Int Urogynecol J (2003) 14: 295
DOI 10.1007/s00192-003-1109-5

EDITORIAL

Jerry G. Blaivas

Filling in the blanks

Published online: 25 October 2003

Gynecologists can palpate the ureter and they can identify the uterosacral ligament; urologists cannot. Urologists can sew up bladders and catheterize ureters; gynecologists cannot. Even though some of each can, of course, perform some of the tasks of the other, this generalization holds true. Why? Gynecologists are terrified of the ureter and bladder; they see them only by accident. Urologists catheterize ureters and close cystotomies routinely. During residency, urologists never see the uterosacral ligament, whereas gynecologists see and feel the uterosacral ligament during every hysterectomy. I used to think that the ability to palpate the ureter through the open peritoneum during vaginal surgery was a myth propagated by the uninformed until a colleague of mine, a gynecologist, showed me how to do it.

Gynecologists know about childbirth, prolapse, fibroids, endometriosis, gynecologic malignancies and the menstrual cycle. Urologists know about bladder cancer, neurogenic bladder, urethral and ureteral obstruction and about the physiology of micturition.

Some members of each of the two groups know about incontinence, but far too few.

Neither group knows very much about the lower gastrointestinal tract, yet both touch it during every physical examination and most operations. During residency, urologists get more than twice as much operative training as gynecologists.

Urology has much to learn from gynecology, and vice versa. It's not possible for each to learn enough about the other's specialty during residency. Hence, the need for multidisciplinary training involving both specialties, and a little colorectal surgery to gild the edges.

J. G. Blaivas (✉)
Urology, Weill Medical College,
Cornell University, New York, NY 10021 USA
E-mail: kblvs@rcn.com

J. G. Blaivas
Urogynecology, Lenox Hill Hospital,
New York, NY 10021 USA

The first attempt at such joint fellowships, co-sponsored by the ACOG and the ABU, is entitled Female Pelvic Medicine and Reconstructive Surgery. As the name implies, this combined effort was an uneasy compromise. Urogynecology is the obvious choice of names, but fraught with political overtones that made it unacceptable to urologists. Urologists call the specialty female urology, but when patients go to see a female urologist, they expect to see a woman practicing urology. When they go to see a urogynecologist they expect to see an expert. In both instances, they are too often getting less than they deserve.

Currently, there are about 25 of these programs and sadly, none have both a urologist and gynecologist on their full-time staff. Only three have a urologist as program chairman and most programs have no more than several months of urology rotations during their three-year fellowship. This, in my judgment, is unacceptable.

What can done?

First, urologists and gynecologists should discard their petty differences and recognize that, in the words of Pogo, "I have seen the enemy and they is us." They should recognize that it is in both their own best interests and those of their patients to work together.

Secondly, all programs should enjoy approximately equal input from urology and gynecology. At the present time, I don't think that there are enough qualified specialists at the parent institutions that currently sponsor programs to accomplish this, so this requirement will have to be phased in. Thirdly, in order to make this workable, I believe that existing financial and psychological barriers that separate the two specialties need to be dismantled. Specifically, there must be no financial disincentive against working together. The best way to accomplish this is to set a single entity that receives all income, pays expenses and then splits revenues between urology and gynecology in an equitable fashion.

None of this is happening in the foreseeable future. My advice? Get involved and make it happen.