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Why do surgeons leave Germany?

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Abstract

Introduction: The topic of migrating doctors and in particular surgeons is not confined to Germany. Many countries, amongst them Australia, simply do not train enough doctors to be self-sufficient. Germany is different. It has excellent university facilities and a well-defined and structured medical curriculum. Junior surgeons have a very high exposure to patients and procedures as compared to Australia. Yet increasing numbers of students and potential surgeons are leaving Germany. Why is this?

Materials and methods: In a mix of personal experience, literature review and reasoning the problems of retaining junior surgeons shall be demonstrated. Experiences from fellow colleagues working overseas shall be added.

Results: Since the public shift of concern from “Ärzteschwemme” to “Ärztemangel” especially the surgical departments are starting to feel the heat. Numerous surveys, articles and suggestions on how to tackle the problem constantly resist naming the real problems. Years of demeaning behaviour from administrations, the public and the media paired with the experiences of senior surgeons bullied out of office or simply made redundant with no reason are not an incentive to become a surgeon in Germany, no matter how fulfilling the life as a surgeon may be.

Conclusion: While the suggestions from the BDC and DGCH to ease the situations may be all correct:

create more half-day jobs

create childcare facilities open during working hours

create structured training plans facilitate implementation of the EU working directive and others

there are no plans to addres;' the unscrupulous behaviour of administrations towards doctors in general and to senior surgeons in particular the fraudulent attitude as far as payment is concerned more to add…limited list as no. of words limited.

The examples of Australia and England show us the consequences of an over boarding bureaucracy.

Germany with its genuine history of medical development deserves better.

Keywords

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WHY DO SURGEONS LEAVE GERMANY?

HANS D. DAHL

Passion and enthusiasm are main driving forces for becoming a surgeon. These virtues are beyond teaching. Many of us had earlier or later in our career contact with inspiring surgeon personalities. The passion for surgery was reinforced over time again and again through living examples.

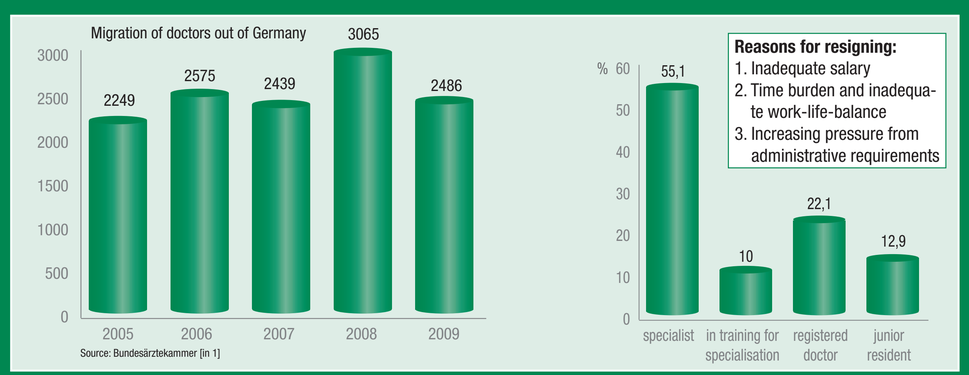
The topic of migrating doctors and in particular surgeons is not confined to Germany. There have been migrations over centuries for the better of medical education and to the advantage of patient care. Migration used to be an important way of spreading new techniques and knowledge. William Osler may be a good example. Born in Canada, he later travelled in Europe and brought the latest developments home to the American continent. His publications made him subsequently the father of modern Medicine in the English speaking world. His reputation is held high amongst English speaking colleagues until today.

Many countries, amongst them Australia, simply did not train enough doctors to be self-sufficient. Germany is different. Applications for Medical Studies and student numbers had been sufficient for maintaining a sustainable workforce. It has excellent University facilities and a well-defined and structured medical curriculum. Junior German surgeons have a very high exposure to patient numbers and procedures. Yet increasing numbers of students, potential surgeons and even fully trained surgeons are leaving Germany. Why is this?

The Numbers: There are insufficient data to quantify the exact numbers and reasons for leaving the profession. The following is therefore from a mix of personal experience, literature review and interviewing fellow expatriate colleagues.

In regards to the total population in 2008 for the first time since 1984 the net balance of migration in Germany was negative (-66,000) with the highest number of emigrants (175,000) since 1954 (Stat. Bundesamt). The migration of doctors had not been recorded for many years. Only in recent years estimates can be made from indirect indicators, such as number of accreditations, number of graduations, number of certificates of good standing requested. (Certificate of good standing is not required in the German system, therefore a request is indicative of a job application outside of Germany.). All these figures can only be estimates as legislative changes to the requirements of data collection had varied over the years. The following table had been composed by figures from requests to several medical boards and is not complete. [from 1, author's translation]

Country	Year	Number	Diff. %	Year	Number	Source
Belgium				2007	338	Föderaler Öffentlicher Dienst Volksgesundheit
Denmark				2007	194	Dänische Gesundheitsbehörde -Sund-hedsstyrelsen
Finland				2008	41	Finland Medical Board
France	2000	593	1,64	2010	975	French Medical Board
GB				2010	3429	General Medical Council
Ireland				2009	127	Medical Council Ireland
Italy				2009	398	Nationaler Dachverband der Ärzte- und Zahnärztekammern Italiens
Canada				2008	160	Canadian Institute for Health Information
Luxembourg				2009	240	Collège médical Grand - Duché de Louxembourg
NZ				2009	156	Medical Council of New Zealand
Netherlands				2009	740	Ministry of Health, Welfare and Sport
Norway				2009	808	Ärztevereinigung Norwegen
Austria	2003	547	2,85	2009	1560	Austrian Medical Board
Portugal				2009	130	Portugal Medical Board
Sweden				2009	546	National Board of Health and Welfare
Switzerland	2003	1474	2,73	2009	4026	Verbindung der Schweizer Ärztinnen und Ärzte
Spain				2001	259	Conférence Européenne des Ordres des Médicins
USA				2007	2670	American Medical Association
					16797	



