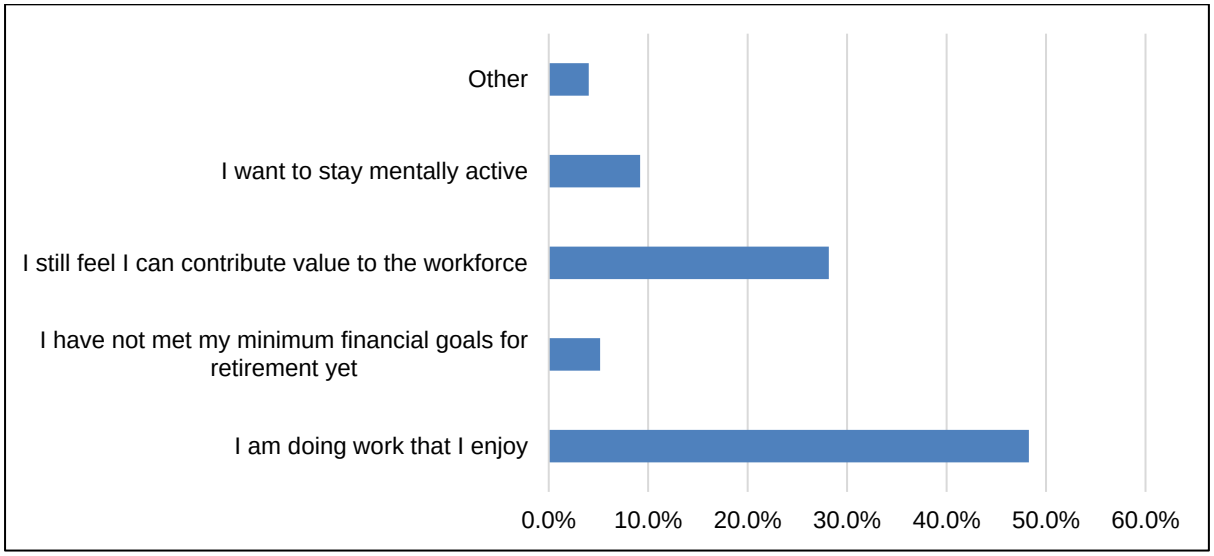
Figure 6.3: Type of work Fellows aged 65 years or older plan to do in the next two years



Note: Refer to Table A6.4b in Appendix A for the tabulated data

Of the Fellows aged 65 years and older who plan to continue in paid employment for the next two years, the main reason given for continuing in paid employment was because they are doing work that they enjoy (48.3%) and approximately 28% reported their main reason was because they believed that they could still contribute value to the workforce (Figure 6.4). This is consistent with the previous Surgical Workforce Census results.

Figure 6.4: Main reason why Fellows aged 65 years or older continue to be engaged in paid employment for next 2 years



Note: Refer to Table A6.5 in Appendix A for the tabulated data.

RACS would like to acknowledge and thank the Fellows who gave their time to participate in the 2022 Surgical Workforce Census.

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APPENDIX A

Chapter 1 Supplementary data

Appendix A1.1 Sex profile of Active Census respondents and Active RACS Fellows, 2022

	2022 Census Active Respondents	2022 Activities Report
Female	261	1015
Male	1133	5596
Unspecified	0	3
Total	1394	6614

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand, Retired Fellows.

Appendix A1.2: Age profile of Active Census respondents and Active RACS Fellows, 2022

	2022 Census Active Respondents	2022 Activities Report
<40	121	821
40-49	344	2184
50-59	382	1847
60-69	348	1131
70+	199	631
Total	1394	6614

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand, Retired Fellows.

Appendix A1.3: Location profile of Active Census respondents and Active RACS Fellows, 2022

	2022 Census Active Respondents	2022 Activities Report
ACT	16	100
NSW	312	1828
NT	7	32
QLD	238	1148
SA	107	469
TAS	23	108
VIC	322	1541
WA	99	513
AoNZ	270	875
Total	1394	6614

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand, Retired Fellows.

Appendix A1.4: Specialty profile of Active Census respondents and Active RACS Fellows, 2022

	2022 Census Respondents N	2022 Activities Report N
CAR	48	226
GEN	538	2255
NEU	61	302
ORT	291	1738
OTO	157	601
PAE	36	120
PLA	109	573
URO	88	544
VAS	66	255
Total	1394	6614

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand, Retired Fellows.

