Is the number of new trauma and orthopaedic consultant posts increasing or decreasing?

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ABSTRACT

INTRODUCTION Trauma and orthopaedics is a popular surgical specialty in the UK. Recent changes to the National Health Service have suggested an imbalance with fewer jobs yet more trainees. Furthermore, subspecialisation is emerging within all surgical disciplines. The aim of this study was to examine whether there were decreasing numbers of trauma and orthopaedic (T&O) consultant appointments in the UK, and to determine the frequency of subspecialisation.

METHODS All 51 issues of the *British Medical Journal (BMJ)* careers supplement from the year 2000 were reviewed as well as the 51 issues from 2010. The number of T&O posts, requested subspecialty interests and the number of posts in other surgical specialties were analysed.

RESULTS A total of 481 consultant posts in T&O were advertised in the 102 issues of the careers supplements reviewed. Of these, 281 were advertised in 2000 and 200 in 2010. The mean number of posts per issue was 5.5 in 2000 and 3.9 in 2010. In 2000 orthopaedic posts represented 30.5% of all surgical posts while in 2010 this was 37.8%. Under two-thirds (61.6%) of posts requested a specialty interest in 2000 but this increased to 93% in 2010. The greatest increase in named subspecialty was seen in 'spine' (from 4.1% to 19.0%) while 'general' had the greatest decrease (from 38.4% to 7.0%).

CONCLUSIONS UK consultant posts in T&O are decreasing in frequency. Most advertised posts request a subspecialty interest but registrar training focuses on producing 'generally' competent orthopaedic consultants. The onus is therefore on fellowships to develop subspecialty interest. As these are not all educationally approved, reconfiguration of fellowships is likely to be necessary.

KEYWORDS

Jobs – Consultant – UK

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Trauma and orthopaedic surgery (T&O) is a popular surgical specialty in the UK. However, recent changes to the National Health Service have resulted in speculation regarding the prospect of saturation of the consultant job market with fewer consultant posts in T&O being available for an increasing number of trainees.¹ In addition, the advent of subspecialisation in surgery has led to the emergence of subspecialty positions in all surgical disciplines including T&O. Such changes bring about the prospect of a discordance between specialist trainee numbers and available consultant posts at the end of training as well as issues regarding the availability of suitably trained trainees for appropriate subspecialty posts. The aim of this study was to determine whether there was indeed a decrease in the number of consultant posts available in T&O in the UK and to assess the frequency of subspecialisation in these posts.

Methods

All 51 issues of the *British Medical Journal (BMJ)* careers supplement from the year 2000 were reviewed as well as the

51 issues from 2010. Each issue was assessed for the number of consultant posts advertised in T&O and whether these posts had a subspecialty requirement. The total number of all surgical specialty posts was also recorded. The data gathered for both years were compared for the number of overall orthopaedic jobs and the named subspecialties advertised in the supplement. This was then reviewed to observe any trends in overall number of jobs and number of jobs in subspecialties.

Results

Four hundred and eighty-one consultant posts in T&O were advertised in the 102 issues of the *BMJ* careers supplements that were reviewed. Two hundred and eighty-one were advertised in the year 2000 and 200 in 2010. The mean number of posts advertised per issue was 5.5 in 2000 and 3.9 in 2010.

In 2000 the 281 orthopaedic posts represented 30.5% of the 926 posts advertised for all surgical specialties while the 200 orthopaedic posts in 2010 represented 37.8% of the 529

posts advertised for surgical specialties. The 200 jobs in 2010 represented a significant reduction on the 281 jobs available in 2000 ($p=0.045$).

In 2000, 108 jobs (38%) were advertised as 'general orthopaedic surgeon' with the remaining 173 jobs (62%) requesting a subspecialty interest. In 2010 there were only 14 'general orthopaedic surgeon' jobs (7%), meaning that 93% of posts stated a subspecialty requirement. The most popular stated subspecialty in 2000 was 'general' followed by 'self-selected' while in 2010 it was 'hip and knee arthroplasty'.

The greatest increase in named subspecialty between 2000 and 2010 was seen in 'spine' from 4.1% to 19.0%. Of those that decreased in frequency, 'general' was the most common, decreasing from 38.4% to 7.0%. Fig 1 compares the frequency of different subspecialties required for consultant posts in the two years studied.

Discussion

The number of new consultant posts in 2010 was 28.9% lower than in 2000 despite an approximate 10% increase in the number of specialist trainees appointed during this ten-year period.¹ Such discordance questions the accuracy of the workforce planning that has been used to determine the number of specialist trainee positions. Furthermore, any trainees who fail to progress to the Certificate of Completion of Training (CCT) or for those who elect to work abroad after being awarded their CCT are not accounted for in the aforementioned figures.

