EDITORIAL

Don't call it a job market

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It is truly a fable of our time. Drs. Nephro Baggins, Stentwise Gamgee, and others joined by Fellowship on a harrowing, nigh impossible, quest. They must evade the wizened uro-Nazgûl, once fresh Fellows like them, accursed to troll highway 401 for morsels of cysto time. The fresh and the fallen, each consumed with the precious, the *One Job*. How will it end? Stay tuned as the calendar turns for the next instalment, *"The Two Locums."*

Ok, a wee bit hyperbolic, but it is springtime again and the urology mint is preparing to put another 30 odd surgeons into circulation, while a brace more emerge from fellowships. We therefore come around (and around) to discussions of "the job market." We have been picking this scab for more than 20 years, from Pace et al's prediction of a 101-urologist shortfall in Ontario to Hosier's articulation of the dreary mindset of graduates in 2018.[1-3] I have not stumbled upon a great revelation or solution here, but perhaps at least for clarity and respect's sakes, we can dispense with the term *market* to describe the clamorous whac-a-mole of Canada's urology job bazaar.

What would a true *market* look like? It would have some predictability and steady-state around entry and exit — responsiveness to population need would foresee new spots, and practices closing or ending would have a long-broadcast off-ramp. Training duration and specialization would be matched to job type, with appropriate direct entry into generalist spots and centralization of tertiary and quaternary skillsets. Solo and small community practices would be on equal footing with urban groups. There would be a reward of choice at least for the "stars" in training, and perhaps more tenuousness or risk of obsolescence and replacement for those closer to the value-to-the-community margin. Novel practice phenotypes, including models like acute care urology, roving locum, or surgical/clinical assist roles, would arise bottom-up, driven by the desires of the applicant for less overhead or continuity, and not top-down, offered up as leavings from those able to offload them.[4]

What we've got is often the opposite. A large number of us find our practices at the last minute, when an unannounced retirement or move suddenly frees a spot that we sidle into. Job postings are often perfunctory, legitimizing a process whose winner was predetermined. Jobs are akin to senate appointments, ours for a lifetime if we want, and with an endowment of OR time and near total control over its use. Overtrained or overspecialized urologists incongruently land where their vital generalist skills may have atrophied (and in any case, have lost out with the opportunity costs of fellowship). Itinerant big-city underemployed urologists occupy partial-privilege positions that seem like they should be jobs. Those of us in practice have almost total control over future hires, balancing our obvious position to understand local needs and the risks of biased recruitment from protecting one's own bailiwick or dominant actors in an unharmonious workplace.

I'll admit this editorial arose from a few fractured sleeps feeling empathetic frustration and a bit of guilt as I prepared to rationalize the job market and prepare the next verbal contortions of "it all works out in the end."

But as I tried to crystallize the immorality I *just knew* was there, I couldn't pin it down. Job security is *good*, of course! We aren't pro sports teams, where high-upside draft picks routinely displace mid-career grinders, or in a corporate cage match waiting to be usurped. We train in large cities and hospitals with all their trappings and feel comfortable there, so remote or solo-practice opportunities that languish are frustrating and revealing, but not *wrong* per se. In the world where we serve patients and communities, there are no *good* or *bad* jobs, only mismatches. Urology is wonderful for a lot of reasons, the people high among them, but of course honor and selflessness are not universal. Is self-serving behavior the problem, however, or just stark and thus cognitively overweighed in those rare instances we encounter it? Exclusionary fiefdom, resource stockpiling, hemming and hawing around leaving practice, or "opening a spot" hap-

pen, but blaming individuals may just scratch a dark itch, divining straw men to pillory and letting us shrug off the complicated structures that can really address the problem.

So what might make it better? Responsiveness and proportion to population need means that new spots appearing in town would be created and resourced without reflexive veto power. Urologists are uniquely positioned to know their own local culture and needs, but total control has its perils and may not best serve community and person-power needs. Meaningful input from that community and from surgical leadership is essential.

Perhaps the numerator merits attention through more fluid allocation of residency spots at the outset. Increasing exposure to and awareness of excellent smaller practice types might mitigate against the high proportion of trainees jostling for large urban practices (notwithstanding the issue of partners tied to certain locations).[3] The need for true bread-and-butter generalists, the engine of urological care, should be clear so our well-trained graduates aren't obliged to undertake time-buying fellowships if not needed.

Operating room time is still about the most obvious cash faucet in hospital care, and zero-order kinetics of patient throughput in a fixed-resource system does not reward having more surgeons at the ready. Systems change seems critical here and advocacy to improve access should be constant; however, it is important not to use the inflexibility of the system to let us shrug our shoulders hopelessly and stop thinking where we *can* adjust and align urologists with practices. A somewhat cynical thought experiment: if a surfeit of OR time suddenly appeared, would it *really* be followed by proportionate new positions for the aspirant pool?

The needs of the late-career urologist might be anticipated years earlier, whether simply through introspection, financial planning resources, or more options to again match desires and skills to community need. It is *not* an issue of fixed retirement or forced restrictions; assumptions about care and merit by any demographic descriptor alone are ethically fraught and would do net harm. That said, clearer plans or commitments around succession would be particularly clarifying in this space.

I'm aware that implying the addition of forcing functions to individual lives may read like unacceptable limitation on personal freedom. To be sure though, we aren't entrepreneurs setting up surgery "studios" to hock our wares; rather, we enter into a needs-based system with the public good at the center. It seems reasonable that we acquiesce to some funnelling if we're aware of it upon entry. To those aghast that this all seems to flex the muscles of the state over our lives, alternate funding through movement of lower-value or non-essential services out of public purview is on the table as well.

The scramble for jobs in urology stinks, but maybe it stinks without being rotten. If there is a moral issue, perhaps it's not a jealous hoarding of every calorie by a few jewel-encrusted oligarchs, but in not recognizing that we *The Employed* are so lucky and may feel unobliged to invest in ensuring that the steady state from training to employment to sunsetting is managed more effectively and equitably. We need light-shining in a number of corners, advocacy for our colleagues through advocacy for our patients, and perhaps a few uncomfortable conversations.

References

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