Appendix A1.5: Fellowship status of Census respondents, 2022

	N	%
Active Fellow	1180	73.4
Semi-retired Fellow	195	12.1
Retired Fellow	233	14.5
Total	1608	100.0

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand.

Appendix A1.6: Age distribution and Fellowship status of Census respondents, 2022

Age Group	Active Fellow	Semi-retired Fellow	Retired Fellow	N	%
<40	121	0	0	121	7.5
40-49	343	0	1	344	21.4
50-59	379	3	1	383	23.8
60-69	286	57	29	372	23.1
70-79	46	101	103	250	15.5
80+	5	34	99	138	8.6
Total	1180	195	233	1608	100.0

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand.

Chapter 2 Supplementary data

Appendix A2.1: Employment status of Fellows by country, 2022

Country	Full time	Part time	Locum	Parental leave	Unemployed	Retired	N
Australia	802	274	20	3	8	187	1295
Aotearoa New Zealand	215	50	3	0	0	46	314
Total	1017	324	23	3	8	233	1608

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand.

Appendix A2.2: Employment status of Fellows by age group, 2022

Age group	Full time	Part time	Locum	Parental leave	Unemployed	Retired	N
<40	90	22	5	3	1	0	121
40-49	305	37	1	0	0	1	344
50-59	349	30	2	0	1	1	383
60-69	240	89	12	0	2	29	372
70-79	31	110	3	0	3	103	251
80+	2	36	0	0	1	99	138
Total	1017	324	23	3	8	234	1608

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand.

Appendix A2.3: Mean hours worked per week and preferred weekly work hours by workforce status, 2022

Status	Hours worked per week			Preferred weekly work hours		
	N	Mean	SD	N	Mean	SD
Full time	1017	45.9	12.1	966	43.8	11.6
Locum	23	26.5	21.0	18	23.9	16.6
Part time	324	18.7	13.3	304	20.8	13.2
Total	1364	39.1	17.2	1288	38.1	15.6

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; unemployed or parental leave.

Appendix 2.4: Mean hours worked per week by age group, 2022

Age Range	Mean			Standard Deviation			
	M	F	Total	M	F	Total	N
<40	42.2	36.8	40.0	14.6	15.4	15.1	117
40-49	46.1	39.6	44.0	11.5	13.0	12.4	343
50-59	46.7	38.7	45.4	12.4	15.9	13.4	381
60-69	38.5	37.3	38.4	17.7	15.3	17. 5	341
70-79	19.3	15.7	19.3	15.9	8.4	15.8	145
80+	10.3	0.0	10.3	10.1	0.0	10.1	38
Total	39.3	38.3	39.1	17.7	14.6	17.2	1365

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; unemployed or parental leave.

Appendix A2.5: Mean hours worked per week and preferred weekly work hours for all Active Fellows by surgical specialty, 2022

	Current hours worked per week			Preferred hours to work per week		
	Mean	SD	N	Mean	SD	N
CAR	37.6	19.7	48	41.8	18.3	46
GEN	37.9	18.0	523	38.2	17.4	494
NEU	39.2	18.5	59	37.9	16.7	56
ORT	39.6	17.6	286	38.1	14.6	262
OTO	39.2	14.9	158	35.8	13.4	153
PAE	40.5	19.5	35	38.7	13.8	34
PLA	42.3	15.3	107	40.1	12.9	102
URO	42.1	14.1	84	38.2	13.8	82
VAS	37.2	15.4	65	36.4	13.6	59
Total	39.1	17.2	1365	38.1	15.6	1288

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; Fellows not currently working full time.

Appendix A2.6: Fellows working in public or private practice by surgical specialty, 2022

		%			
	N	Public practice only	Private practice only	Mixed practice	Neither public nor private
CAR	48	29.2	14.6	50.0	6.3
GEN	523	33.8	16.1	48.0	2.1
NEU	59	8.5	33.9	50.8	6.8
ORT	286	15.0	28.0	53.5	3.5
OTO	158	13.3	24.7	61.4	0.6
PAE	35	60.0	0.0	40.0	0.0
PLA	107	9.3	41.1	46.7	2.8
URO	84	10.7	22.6	66.7	0.0
VAS	65	21.5	24.6	50.8	3.0
Total	1365	23.0	22.6	51.9	2.5

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows.

