

## Herding Cats Part 2: The Plight of Female Pelvic Medicine and Reconstructive Surgery Fellowships

In the early 1990's, an experienced group of 8 cardiothoracic surgeons outside of Baltimore were performing approximately 110 open heart surgeries a month.\* Most of their referrals came from an even larger group of experienced cardiologists. By August 2000, the surgeons' caseload had fallen to 25 a month. The reasons? There are two. After a failed attempt by the two groups to merge their practices, the cardiologists hired and partnered with their own cardiothoracic surgeons. In addition, as technology changed, i.e., more stents and less operations, the market place changed.

The result? The experienced surgeons are doing far less of what they do best; the newly hired, less experienced surgeons are doing much more and their patients are subjected to the inevitable learning curve that accompanies young surgeons and new technologies. In the long term, though, when the newly hired cardiothoracic surgeons have become the experienced ones, both patients and doctors will benefit. All will benefit except the original group of cardiothoracic surgeons who may well become extinct.

The first attempt at joint urology gynecology fellowships is headed in the same direction as the merger between the cardiologists and cardiothoracic surgeons. This experiment, a joint venture between The American Board of Urology (ABU) and the American Board of Obstetrics and Gynecology (ABOBYN) is entitled Female Pelvic Medicine and Reconstructive Surgery (FPMRS). The name itself is a tacit recognition of the uneasy compromise that led to its formation—neither the word urology nor gynecology appears in its title, yet its graduates routinely refer to themselves as urogynecologists. To date, there are 24 approved programs, none of which has ever accepted a urologist; I doubt that any have ever applied. Seventeen fellows have graduated, all gynecologists. Only three programs have any significant input from urology; the remainder have urology rotations of only a month or two during the three year training program. If something is not done, I'm afraid that the urologists will go the way of the cardiothoracic surgeons alluded to above, to the detriment of all involved.

This is bad for urologists for obvious reasons. It is bad for gynecologists because they will never obtain the expertise that

is inherent to the urologic experience. It is bad for patients because they will never receive the level of expert care that they deserve.

Gynecologic residencies are geared toward preparing their graduates for either a primary care kind of practice or subspecialty training; its graduates are not equipped to practice FPMRS. Urologists, by training, are equipped to practice (at least) the basics of this subspecialty. Both the ABU and the ABOBYN recognized this by requiring 3 additional years of training for gynecologists versus two years for urologists. This, of course, assumes that the gynecologists receive a significant urologic experience, which they currently do not.

Gynecologists are terrified by the bladder and ureter; they encounter it only by accident. Urologists operate on these structures routinely. The prostate offers urologists a unique vision of voiding dysfunction and the physiology (and pathophysiology) of voiding dysfunction, which although common in women, is ignored during gynecologic residencies.

For all these reasons, multidisciplinary training for those who diagnose and treat women with lower urinary tract symptoms and pelvic floor dysfunction is essential for the benefit of our patients and, ultimately, ourselves. Here is my solution, not very different from that proposed in this column in 2001.<sup>+</sup>

Urologists, gynecologists and colorectal surgeons form centers that treat patients and train fellows. These centers are joint ventures between the three groups and all expenses and income are divided in a way that eliminates the financial disincentives that normally make such interactions so difficult. The psychologic and political disincentives are, of course, a major obstacle, even in those countries where finances are not an impediment to cooperation. Hopefully, though, some will possess the foresight to overcome them. The next generation of surgeons who treat these patients will be trained in all three disciplines and, therefore, be Female Pelvic Medicine and Reconstructive Surgeons in the truest sense of the phrase.

Jerry G. Blaivas  
Editor-in-Chief

<sup>+</sup>Blaivas, JG. Herding Cats. *Neurourol & Urodynam* 2001;20:1.

\*Wall Street Journal. Transformation In Medicine Is Putting Specialists At Odds. September 10, 2003.