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URODYNAMICS/FEMALE UROLOGY

REVIEW

Establishing the subspecialty of female pelvic medicine and reconstructive surgery in the United States of America

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Fellowship training

ABBREVIATIONS

FPMRS, female pelvic medicine and repro-

Abstract Objective: In this review I describe the history leading to the creation of the subspecialty of female pelvic medicine and reconstructive surgery and its fellowships, the process involved in the current requirements for subspecialty certification and fellowship applications, and the implications for urological training.

Results and conclusions: The route to subspecialty certification and fellowships for female urology in the USA is a lesson in politics, education, medical rivalries and perseverance, with the goal of improving care for women. This decade-long journey culminated in the recognition of a separate subspecialty by the American Board of Medical Specialties in 2011, accreditation by the American Council for Graduate Medical Education in 2012, and certification to be awarded by the Boards of Obstetrics and Gynecology and Urology in 2013. It remains to be seen whether this effort will improve resident education and patient care, or represent a marketing tool in the competitive USA healthcare environment. While many of the details and regulatory

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ductive surgery; ABOG, American Board of Obstetrics and Gynecology; ACGME, American Council for Graduate Medical Education; ABMS, American Board of Medical Specialties; ABU, American Board of Urology

issues are specific to the USA, elements of the curriculum and procedures should be relevant to other countries.

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Introduction

The first documented call for a separate specialty in female pelvic medicine and reproductive surgery (FPMRS) was at a meeting of the American Urogynecological Society in 1979. Within the specialty of obstetrics and gynecology, the subspecialties in maternal and foetal medicine, gynecological oncology, and reproductive endocrinology and infertility already existed. The American Board of Obstetrics and Gynecology (ABOG) is unique in the USA in that it is able to certify its own subspecialties. In urology only paediatric urology was a subspecialty accredited by the American Council for Graduate Medical Education (ACGME) and recognised by the American Board of Medical Specialties (ABMS).

In 2000, the American Board of Urology (ABU) approached the ABOG about working with uro-gynecologists to establish a fellowship in female urology with similar criteria to existing subspecialties. The desire to collaborate with urogynecologists resulted in a joint committee with appointees nominated by the ABU and approved by the ABOG. Thus began the formal process of approving fellowships. The overhaul and lengthening of female urology fellowships were controversial among academic leaders in the subspecialty who directed the numerous 1-year non-certified fellowships in the USA, who would have to change the duration and financing of their programmes to be compliant with ABU/ABOG fellowships. One of the earliest controversies for these joint fellowships with a common curriculum and evaluation process was what to name the subspecialty. The terms 'female urology' and 'uro-gynecology' are specialty-specific, so the boards compromised and adopted FPMRS as the name. The concern was raised that this could be misleading for those who perform reconstructive surgery in urology, which often encompasses different specialty training. Under the leadership of Dr. Andrew Novick, then President of the ABU, and Secretary Dr. Stuart Howards, an environment was created for both urologists and gynecologists to participate in this committee. The joint committee developed a list of aspirational goals,

with relevant courses, topics and procedures that encompassed training for the subspecialty of FPMRS. A specific amount of time, clinical and non-clinical work was delineated. A year of academic work, whether clinical or basic, was mandated. Regardless of whether the programme director and graduates were urologists or gynecologists, the curriculum needed to be the same to guarantee the consistent training of graduates with an identical subspecialty certificate. This last point engendered debate because urologists in the subspecialty would most likely be undertaking a broader range of duties, such as male incontinence, neurogenic bladder and male voiding dysfunction. Such additional training is allowed but Fellows must meet minimal FPMRS training within the 2-year period.

The duration of Residencies in urology and obstetrics and gynecology in the USA differs. Because Residency training is longer in urology, a compromise was reached whereby the fellowship would run for 3 years for urogynecologists, consistent with the other subspecialty fellowships in obstetrics and gynecology, vs. only 2 years in urology because, especially in the areas of neurogenic bladder and open surgery, urologists have a longer duration of training. Throughout the process of creating this specialty and fellowships, the overall guiding principle was that the fellowships should be academically grounded and not merely apprenticeships, with requirements for programme directors to demonstrate academic productivity. In addition, research and a thesis were required. Fellowship applications would be reviewed by the committee and would either be approved or disapproved. Also programmes could be put 'on probation'.