Appendix A2.7: Number of Fellows working in public or private practice by surgical specialty, 2022

	Public practice only	Private practice only	Mixed practice	Neither public nor private	N
CAR	14	7	24	3	48
GEN	177	84	251	11	523
NEU	5	20	30	4	59
ORT	33	80	153	10	286
OTO	21	39	97	1	158
PAE	21	0	14	0	35
PLA	10	44	50	3	107
URO	9	19	56	0	84
VAS	14	16	33	2	65
Total	3	309	708	34	1365

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows.

Appendix A2.8: Frequency of emergency on-call Fellows took by work sector, 2022

	Public sector		Private sector	
Frequency	N	%	N	%
1:1	21	1.6	85	6.9
1:2	25	1.9	20	1.6
1:3	81	6.3	20	1.6
1:4	108	8.3	30	2.4
1:5	107	8.3	23	1.9
1:6	89	6.9	23	1.9
1:7	82	6.3	23	1.9
1:8	97	7.5	27	2.2
1:9	19	1.5	9	0.7
1:10	68	5.3	25	2.0
≥1:10	131	10.1	38	3.1
No emergency on-call	466	36.0	913	73.9
Total	1294		1236	

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; unemployed or on parental leave.

Appendix A2.9: Method used to obtain private billing income, considering total private procedural income, Australia 2022

	N	%
Only "no gap" (no other additional fees)	165	12.6
>50% "no gap" or "known gap"	196	15.0
"No gap" but "known gap" when available or charge a co-payment	193	14.8
<50% "no gap" or "known gap"	128	9.8
Hardly ever use "no gap" or "known gap"	96	7.4
No response	528	40.4
Total	1306	100.0

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Aotearoa New Zealand Fellows; Retired Fellows; unemployed or on parental leave.

Appendix A2.10: Consideration of a fair professional fee, ignoring current private billing practices, Australia 2022

	N	%
AMA is about right	439	31.9
Higher than private health insurance amount but less than AMA	179	13.0
More than AMA rate	90	6.5
The "schedule fee"	13	0.9
The private health insurance "known gap" amount (when available)	71	5.2
The private health insurance "no gap" amount	55	4.0
No response	528	38.4
Total	1375	100.0

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Aotearoa New Zealand Fellows; Retired Fellows; unemployed or on parental leave.

Appendix A2.10a: Crosstabulation of Fellows' method of private billing and what they considered to be a fair professional fee, Australia 2022

	What Fellows consider to be a fair professional fee (N)							
Method used to obtain private billing income	AMA is about right	Higher than private health insurance amount but less than AMA	More than AMA rate	The "schedule fee"	The private health insurance "known gap" amount (when available)	The private health insurance "No gap" amount	Did not answer	Total
"No gap" but "known gap" when available or charge a co-payment	97	48	9	3	30	6	0	193
>50% "No gap" or "known gap"	106	53	14	1	21	1	0	196
Hardly ever use "No gap" or "known gap"	62	4	29	0	1	0	0	96
<50% "No gap" or "known gap"	76	24	26	0	2	0	0	128
Only "No gap" (no other additional fees)	70	40	3	4	9	39	0	165
Did not answer	0	0	0	0	0	0	528	528
Total	411	169	81	8	63	46	528	1306

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows

Appendix A2.11: Consideration of a fair professional fee, ignoring current private billing practices, by surgical specialty, Australia 2022

	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total
AMA is about right	9	154	24	100	59	4	33	35	21	439
Higher than private health insurance amount but less than AMA	10	65	5	44	18	5	11	10	11	179
More than AMA rate	2	15	8	15	20	1	20	9	0	90
The "schedule fee"	0	8	1	0	1	0	1	0	2	13
The private health insurance "known gap" amount (when avail)	3	32	7	7	8	0	5	6	3	71
The private health insurance "no gap" amount	5	26	3	6	4	2	1	2	6	55
Did not answer	19	228	12	117	47	23	36	23	23	528
Total	48	528	60	289	157	35	107	85	66	1375

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows.

Appendix A2.12: Active Fellows who are involved in other forms of paid employment by age group, 2022

	Yes	%	Total
<40	16	4.7	116
40-49	84	24.5	342
50-59	94	27.4	378
60-69	109	31.8	340
70-79	30	8.7	144
80+	10	2.9	38
Total	343	25.3	1358

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows.