Factors affecting consultant appointments are complex, generally involving both political and local issues. Political factors frequently incorporate waiting list targets as well as attaining 'best practice' tariffs whereas locally, there may be a requirement for a consultant with expertise in a certain subspecialty. There are often contrasting perceptions of the need for quality versus the need for service provision. Nevertheless, the shortfall in consultant posts and the prospect of a significant number of fully trained specialists in T&O facing unemployment is concerning as substantial government funds have been invested in their training.^{2,5}

Figure 1 The frequency of different subspecialties required for consultant posts

There has been a notable shift over the ten-year period of this study demonstrating a stronger preference for stated subspecialties in T&O in recent times. It appears that the 'general orthopaedic surgeon' is becoming obsolete and that surgeons are being subspecialised by upper or lower limb or by an individual joint. Training seems to contradict the need for subspecialty interest as CCT requirements are steered towards obtaining minimum indicative numbers of all procedures. Specialist training is currently designed to deliver an orthopaedic surgeon who is generically competent across all its subspecialties (in essence, a general orthopaedic surgeon). One may therefore question the role and associated cost of this generality in training when studies provide evidence of the growing emergence of subspecialism.^{4,5}

In order to demonstrate a subspecialist interest, trainees often undertake a post-CCT fellowship for 1–2-years to gain the required experience and training in a subspecialty. However, most of these fellowships are not approved by the Royal College of Surgeons, which raises uncertainty regarding their educational quality owing to the unregulated and potentially variable content. Ultimately, this may result in consultant job candidates believing erroneously that they are suitably trained in a subspecialty.

Advocates of subspecialisation would suggest that better understanding and knowledge pertaining to one joint leads to better patient care. This is because surgeons can optimise their skills in a limited number of procedures as well as becoming more clinically aware of rare diagnoses that concern the joint in question.^{6,7}

Sceptics of subspecialisation may argue that both time and money are poorly invested by forcing all trainees to undertake minimum indicative numbers in procedures that they will not perform as consultants. For example, if it is identified early in training that a trainee wishes to become a subspecialist in spinal surgery, the current training system does not allow that trainee to maximise his or her training time in spinal surgery. Instead, all trainees are required to undertake hand surgery and foot and ankle surgery placements through their training. Nevertheless, at the culmination of training, they may be required to specialise in spinal surgery only, often taking part in a specialist spinal on-call service as well.

Some may think such a training structure is counterintuitive. Others may suggest that it is good to experience a range of specialties through training, not only to accumulate generic and transferable skills but also to experience each specialty so that a trainee can determine which subspecialty he or she will ultimately choose. In the rural setting, there will continue to be a need for general orthopaedic surgeons owing to the reduced number of orthopaedic consultants; indeed, with the advent of subspecialism has come the advent of rural surgery as a specialty in its own right.⁸

If the subspecialty culture is to exist, it would benefit trainees to be aware of which subspecialty consultant posts are likely to become available at the culmination of their training period. This would allow them to mould their training in an appropriate manner. Obviously, many trainees decide their subspecialty based on their interest alone. Nevertheless, a proportion of trainees would still be

influenced by the availability of jobs when choosing which subspecialty to pursue.

In 2008 the British Orthopaedic Association gathered data in the form of a questionnaire to all consultants and specialist trainees. The objective was to aid workforce planning in T&O services in the UK until 2028⁹ but no mention was made of desired subspecialty among trainees. It is possible that such information may have been of particular benefit to future workforce planning owing to the emerging subspecialist nature of T&O.

As negative as our reporting is regarding the consultant job opportunities in T&O, it may actually be worse in other specialties. The proportion of T&O jobs in surgical specialties actually increased during the ten years of the study. It may be that other specialties have a lower number of specialist trainees and their situation is therefore not as troublesome. Conversely, if the proportion of trainees is similar, then it is possible that competition for consultant posts will be even greater than for T&O.

It would be beneficial to extend this study and look at the present day consultant posts. However, since 2013 it has no longer been obligatory for trusts to advertise all new consultant posts in the *BMJ* careers supplement.

Conclusions

Consultant posts in T&O in the UK are decreasing in frequency and the majority of posts that are available require a subspecialty. This means trainees need to identify at an early stage which subspecialty they wish to pursue in order to

focus their training and optimise their chance of being appointed to a consultant post.

Could subspecialism see the emergence of a new grade of doctor with the advent of the 'junior consultant'? This would allow trainees increased responsibility as well as permitting time to gain subspecialty competence. On the other hand, it could create a discontented tribe of surgeons awaiting their passage to 'senior consultant' status. Reconfiguration of fellowships may provide trainees with the requirements that subspecialty posts demand.

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