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"Cloning Urologists"

Dolly the Sheep, the 1st cloned mammal, was "derived" from a mammary gland cell—therefore appropriately named after a country singer of the same name, known to have an abundance of such cells.

Having just seen the news about the 1st "cloned" hamburger (apparently, it did not taste all that great) from cattle muscle cells, it made me think about the issue of cloning Urologists. What organ would give rise to the 1st cloned Urologist? What, therefore, might be his name?

In that regard, cloning would hopefully not make us Urologists all "the same" but would **increase our supply in the US to the projected future need.** Of all specialties, urology is "the one" where there seems to be an overall shortfall, not just an issue of mismatch in distribution (too many in Beverly Hills and not enough in Arkansas). A University of North Carolina study, quoting the Dept. of HHS, estimate we need to increase our ranks from about 10,000 nationally currently to 16,000 by 2020. More urologists are needed to care for an aging population with more genito-urinary illnesses. A greater than 50% increase in fewer than 10 years is highly unlikely for several reasons. Reductions in Federal Government subsidies of urology residency programs have contributed to at least a freeze if not a contraction in new doctors entering our specialty. The age distribution of currently practicing urologists is among the oldest in surgery-- only thoracic surgeons are "grayer". About 44% of the urological workforce here is over 55; greater than 7.5% are over 70.

The skewed age distribution in my specialty has good and bad implications. It is only a matter of time before those Urologists who can--due to adequate finances, increased stress and declining health, or fear of what is coming in the form of the "Affordable Care Act"--"put down their cystoscopies" for good. Do patients want older Urologists (assuming patients have a choice)? Probably depends on how the

doctor comes across, as opposed to his/her absolute date of birth. Older doctors do have wisdom (which beats book knowledge any day). Those with steady hands still offer the patient great technical skills; and even if they may not be "up-to-date" on the latest robotic approach to surgery, they can share with their patients an honest perspective on whether the benefits of newer technologies are really justified by their expense.

When I was in residency at MGH and UCLA, women were just starting to come on board into my specialty. Now, about 25% of the Urology residency slots are filled with women--who now comprise 50% of US medical students. Women are great as urologists, and not just for female patients. I have enjoyed tremendously working with my female colleagues. There are some realities, including data suggesting, for lifestyle necessity reasons, women doctors overall work 10-15% fewer hours per week than their male counterparts (I think that attests to their wisdom in pursuing a "balanced life"). Women doctors may be more "biased" towards working for a large group (or be employees thereof) to avail themselves to part-time or flexible hours. In some cases, women urologists may have their practices "crowded" with female patients--thus making it harder to see a broader spectrum of urological problems.

In Great Britain, there is one urologist per 100,000 population versus a ratio in the US of 1:30,000. This means a longer wait to see a "Brit" specialist; many months, as opposed to weeks before elective urological surgery; "lower level" providers (aka "physician extenders") like nurse practitioners doing procedures such as cystoscopies and prostate biopsies and overseeing shockwave lithotripsy stone treatments; and overall low utilization of resources and less intense care. The same trends are seen on a geographic basis in the US, where the chance of having, e.g., a TURP (operation to relive prostate obstruction), is far higher where there is a high density of Urologists as opposed to lesser-served areas. Perhaps surprising to some, the "outcomes" in terms of patient health is not necessarily better where there is "too much" as opposed to [what is perceived as] "too little" care.

When I visit my dentist, his hygienist seems to do most of the work. He comes in for the last few minutes, does a brief oral inspection, and leaves--always with a smile, of course. I myself could not see taking this approach to patient care, since I feel patients come to a Urology office to see a Urologist. However, I suspect in the future of physician shortages, more and more M.D.'s will model themselves after dentists and their way of practicing. As a corollary, for years now, I am seeing a trend of lower level healthcare workers assessing and referring patients directly to me without the primary care doctor ever seeing that individual. "It's a Urological problem; go see the Urologist", she said.

There is a contrary theory that leads to the conclusion we do not need to "clone Urologists". The practice environment for all doctors, let along Urologists, has deteriorated. The urologists are really there—they are just "hiding". When a major surgery, such as removal of the bladder and rerouting of the urinary tract [to cure bladder cancer] is reimbursed at less than 25% of the rates that were paid over 20 years ago, there is a problem. Does such a complex surgery taking 5 hours with limitless patient follow-up (at least the 1st three months of which is not compensated beyond the payment for the surgery) and a significant risk of at least mild to moderate postoperative complications warrant an $8000-10,000 or a $2500 reimbursement? Why do economical "forces" make me sometimes pay more for a visit to the auto mechanic than I get paid (before overhead and taxes) for a major surgery--which can improve the quality of life, or in some cases, save a life? So when Urologists' services are undercompensated and their efforts underappreciated (e.g., by government regulators, insurance companies, politicians refusing to address malpractice reform, and, yes, sometimes patients), there may be no motivation to work harder, see that extra patient, do that difficult surgery. Right now, urologists, inherently highly skilled to solve problems in the operating room, have a money-time incentive to stay in their office and see patients [as does an Internal Medicine doctor]. By the same token, perhaps those policy makers who want to increase the numbers of US Urologists unwittingly are creating a relative oversupply of urologists who will capitulate to lower reimbursements which would the Feds and Insurance companies quite content. Another factor is that in a crowded field of Urologists such as where I practice,

there are fewer barriers to referring a patient with a minor Urological complaint that might be easily handled by a primary care provider elsewhere. Urologists should practice specialty medicine and surgery of the genitourinary tract, i.e., do those things of which other doctors are less capable.

Both of the above perspectives have validity; I myself gravitate toward the second camp, i.e., that “money talks”--and most urologists I know will see more patients, take on more difficult surgical cases, and perhaps extend their working career into their 70’s if the kind of work we do is place into the proper remunerative perspective. Let’s think about investing in urological healthcare from those who “do the work” now, and talk about cloning some other time.

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