Appendix A2.13: Other forms of paid employment for Fellows, 2022

	N
Surgical assisting	38
Medico legal work	115
Research/ academia	126
Clinical Education/ assessment	118
Administration	89
Military service	14
Other paid work	90

Multiple responses given. Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows.

Chapter 3 Supplementary data

Appendix A3.1: Location of work for Active Fellows in Australia and Aotearoa New Zealand, 2022

	N	%
AUS Exclusively working in a regional/ rural/ remote location	167	15.8
AUS Mainly working in a rural/ regional location with outreach to other regional/ rural/ remote area(s)	25	2.4
AUS Mainly working in a rural/ regional location with outreach/ inreach to major metropolitan centre(s)	22	2.1
AUS Mainly working in a metropolitan location with outreach to regional/ rural/ remote location(s)	187	17.7
AUS Does not work in regional/ rural areas	656	62.1
AoNZ Exclusively working in a regional/ rural/ remote location	36	14.3
AoNZ Mainly working in a rural/ regional location with outreach to other regional/ rural/ remote area(s)	10	4.0
AoNZ Mainly working in a rural/ regional location with outreach/ inreach to major metropolitan centre(s)	8	3.2
AoNZ Mainly working in a metropolitan location with outreach to regional/ rural/ remote location(s)	33	13.1
AoNZ Does not work in regional/rural areas	164	65.3
Total	1308	

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows.

Appendix A3.2a: Fellows working in a regional/ rural/ remote location by surgical specialty, Australia, 2022

	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total
Exclusively working in regional/ rural/ remote location	1	86	2	35	17	2	7	13	4	167
Mainly working in rural/ regional location with outreach to other regional/ rural/ remote area(s)	0	16	0	2	1	0	0	5	1	25
Mainly working in a rural/ regional location with outreach/ inreach to major metropolitan centre(s)	0	9	1	7	3	0	1	1	0	22
Mainly working in a metropolitan location with outreach to regional/ rural/ remote location(s)	7	58	12	32	26	5	17	12	18	187
Does not work in regional/ rural area(s)	33	250	39	126	71	20	51	38	28	656
Total	41	419	54	202	118	27	76	69	51	1057

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows.

Appendix A3.2b: Fellows working in a regional/ rural/ remote location by surgical specialty, Aotearoa New Zealand, 2022

	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total
Exclusively working in regional/ rural/ remote location	0	15	0	14	2	0	1	4	0	36
Mainly working in rural/ regional location with outreach to other regional/ rural/ remote area(s)	0	6	0	1	3	0	0	0	0	10
Mainly working in a rural/ regional location with outreach/ inreach to major metropolitan centre(s)	0	5	0	1	0	0	0	1	1	8
Mainly working in a metropolitan location with outreach to regional/ rural/ remote location(s)	0	3	0	5	12	3	5	3	2	33
Does not work in regional/ rural area(s)	5	54	2	46	18	5	19	6	9	164
Total	5	83	2	67	35	8	25	14	12	251

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows.

Appendix A3.3a: Location of work using Monash Modified Model classification for Fellows in Australia, 2022

	Main practice	%	Other practice 1	%	Other practice 2	%	Other practice 3	%	Other practice 4	%	Other practice 5	%
MM 1	173	43.5	134	33.7	61	15.3	26	6.5	16	4.0	12	3.0
MM 2	101	25.4	67	16.8	24	6.0	14	3.5	10	2.5	8	2.0
MM 3	46	11.6	50	12.6	29	7.3	11	2.8	5	1.3	7	1.8
MM 4	11	2.8	26	6.5	13	3.3	5	1.3	5	1.3	2	0.5
MM 5	59	14.8	80	20.1	42	10.6	24	6.0	13	3.3	8	2.0
MM 6	5	1.3	6	1.5	3	0.8	2	0.5	1	0.3	0	0.0
MM 7	3	0.8	7	1.8	7	1.8	4	1.0	3	0.8	0	0.0
Total	398		370		179		86		53		37	

Exclusions: Aotearoa New Zealand Fellows, Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows.