In the decade after establishing the fellowships a 'critical mass' of urogynecology-programme director-based and urology-programme director-based programmes was established and a formal application to the ABMS was made. Initially the application was rejected, not because of arguments against a separate subspecialty, but because of the question of the ability of 'Obstetrics and gynecology' to certify their own subspecialties. When both boards acquiesced to having the ACGME oversee the fellowships, in 2011 the ABMS recognised the subspecialty.

Methods

The goal in establishing a fellowship in FPMRS was to improve the healthcare of women. It was recognised that residency training in urology and obstetrics and gynecology varies. Although there are common overlapping areas of procedures for the care of women, each specialty has its own domains. The fellowship in the USA encompasses both elements of gynecology and urology, in addition to having common ground. For example, it is recognised that procedures for prolapse and stress urinary incontinence are the same in both specialties. Both specialties also care for recurring UTIs and painful bladder/interstitial cystitis syndromes. However, urogynecologists also feel the need to screen for cervical cancer and take care of more patients with faecal incontinence and other anogenital disorders. In the previously named 'female urology', patients were also evaluated for haematuria and there was a larger focus on neuro-urology, and bladder outlet and ureteric obstruction. Both specialties also use urodynamics, although historically Valsalva leak-point pressures are used in urology to measure bladder outlet resistance, as opposed to urethral pressure profiles, which tend to be favoured in urogynecology. Recognising the differences between the two areas, a common ground of topics and procedures was developed to include lower urinary tract and pelvic floor disorders in both. The programme director in urogynecology can also focus more on areas specific to gynecology, whereas a urology training programme includes male voiding dysfunction and other urological conditions.

Regardless of whether the proposed programme director is a gynecologist or urologist, both need to be Board-certified and have 5 years of experience after Board certification to be considered. Programme directors must have a record of scholarly activity, full-time employment, and direct responsibility for Fellows. There must also be at least one other faculty in the subspecialty as part of the training programme. The number of training places and the rationale for inclusion must be delineated. The curriculum consists of didactics, graduate courses, inpatient and outpatient experience, as well as diagnostic evaluation and operative procedures.

With regard to didactics, the scientific foundations of FPMRS are listed among the requirements and the programme must cover anatomy, physiology, pharmacology and pathophysiology of the pelvic floor, as well as urinary and faecal incontinence. The clinical domains would include urinary incontinence, rectal issues, inflammation of the lower urinary tract and pelvis, geriatric conditions, neurogenic bladder and urogenital fistula.

Graduate courses must be included in the fellowship, which usually focus on statistics, epidemiology and

research design. Course listings and grading must be included. The inpatient and outpatient experience, as well as patient numbers in the hospital and clinics, are noted. The diagnostic procedures and endoscopic evaluations are included. The number of Fellows and whether they are gynecologists or urologists, and whether the course is for 2 or 3 years, as well as a block diagram of rotations that include personnel and location, must be included in the application. The fellowship's ongoing logs are reviewed for a range of procedures for urinary incontinence, faecal incontinence, prolapse, obstetrics exposure and reconstruction of fistulae. Adequate diversity in pharmacological, behavioural and surgical-device treatment of these areas is required. The facilities must have adequate diagnostic machinery and operating rooms, and offer endoscopy at the site.

A thesis must be completed at the end of the fellowship that meets journal requirements in terms of patients and appropriate subject matter. The thesis must have a proper statistical analysis and reach appropriate conclusions. The thesis should demonstrate the candidate's knowledge of the field. The thesis cannot just be a literature review.

A list of the procedures for female reconstructive surgery is given at the ABU website (www.abu.org). For those already in clinical practice wishing to certify for the subspecialty of FPMRS, these procedures should account for 60% of the practice experience in the subspecialty. The prescribed annual surgical logs should include 45 cases in urodynamics, 25 in incontinence, and 40 in the reconstruction/prolapse/fistula and tissue-transfer categories.

