

Teaching undergraduate urology: It takes a village

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This article by Hoag and colleagues is both an interesting and well-executed study that examines the current status of the distributive undergraduate education model at the University of British Columbia.¹ Although undertaken at a single institution, the article is very likely an accurate snapshot of undergraduate urologic education throughout Canada. The study found no major differences in student perceived levels of urologic knowledge between three distributed clerkship sites. Additionally, most graduating students (55.8%) felt their overall exposure to urology was sufficient. These are important findings, as over the last decade there has been a well-documented progressive decline in formal urologic education across North America.² Despite this, it appears that many medical students continue to develop a solid foundation of clinical urologic skills. However, several key areas for improvement (male genitourinary exam, digital rectal exam and sexual history) were identified among undergraduates. Although this survey addressed students' opinion rather than direct testing of their knowledge, these are also very valuable insights.

A distributive model of medical education appears inevitable for several reasons. With medical school enrollment in Canada increasing and many schools graduating record numbers of students, there is an increasing demand on all physicians to act as clinical preceptors. In an effort to minimize "preceptor burnout" and maintain sustainable preceptor to student ratios, many schools have employed a distributed model of medical education with part or all of clerkship performed at community centres. Additionally, there is a well-recognized shortage of rural and community physicians across Canada.³ This has been in part due to the "geographic paradox" of the medical education model. Why

have we educated and trained students to be rural/community physicians in a handful of predominantly urban centres? It only makes sense to train these students in a community environment if we expect them to practice in such centres. To reduce both preceptor burden and encourage community practice, the transition to distributive learning models will continue to progress. It will be more important than ever that all urologists contribute to undergraduate education.

The burden of urologic disease in North America is substantial and increasing.⁴ This "demographic imperative" (especially in Canada) has created a reliance on generalist physicians to participate in the care and screening of our urologic patients. With most graduating students entering generalist specialties, the onus will be on us to ensure "urologically well-informed" students graduate from our medical schools. And if this isn't enticement enough, keep in mind that many of these students are also our specialty's lifeblood. Without interested students pursuing our specialty, urology could wither like a neglected garden. By simply getting involved and mentoring students, a single urologist can make a difference.⁵

We must also continue to innovate the way we teach urology. In this current study only 31.4% of students used locally developed online case-based educational modules. Online and downloadable resources, such as podcasts, are a novel way to equalize teaching across different centres.⁶ With the inevitable growth of distributed clerkship models, it is critical that we continue to develop an exciting and unified national curriculum complete with online resources; this should be promoted effectively to encourage widespread adoption.

To attract the best to urology, to create "urologically-informed" generalists, and to ensure our future patients receive the best care, the responsibility of educating our undergraduates must be shared. More than ever it will take a village to "raise" the next generation of urology caregivers. The next time a medical student joins you in clinic (or the

operating room), get involved and teach them well for they are the future of urology.

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