Appendix A3.3b: Location of work using Functional Urban Areas (FUA) classification for Fellows in Aotearoa New Zealand, 2022

	Main practice	%	Other practice 1	%	Other practice 2	%	Other practice 3	%	Other practice 4	%	Other practice 5	%
Large regional centre	42	48.3	45	51.7	11	12.6	6	6.9	6	6.9	4	4.6
Medium regional centre	6	6.9	8	9.2	8	9.2	1	1.1	2	2.3	1	1.1
Metropolitan area	39	44.8	28	32.2	10	11.5	5	5.7	2	2.3	2	2.3
Small regional centre	0	0.0	2	2.3	2	2.3	1	1.1	0	0.0	0	0.0
Land area outside FUA	0	0.0	1	1.1	1	1.1	0	0.0	0	0.0	0	0.0
Total	87		84		32		13		10		7	

Exclusions: Australian Fellows, Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows.

Appendix A3.3c: Monash Modified Model main practice location by specialty, Australia 2022

Speciality	MM 1	MM 2	MM 3	MM 4	MM 5	MM 6	MM 7	Total
CAR	5	3	0	0	0	0	0	8
GEN	52	41	26	10	32	4	2	167
NEU	10	3	2	0	0	0	0	15
ORT	34	16	9	0	14	1	1	75
OTO	26	12	2	0	7	0	0	47
PAE	4	3	0	0	0	0	0	7
PLA	15	7	2	0	1	0	0	25
URO	12	12	3	1	3	0	0	31
VAS	15	4	2	0	2	0	0	23
Total	173	101	46	11	59	5	3	398

Exclusions: Aotearoa New Zealand Fellows, Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows.

Appendix A3.3d: Functional Urban Areas main practice location by specialty, Aotearoa New Zealand 2022

Speciality	Large regional centre	Medium regional centre	Metropolitan area	Total
CAR	0	0	0	0
GEN	19	2	8	29
NEU	0	0	0	0
ORT	14	2	5	21
OTO	4	0	13	17
PAE	0	0	3	3
PLA	0	1	5	6
URO	4	1	3	8
VAS	1	0	2	3
Total	42	6	39	87

Exclusions: Aotearoa New Zealand Fellows, Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows.

Appendix A3.4a: Workforce status of Fellows who work in a regional or rural area only, 2022

		Full time	Locum	Part time	N
Regional or rural only	Australia	153	11	28	192
	Aotearoa New Zealand	35	0	11	46
	Total	188	11	39	238

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; Fellows mainly working in metropolitan location with outreach to regional/ rural/ remote location(s); Fellows mainly working in a regional/ rural location with outreach/ inreach to major metropolitan centre(s).

Appendix A3.4b: Mean weekly hours worked for Fellows who work in a regional/ rural/ remote location only by employment status, 2022

		Full time	Locum	Part time	N
Regional or rural only	Australia	40.0	16.8	16.1	189
	Aotearoa New Zealand	39.6	-	23.2	46
	Total	39.9	16.8	18.1	235

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; Fellows mainly working in metropolitan location with outreach to regional /rural/ remote location(s); Fellows mainly working in a regional/ rural location with outreach/ inreach to major metropolitan centre(s).

Appendix A3.5a: Outreach services for Fellows who work in regional/ rural only and rural and metropolitan locations, 2022

	N	%	Mean hours
No outreach services	357	73.2	
Yes, monthly outreach	103	21.1	9.3 per month
Yes, weekly outreach	28	5.7	7.8 per week
Total	488	100	

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; Active Fellows do not work in regional/ rural area(s).

Appendix A3.5b: Frequency of outreach surgery for Fellows who work in regional/ rural only or rural and metropolitan centres by work location, 2022

	Per month	Per week	No outreach	Total
Exclusively working in regional/ rural/ remote location	22	7	174	203
Mainly working in rural/ regional location with outreach to other regional/ rural/ remote area(s)	55	8	157	220
Mainly working in a rural/ regional location with outreach/ inreach to major metropolitan centre(s)	18	8	9	35
Mainly working in a metropolitan location with outreach to regional/ rural/ remote location(s)	8	5	17	30
Total	103	28	357	488

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; Active Fellows do not work in regional/ rural area(s).

Appendix A3.6: Rural or regional area future work intentions over the next five years, Australia and Aotearoa New Zealand, 2022

	Australia	Aotearoa New Zealand	N	%
Continue working in city/ metropolitan area (or considering locating to a city/ metropolitan area)	524	134	658	54.9
No plans to change current rural/ regional work pattern	210	46	256	21.4
Decrease work hours in rural/ regional area	76	16	92	7.7
Increase work hours in rural/ regional area	41	10	51	4.3
Uncertain	122	19	141	11.8
Total	973	225	1198	100

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; missing work location responses

Chapter 4 Supplementary data

Appendix A4.1: Percentage of Fellows who undertake volunteer or pro bono work by surgical specialty, 2022

	Pro bono work	%	N
CAR	31	63.3	49
GEN	392	66.0	594
NEU	42	61.8	68
ORT	203	66.8	304
OTO	104	62.3	167
PAE	33	80.5	41
PLA	81	66.9	121
URO	62	61.4	101
VAS	50	68.5	73
Total	998	65.7	1518

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand.