Reasons given for resignation from curative medical occupation were gained from a survey on 4619 doctors and doctors attending to other occupations: [Rambøll Gutachten; in 1]

Working in a German hospital always had challenging aspects. From my own experience over four decades juniors had to cope with: inadequate rooms or beds in on call quarters; in house on call in a shabby room under the roof without insulation (too cold in winter, too hot in summer); poor or no catering during night and weekend hours; constant exposure to expressions of envy from administrative staff in regards to the "exorbitant high salary" (never heard any complaints about the number of hours worked for the money). The majority of my previous employers found some ways to cheat on payments. Never mind, before the mid 1980-ies these nuisances were fairly well tolerated by younger surgeons in view and expectation of a very good training and the prospect of a satisfying position either in the hospital or in free praxis later on. Of course a major factor enduring or even overlooking these conditions was the great satisfaction in practicing surgery and in gaining acknowledgment from mentors and patients. Instantly a number of very respected mentors who added professional satisfaction through teaching, research and exemplary conduct, come to mind.

The changes:

- The gradual shift from a patient focused medicine and surgery to an economically focused patient care from the mid 1980-ies onwards took its toll over time. Even employers with a Christian background and commitment (nowadays as "values" on their website) stated: "The only Christian item in our business is the name" (CEO of a St. ... Hospital; name withheld).
- An across-the-board public defamation of the medical profession, and in particular the surgical profession in printed media at some stage started to hurt.
- Even politicians made inappropriate comments in public – I cannot recall similar comments from an Australian, NZ or UK politician about their own doctors.
- It became fashionable to employ doctors half-time and expect them to work full time.
- Hospital administrations started to pretend that on calls would be paid by in lieu leave, which in reality did not happen for a number of reasons. When finally, after years of complaints and struggle, junior doctors decided to actually leave after on call, the EU working time directive made this a mandatory requirement. In many cases unpaid work still was not resolved.
- In turn the prolonged mandatory absence from regular work meant a sharp decline in the number of educational and departmental meetings, journal club meetings, X-ray meetings, etc. due to lack of attendance. This gave rise to the complaint, that junior surgeons did not receive the training and attention they originally and rightfully had expected and the older generation took for granted.
- The cut down on on-call payments was severed by cut downs in additional payments subordinate doctors had gotten used to over the years. As contracts between hospitals and leading surgeons increasingly became less favourable for the chief surgeon, there was less money to distribute from this source. Depending on the stand within the structure of the hospital, this was a severe cut for some colleagues and administrative staff. Hence the ongoing debate about inadequate salary.
- Unlike in England, NZ and Australia the complete DRG and ICPM coding work became an integral part of the doctor's duties. Speed of code alterations, retrograde alterations in application rules, increasing numbers of enquiries from insurance companies etc. turned life of a junior surgeon into a servant of various administrations. We know, that today up to more than 50 % of a junior surgeon's time is tied with these administrative tasks.
- One should not forget, that the treatment of senior surgeons by administrators, politics and media will leave an impression on junior surgeons also. Just as an example part of a conversation during contract negotiations for a chief surgeon position: On legal advice a sentence in the contract (allowing to fire the chief surgeon at any time) was requested to be removed. Happily the CEO of the hospital agreed and commented: "If I take half sentence on page X and half sentence on page Y I can fire you any time". The number of contracts between chief surgeons and hospitals which had been terminated by administrations on questionable legal terms is unknown. Attempts to gain numbers on this topic failed. A fair description of the circumstances a chief doctor finds himself in today was published by König [2]. The most recent BDC publications contain some reference to the addressed issues [3; 4; 5].

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Since the public shift of concern from "too many doctors" to "lack of doctors" especially the surgical departments are starting to feel the heat. Numerous surveys, articles and suggestions on how to tackle the problem constantly resist naming the real problems. Years of demeaning behaviour from administrations, the public and the media paired with the experiences of senior surgeons bullied out of office or simply made redundant with dodgy reason are not an incentive to work as a surgeon in Germany, no matter how fulfilling the life as a surgeon as such may be. A fair number of surgeons and other doctors left and are still leaving the system.

While the suggestions from the BDC and DGCH to ease the situations may be all correct:

- create more half-day jobs – addressing the increasing number of women surgeons,
- improve childcare facilities and opening hours to match working hours – as above,
- create structured training plans – addressing the losses through economisation,
- facilitate implementation of the EU working directive – addressing the still unsatisfactory working constraints for junior doctors in particular.

There are no official action plans visible to address the unscrupulous behaviour of some administrations towards surgeons and doctors in general.

Answer to the initial question:

- Respect and friendly reception: Thanks to the excellent education and training they received in Germany surgeons are generally well regarded abroad. The respectful and friendly contact appears like a totally new experience.
- Word of mouth: Students who decided to spend some time overseas, may fall for the seemingly obvious ease of life outside of Germany. Caution: Things are not as easy as they may look.
- Good work-life-balance: Could have never imagined something like it. Yes, there is a rewarding life aside from surgery.
- Live changing experiences: Work without the above named hassles does not trigger a wish to go back despite the enormous bureaucratic mountain to tackle for accreditation.
- Adequate income: The position of a surgeon is valued and there appears to be no envy in regards to position and wage.
- Adventure: No doubt, the experience of combining work with the intense exploration of a foreign culture has its own charm.

Disclaimer: The author has no business intent with this publication.

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