EDITORIAL

Halloween hot takes: A "conscious uncoupling" of urology

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An eye-opening talk by Dr. Razvi at our Saskatoon CUA meeting painted a stressful picture of the urology workforce falling desperately behind demographic needs in our era of population growth and increased medical complexity. A commissioned assessment calls for almost 400 additional urologists by 2036, with a predicted supply increase of just 26. This, of course, occurs in a reality of decabillion-dollar hospital builds and existing operating rooms that are effectively fixed resources in space and personnel.

Where my mind went, however, was to the question of the extent to which more *urologists* really means more *surgery*. In the late 2020s, ought we really think of urologists as a homogeneous group of doctors allocated equally to clinical and surgical work? Are waitlists for consults ballooning differently from OR lists? Are consults for non-surgical care squeezing out those destined for surgery?

I've riffed, if tangentially, about this before, and can apply it to surgical waits.[1] Variables affecting surgical waits are reasonably couched as an OR availability issue. If one side of the equation is fixed and the other increasing, then waits should be ever-growing, with no steady state. I'm not clear that that's the case; rather, people leave the list for futility or loss of eligibility (that is, they get sick, age out, or progress while waiting) to stanch eternal expansion. The real math is more complex over longer timelines. Population increases, longer health span, universal primary care, and new surgical indications broaden the pool, while the crest and fall of the Boomers and better ablative and medical therapies moderate it.[2,3]

A mixed practice of medical and surgical care is canonical to our specialty. Urology evolved as the home of comprehensive urinary tract and male genital care, while other systems bore surgical and medical specialties in parallel jurisdiction. The urinary tract was always a technical space (as even Hippocrates bemoaned), medically inscrutable until the development of sophisticated diagnostics, while tinctures and tonics were remedies for digestive maladies, separate from abdominal wall calamities seen by early surgeons. And so, we are stewards of the entire arena of care, at the encounter level disproportionately non-surgical.

Surgical practice for urologists itself evolves. Fellowship training and narrower scope are now the rule among graduates working in group practices of any significant size. Centralization and robotization put once-ubiquitous cases in fewer hands. The phenotypic delta between "bread-and-butter" urologists providing excellent high-volume care and subspecialists providing excellent niche care grows. On another axis, surgical cases *tend* to find their way into the system (think stones, retention, roaring hematuria) more so than non-surgical ones, and so the latent and future need for care is likely imbalanced toward "medical" urology work while surgical need grows less steeply.[2]

And so, the take, and note this is a "hot take"; provocative, subversive, intended to broaden the map, not a white paper! *Be it resolved that urology ought be unbundled into surgical and medical subspecialties, and that residency training may be compressed to four years.*

First, consider the precedent of multiple specialties with domain over the same systems. Evolution developed discrete functions, but is agnostic to our desire to assign X-ologists to those functions. General surgeons overlap with gastroenterologists and endocrinologists; rheumatologists are clinical immunologists but hinge on joints with orthopods. Interventional cardiology and cardiac surgery are increasingly convergent. We, of course, yield the "magic" in blood→magic→urine to nephrologists. Our family medicine colleagues share management of *everything*.

Second, consider the imbalance in the trajectory of surgical needs in urology. Several pools emerge. The first comprises highly prevalent symptoms and QoL-based disorders, often LUTS

or penoscrotal work that rises absolutely with an aging population, and emerges from obscurity with more primary care. Second is emergent or semi-urgent care, which finds its way to specialists but really rises only with population. Similarly, the third pool of true tertiary cases: staghorns, strictures, sphincters, re-do slings, and oncology, balancing non-surgical advances against better identification of salvageable-before-metastatic presentations.

All of these pools grow in the foreseeable future, but none more than the first, which invites a cadre of urologic surgeons skilled in this fundamental work. Residency programs can absolutely prepare these surgeons in four years, launched to do great work in service of great swaths. Many—solo practitioners, the new acute-care urologists—already do this![4] They (and their hypothetical four-year colleagues) surely learned interesting and helpful material in complex PGY5 ORs, but the era of deploying practice-ready prostatectomists, cystectomists, urethroplasty and PCNL practitioners has thinned; the median urologist has a narrower surgical scope than a generation ago.

Let these talented urologists out a year earlier to pay down debts, set up leaner practices, convert more clinic to procedural bandwidth, and mop up a great care need. Bump the fellowship process up a year. Hire generalists into academic sites to ensure the substrate is robust in training, and use CBD levers to front-load expert secondary care surgery. Go wild with the "urosurgeon" moniker.[5] This is simpler if the academic program is distilled into a more anatomic and somewhat less physiologic brew.

The latter requires a seismic shift: introducing the medical urology specialist. This physician takes the structural and functional underpinnings of urinary and male genital disorders, along with the broad-based metabolic knowledge we associate with internists and family docs. Advantages are obvious and myriad. Medical training means more comprehensive management of the neurological, endocrine, cardiovascular, and psychological matrix within which our surgical disorders emerge. Urologists are pretty smart about this stuff, but how many are actually prescribing CV risk, movement disorder, or psychoactive medications regularly? New metastatic prostate cancer? "See your family doc to watch your blood pressure and cholesterol." Erectile issues and HbA1c=10? "Make sure you're staying on top of your sugars." OAB complicated by MS or cognitive decline? "Your bladder will do best if your neurological issues are under control." Why rely on hope and complexity when a sophisticated single specialist can optimize and treat, then refer a filtered cohort of surgical cases to the urosurgeons?

I can envision two pathways for these specialists: a CCFP "plus one" and an FRCPC internal medicine route. The family doctor exploits their faculties in longitudinal care, risk factor mitigation, health promotion, and psychological medicine in an integrated GU or men's health model. Sexual dysfunction, hypogonadism, cancer therapy side effects and surveillance, pain and the psychological distress downstream of these are in their strike zone. The GU internists manage pyelonephritis, metabolic stone disease, AKI-adjacent derangements, and complex infections. They also bring to bear a technical toolkit of catheters, percutaneous access, biopsies, and even scopes, like their respirology and GI colleagues.

Urology is a surgical specialty. Shout it from the rooftops, but acknowledge that "the mix of medicine and surgery" is as omnipresent in CaRMS interviews as "Ring Around the Rosie" is on the schoolyard. Uromedicine stewardship is baked into the specialty, and most of us derive satisfaction from the ability to sleuth and correct the many non-surgical issues we face. But does this optimize for the doctor or the patient? Imagine a counterfactual in which urology and GU medicine as I've described *had* evolved separately over the past century. Would it seem silly or ineffective? Would calls cry out to unify the disciplines? Which one would you be, or would each be just unattractive enough to have led you elsewhere? Maybe that immediate qualm is part of the point: despite scrub caps and email signatures flexing "urologic surgery," we're lucky and happy to get to play in both sandboxes.

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