Appendix A4.2: Types of pro bono or volunteer activities Fellows participate in, 2022

N=965, Avg hours per month = 10.5	N	%
Domestic clinical work	230	23.0
Domestic aid work	32	3.2
International aid work	103	10.3
RACS (incl. SET Program training and supervision)	712	71.3
Specialty Society/ Association	345	34.6
Clinical education not related to SET Program	580	58.1
Non-clinical work (e.g. administration, charity, committee appointments)	491	49.2
Other volunteer work	141	14.1

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand.
Note: those participating in multiple areas may be counted more than once.

Appendix A4.3: Mean hours worked per month on pro bono or volunteer activities, 2022

N=998, Avg hours per month = 10.7	Mean hours per month
Domestic clinical work	11.0
Domestic aid work	11.1
International aid work	8.6
RACS (incl. SET Program training and supervision)	17.9
Specialty Society/ Association	7.0
Clinical education not related to SET Program	9.1
Non-clinical work (e.g. administration, charity, committee appointments)	10.7
Other volunteer work	10.0

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand.
Note: those participating in multiple areas may be counted more than once.

Appendix A4.4: Types of RACS pro bono roles Active Fellows participate in, 2022

N=705	N	%
Council/ board/ committee member	150	21.1
SET Program supervisor	215	30.2
Educational instructor/ presenter	252	35.4
Examiner/ interviewer	190	26.7
International aid	13	1.8
Surgical mortality audit assessor	202	28.4
Other	66	9.3

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand.
Note: those participating in multiple RACS activities may be counted more than once

Appendix A4.5: Percentage of Fellows involved in RACS pro bono activities by surgical specialty, 2022

	RACS pro bono activities	N	%
CAR	20	49	40.8
GEN	295	594	49.7
NEU	30	68	44.1
ORT	140	304	46.1
OTO	75	167	44.9
PAE	24	41	58.5
PLA	47	121	38.8
URO	47	101	46.5
VAS	34	73	46.6
Total	712	1518	46.9

Chapter 5 Supplementary data

Appendix A5.1: Workplace sources of Fellows' self-rated stress levels, 2022

	N	No stress	Little stress	Moderate stress	High stress	Extreme stress
Administrative regulation	1273	154	373	403	222	121
Administrative processes	1278	138	369	422	250	99
Threat of litigation	1275	446	467	211	99	52
Workplace culture	1277	361	390	266	155	105
Adopting new technologies	1240	528	523	159	26	4
Maintaining and updating knowledge base	1294	530	554	173	29	8
Maintain skill set	1284	482	520	230	44	8
COVID-19	1296	200	461	411	169	55

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows and Fellows who selected not applicable to me responses.

Appendix A5.2: Proportion of Fellows who have sought professional assistance to deal with stress or a mental health issue in the last 2 years, 2022

	N	%
Yes, I sought professional assistance	158	9.8
No, I had not sought professional assistance	638	39.7
I have not experienced any mental health issues in the last 2 years	702	43.7
I'd rather not say	21	1.3
Fellows who skipped the question	89	5.5
Total	1608	100

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; missing responses.

Appendix A5.3: How Fellows monitored their general health in the last 2 years, 2022

	N	%
I did my own health check-ups	131	8.6
I visited a medical doctor for a health check-up	536	35.3
I see a GP/medical doctor at regular intervals as dictated by my existing medical condition requirements	567	37.3
It has been more than 2 years since I've had a general health check-up	285	18.8
Total	1519	100.0

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; missing responses.

