

Challenges Facing Academic Urology Training Programs: An Impending Crisis

Chris M. Gonzalez and Patrick McKenna

OBJECTIVE	To determine the most pressing issues facing academic urology training centers. The supply of urologists per capita in the United States continues to decrease. Stricter resident requirements, restriction of resident duty hours, and a Graduate Medical Education (GME) funding cap on resident education has led to significant challenges for academic centers.
METHODS	A 32-question survey was sent to Society of University Urologists members. Respondents defined themselves as academic faculty tenure track, program director, academic chair, program director and academic chair, clinical faculty nontenure track, and community faculty member.
RESULTS	A total of 143 of 446 members (32%) responded. A lack of funding was indicated as an obstacle to adding new residency positions (65% respondents) and recruiting new faculty (60% respondents). Residency positions not funded by GME (40% respondents) required either clinical or hospital dollars to support these slots. Most respondents (51%) indicated resident research rotations are funded with clinical dollars. Surgical skills laboratories are commonly used (85% respondents) and are supported mostly with hospital or clinical dollars. The majority of respondents (84%) indicated they would expand simulation laboratories if they had better funding. Other than urodynamics and ultrasound, urology residency training programs reported little income from ancillary dollars.
CONCLUSION	There is a significant workforce shortage within urology training programs. Clinical revenue and hospital funding seem to be the main financial support engines to supplement the GME funding shortage, proficiency training, and faculty salary support for teaching. The current system of GME funding for urology residency programs is not sustainable. UROLOGY 81: 475–479, 2013. Published by Elsevier Inc.

The supply of urologists per capita in the United States continues to decrease, a trend that started in 1991 and continues to accelerate. In 2009, there were only 3.18 urologists per 100,000 population, a 30-year low.¹ Mirroring this nationwide shortage of urologists, a recent survey of the academic urologic workforce projected that over 369 faculty positions need to be filled over the next 5 years, suggesting that the shortage of academic urologists is more severe than that of independent practice urologists.²

Since 1997, there has been a cap on government funding for residency training. In addition to this funding cap, the new Accreditation Council for Graduate Medical Education (ACGME) initiatives have placed many new mandated requirements on urology training programs including specific restrictions on resident duty hours. Furthermore, there is a more focused emphasis on didactic teaching and independent learning through organized proficiency laboratories in many training

programs. These new methods have proven to be costly and are not supported by existing Graduate Medical Education (GME) funds. In essence, there is more to teach and less time and resources available to provide these educational standards.

With 10,000 seniors aging into the Medicare program every day for the next 18 years, along with the impending influx of patients as a result of the Patient Protection and Affordable Health Care Act urology is facing severe workforce shortages. The independent practice workforce shortage has raised the salary discrepancy between independent practice and academic practice. Furthermore, the rising practice dissatisfiers of less research dollars, less support for teaching, and pressure to produce clinical revenue contributes to the even greater shortage of academic urologists.

There is a need to train more urology residents; however, with a GME residency funding cap, newly mandated teaching requirements, resident duty hour restrictions, decreasing reimbursement, and academic physician shortages, urologic residencies are in jeopardy.

We sought to determine the most pressing issues faced by academic urology centers with a special focus on faculty recruitment and retention, faculty teaching requirements, funding for residency training, the use of

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From the Department of Urology, Northwestern University, Chicago, IL; and Department of Urology, University of Wisconsin-Madison, Madison, WI

Reprint requests: Chris M. Gonzalez, M.D., M.B.A., 675 N. St. Clair, Galter 20-150, Chicago, IL 60611. E-mail: cgonzalez@nmff.org

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ancillary services and physician extenders, and the need and support for proficiency training laboratories. We hypothesized that the lack of GME funding, more stringent ACGME requirements, declining payer reimbursement, and a decreasing academic urology workforce has led to a challenging situation for academic urology training programs.

METHODS

A 32-question internet survey was sent to Society of University Urologists members across the United States (Appendix, online only). Respondents defined themselves as academic faculty tenure track, program director, academic chair, program director and academic chair, clinical faculty nontenure track, and community faculty member.

RESULTS

A total of 143 of 446 members (32%) responded. Geographic representation was from 14 states. Survey respondent's self description of their academic appointment is shown in Figure 1. A total of 54 of 140 respondents (39%) described themselves as hospital employees.

