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We are entering our second year of publication in robust health. You, the urological community, has been hugely supportive of our new journal, with submitted articles and reviews and positive feedback. We understand that indexation, retroactive to the first issue, is imminent. Thank you for your support and encouragement. We invite you to respond to these provocative articles in writing.

This issue is a humdinger, by far the best our 1-year-old journal has produced. There are sparkling gems and intense controversies.

The article on the perceptions of the impact of fellowship training on residency education at the University of Toronto is fascinating. Like any good research it raises more questions than it answers. Dr. Ethan Grober and colleagues report that many residents believe there are too many fellows. The implication is that their surgical experience has been diluted.

The increase in urologists doing postresidency training has been dramatic. The most important driver of this trend is that acquiring expertise in urology has become more challenging. Routine bread-and-butter procedures like TURP and open ureterolithotomy, which could be learned relatively quickly and performed successfully by most practitioners (thus the mantra see one, do one, teach one), have been replaced by more technically challenging procedures. The success and morbidity of these procedures are a function of clinical volume and experience. The shift to minimal access surgery has augmented this dramatically. The number of these complex procedures that a resident performs in his training may not be sufficient to confer expertise. Thus it is natural that residents completing their training seek to polish their skills.

Fellowships offer an opportunity to work with colleagues who have different perspectives and approaches, to focus on a particular area of interest, to acquire research skills in preparation for an academic career and to see the world. Fellows can augment a resident's experience, but the downside is that they enter a surgical arena where residents are hungering for cases. This has the potential to create conflict. For example, Dr. Grober and colleagues suggest that residents must continue to take an "active role in complex cases." Does this mean that a resident is entitled to elbow a fellow aside during a postchemo retroperitoneal lymph node dissection, a laparoscopic redo pyeloplasty or other procedures that a general urologist likely would not perform, in the interests of resident training?

There is a widening consensus by health policy makers that complex procedures should be performed by practitioners with a large volume of those cases, reflecting the volume-quality outcome relationship. In England this has become formalized. Hospitals that perform fewer than 50 major pelvic surgeries per year lose the funding for those procedures. Recognizing this trend, many residents in British training programs are trained from the start to be nonsurgical urologists.

We have not gone that route in Canada, thankfully. But we must grapple with the realities of increasing surgical complexity and what this means for surgical training. Fellowship training is likely to increase, and the impact on residency training must be managed carefully and thoughtfully.

The Point / Counterpoint debate on the use of androgen replacement therapy for "andropause" is exactly the kind of writing that we hoped for in this section. It is a must-read. Both sides of the debate are informed and deeply considered. Dr. Morales presents a compelling and authoritative case for TRT; Dr. Casey, with characteristic wit, probes the soft spots in his arguments.

It is the "weird" cases in medicine that often provide clues to disease biology. The 3 cases of penile cancer in neonatally circumcised men are interesting. All 3 men had a history of HPV infection. Perhaps, analogous to HIV, circumcision provides protection against penile cancer by reducing the likelihood or severity of HPV infection in men. This is a research question which has been largely neglected.