Appendix A5.4: Distribution of leave Fellows took over the past 12 months, 2022

	N				%			
Leave	CPD/ Study	Annual	Sick	Parental	CPD/ Study	Annual	Sick	Parental
1 week	447	61	411	43	34.8	4.7	32.0	3.3
2 weeks	382	168	108	12	29.7	13.1	8.4	1.0
3 weeks	133	248	18	2	10.3	19.3	1.4	0.2
4 weeks	34	374	20	6	2.6	29.1	1.6	0.5
6 weeks	13	210	12	0	1.0	16.3	0.9	0.0
>6 weeks	8	122	18	11	0.6	9.5	1.4	0.9
Yes	1017	1183	587	75	79.1	92.0	45.6	5.8
No leave	269	103	699	1211	20.9	8.0	54.4	94.2
Total	1286	1286	1286	1286	100	100	100	100

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; missing responses.

Appendix A5.5: Duration of parental leave Fellows took over the past 12 months, 2022

		N		%	
	N	≤6 weeks	>6 weeks	≤6 weeks	>6 weeks
Female	25	15	10	60.0	40.0
Male	50	49	1	98.0	2.0
Total	75	64	11		

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; missing responses.

Chapter 6 Supplementary data

Appendix A6.1: Fellows current and future work intentions over the next 10 years, 2022

		Mean work hours per week				
N = 1299		Now 2022	2 years 2024	5 years 2027	10 years 2032	N
Female	<40	36.8	40.0	40.7	39.6	43
	40-49	38.6	40.0	38.3	35.4	106
	50-59	37.5	37.4	31.8	19.2	60
	60-69	36.7	28.6	10.4	3.4	30
	70-79	16.7	10.0	0.0	0.0	3
	80+	0.0	0.0	0.0	0.0	0
Male	<40	43.0	45.6	42.8	40.7	66
	40-49	44.9	45.6	43.8	39.6	223
	50-59	45.0	43.6	38.1	26.1	308
	60-69	35.1	26.4	13.3	3.6	293
	70-79	20.7	12.9	3.5	0.6	130
	80+	15.7	9.9	4.1	1.8	32

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; missing responses.

Appendix A6.2: Proportion of Fellows aged less than 50 years and 50 years and over who intend to retire within the next 10 years from clinical practice and all forms of paid work, 2022

Age <50 years	Public	Private	Medico legal work	All forms of paid work
In < 10 years	60	27	11	14
Total	401	365	88	399
%	15.0	7.4	12.5	3.5

Age >=50 years	Public	Private	Medico legal work	All forms of paid work
In < 10 years	459	490	246	535
Total	584	656	323	792
%	78.6	74.7	76.2	67.6

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; missing responses.

Appendix A6.3: How RACS can further support Fellows leading up to retirement, 2022

N=130	N
Reduce/ tailor the CPD Program requirements for semi-retired Fellows	26
Offer supportive seminars/ webinars/ eLearning about transitioning to retirement	20
Utilise the expertise of senior Fellows (e.g. teaching, mentoring, supporting colleagues transitioning into retirement)	14
Provide resources, roadmap and checklists to help manage the transition from active surgery to non-operative roles	11
Advocate to remove barriers to continue to practice (e.g. cost of medical indemnity insurance, medical board registration)	9
Reduce subscription fees/ conference costs	8
Satisfied with current offerings	7
Engage with senior surgeons on a regular basis	6
Make transition part of the RACS dialogue	4
Make regional work more attractive and support rural surgeons more	3
Promote non-clinical/ alternative work options for surgeons	2
Support the Senior Surgeons Section	2
Other	9
Unsure	9
Total	130

Appendix A6.4a: Proportion of Fellows aged 65 years or older who intend to be engaged in paid employment for the next two years, 2022

N=303	N	%
No	129	42.6
Yes	174	57.4

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; missing responses.

Appendix A6.4b: Type of work Fellows aged 65 years or older plan to do in the next two years, 2022

N=174	N	%
Operative practice in hospitals or day surgery units	93	35.4
Operative practice in rooms	26	14.9
Surgical assisting	28	16.1
Clinical consulting practice	101	58.0
Administration	53	30.5
Medico legal work	74	42.5
Research/ academia	47	27.0
Education and assessment	57	32.8
Military service	0	0.0
Other	20	11.5

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; missing responses.

Appendix A6.5: Main reasons why Fellows aged 65 years or older continue to be engaged in paid employment for the next 2 years, 2022

N=24	N	%
I am doing work that I enjoy	84	48.3
I still feel I can contribute value to the workforce	9	5.2
I want to stay mentally active	49	28.2
I have not met my minimum financial goals for retirement yet	16	9.2
Other	7	4.0

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows; missing responses.

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