Faculty Recruitment and Retention

Most respondents (all = 73%, chairpersons = 83%) indicated that their program was actively recruiting a new academic or research faculty member. A majority of respondents (all = 60%, chairpersons = 71%) indicated that salary is an obstacle to faculty recruitment. Pressure on the academic faculty to produce clinical revenue was identified as a problem affecting resident teaching time by the majority of respondents (all = 91%). A majority of respondents indicated that faculty salary support was mainly from clinical revenue (all = 85% [range 71%-95%]), hospital (all = 69% [range 70%-83%]), endowed chairs (all = 61% [range 50%-69%]), and medical school funds (all = 56% [range 46%-66%]).

Residency Funding

Residency positions not funded by Medicare, Medicaid, or the Veterans Administration were reported by 40% of respondents (chairpersons = 54%). Funding subsidies for these residency positions are shown in Figure 2. The majority of respondents indicated that these positions are funded by clinical revenue or hospital funds. The lack of GME funding was reported to be an obstacle to adding new residency positions by 65% of the respondents.

Most respondents (all = 59%, chairperson = 39%, program academic faculty = 64%, and program director = 73%) indicated that their program had a dedicated research rotation. Clinical revenue (all = 51%), hospital funding (all = 33%), institutional support (all = 27%), and grant support (all = 23%) were indicated as sources of funding for this rotation. Funding for overall program research activity was reported to be from clinical revenue (all = 68%), federal grants (all = 66%), local grants (all = 58%), and philanthropy (all = 52%). The majority

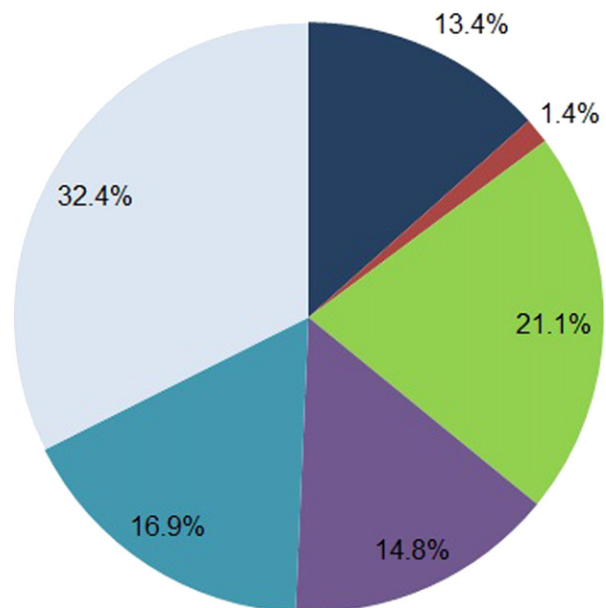


Figure 1. Survey respondents self-description of their academic appointment. (Color version available online.)

of respondents (all = 65%) indicated that funding for all forms of research has decreased in the last 5 years.

Surgical Skills and Simulation Laboratories

Surgical skills laboratories are commonly used (all = 85%) and are supported mostly with clinical revenue (all = 41%), hospital funds (all = 39%), medical school funds (all = 36%), and private donations (all = 30%). The majority of programs (all = 84%) reported they would expand their laboratories if they had better funding.

Ancillary Income and Physician Extenders

Other than urodynamics and ultrasound, none of the urology residency training programs reported significant revenue from ancillary dollars (Table 1). The need to hire physician extenders in order to compensate for the lack of resident availability due to new ACGME requirements on duty hour restrictions was reported by 70% of respondents. Nearly half of the survey respondents (all = 49% [range 48%-57%]) indicated that physician assistants and/or nurse practitioners were used to teach residents.

Health Policy

The most pressing health policy issues facing academic urology currently are Medicare reimbursement (all = 74%), GME funding (all = 68%), academic physician work and manpower shortage (all = 59%), and shortage of research funds (all = 12%) (Table 2). The most pressing issues facing the residency program were financial support for faculty teaching (all = 87%), faculty recruitment (all = 59%), obtaining research grants (all = 50%), hospital service requirements unrelated to education (all = 44%), and faculty retention (all = 35%).

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