Challenging the rationale for forming a joint committee between urology and urogynecology was the need to oversee formal training. Forming a subspecialty with formal fellowships was also the best way to recruit young urologists to the discipline. Concerns were expressed that subspecialty certification could be used for marketing, to limit the scope of care for general urologists, which has not happened to date. Subspecialties need to proceed with a vigorous oversight of the curriculum to avoid haphazard training. The quality of patient care, manpower, training and competition seem to be recurring themes with the establishment of fellowships in the USA. Finally, the Boards recognised the effect of the core curriculum, and the challenge of billing and financing Fellows, and the need to obtain a critical mass of Fellows in the subspecialty, especially in academics, to train the next generation of urologists.

Published material on training in FPMRS, and workforce needs

Cundiff et al. [1] assessed the effect of FPMRS on resident education using a survey instrument. Fellowships were initially perceived as detracting from education, at

least in oncological fellowships, but after establishing the programme there was a positive effect sustained for at least 3 years, as noted by Residents and interviewers. Cundiff et al. also assessed the responses from 250 obstetrics and gynecology residents, showing that 46% were dissatisfied with urogynecology residency education and wanted improvements in fellowships, thus establishing the need for formal fellowships, rotations and training. Only 24% of Residents surveyed actually had exposure to Fellows. Work force needs by peers and others show that there will be a 20% larger female population by 2020 in the USA that needs care. A survey of Urology chairs in the USA showed that the main area of recruitment needed was in female urology and reconstructive surgery [2]. Thus there is a tremendous need for fellowships in this under-served area in the USA.

Changing subspecialty certification by the ABMS

The first reading of the application for recognition of the subspecialty was in July 2010. At that time the application included a justification for the certification of the subspecialty and a delineation of how the fellowships would be organised, including the curriculum, block diagrams, and basic requirements. The documentation provided showed that there were six standard textbooks on gynecology and urology, with chapters devoted to urogynecology and female urology, and reconstructive surgery and female pelvic medicine. It also noted that the joint fellowships between the ABU and ABOG had existed for 11 years, and at the time of the application there were 38 fellowships and 41 Fellows per year. There were 3000 positions in the USA for urogynecologists or female urologists as the primary focus of their clinical practice. The subspecialty had national societies and international meetings devoted to this specialty. There were 38 programmes; six had urology programme directors, two had combined gynecology and urology training, and 30 had urogynecology programme directors. Two programmes actually had two separate fellowships, one led by urologists and the other by gynecologists. A justification was given for the difference in training periods for urologists and gynecologists based on the differences in subject material and exposure during residency training. The method of evaluation of Fellows consists of a secure written examination of 200 questions, a thesis, and successful completion of the fellowship.

Future directions

In the 13 years since the formal fellowships were started, the specialty has changed to include robotics. The

fellowships have been successful by any measure in the USA, with high-calibre graduates going into specialty practice. These fellowships have generated tremendous volumes of research in FPMRS. It will probably be decades before enough Fellows have graduated and their patient outcomes and academic productivity assessed to know whether establishing a formal subspecialty in FPMRS has improved the healthcare of women or residency training beyond the former status quo. The adoption of new procedures and additions to the curriculum requires a dynamic process. Currently the fellowships are evaluated by the ABOG review committee with ad hoc members from urology to help review the urology programmes. The joint fellowship committee exists for guidance and to write questions for the certifying examination. In the USA subspecialty certification will also be given through the 'grand-fathering' process, whereby urologists with adequate clinical logs in the discipline and the proper clinical focus can be certified by passing the examination, showing appropriate Continuing Medical Education credits, and meeting the criteria established by the ABU, despite not having completed a formal fellowship.

Conclusion

It is envisioned that these fellowship programmes will continue to expand over time. The entire process, although challenging, has led to the improved care of women in the USA, through rigorous advance training of both urologists and urogynecologists beyond residency.

Source of funding

None.

Conflict of interest

None.

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