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Authors

Bowman, Max
Breyer, Benjamin N
Hampson, Lindsay A

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Bridging Gaps in Urology Training

Max Bowman [1], Benjamin N. Breyer [1], and Lindsay A. Hampson [1]

[1]Department of Urology, University of California, San Francisco, San Francisco, California

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In addition to their clinical duties, physicians are also required to manage several nonclinical responsibilities in their daily work. Despite this, they seldom receive formal training to prepare them for these roles.[1] In fact, the term "accidental administrator" has been coined to describe physicians thrust into leadership without proper training or intention, and most residents feel unequipped for such positions.[2,3] In the evolving landscape of health care, in which medicine is becoming ever more of a business model, it is increasingly obvious that clinical acumen is not all that is required to become a successful physician. Thus, the need for comprehensive skill sets that extend beyond clinical practice is more pressing than ever. Accordingly, there have been multiple calls for formal efforts to address these deficits in United States residency programs.[1,2,4]

Although it has been demonstrated that residents desire more leadership training, this is not often included in urology residency curricula, and some argue that this deficiency requires immediate attention.[5-7] While other specialties have published attempts at formal comprehensive skills development, they mostly involve primary care or focus on specific resident cohorts.[3,4] Within our academic urology program, we aimed to develop a training curriculum that focuses on skills beyond clinical medicine, including domains such a health care context, leadership, team building, and business and finance. Resident perceptions were assessed via online evaluations. Herein, we describe the process of creating the curriculum and lessons on how to achieve implementation success.

Methods

From July 2020 to June 2023, 27 sessions were introduced into our resident education schedule as part of the longitudinal comprehensive training curriculum. Each fell under one of 4 domains: Health Care Context, Leadership, Team Building, and Business Acumen and Finance (Figure). Lectures were held periodically during preexisting educational time, such as weekly didactics or monthly journal clubs. They were delivered by our own faculty or experts invited from other institutions. Afterward, residents evaluated the lectures on a 5-point Likert scale (poor, below average, average, above average, or excellent) to assess the domains of topic relevancy, instructor knowledge, instructor effectiveness, and session usefulness. Respondents also indicated if they would recommend the lesson and/or the instructor in future years. The data sets generated during and/or analyzed during the current study are available from the corresponding author upon reasonable request.

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Data Availability: The data sets generated during and/or analyzed during the current study are available from the corresponding author upon reasonable request.

Corresponding Author: Max Bowman, MD, Department of Urology, University of California, San Francisco, 400 Parnassus Ave, 6th Floor Urology Clinic, San Francisco, CA 94143 (max.bowman@ucsf.edu).

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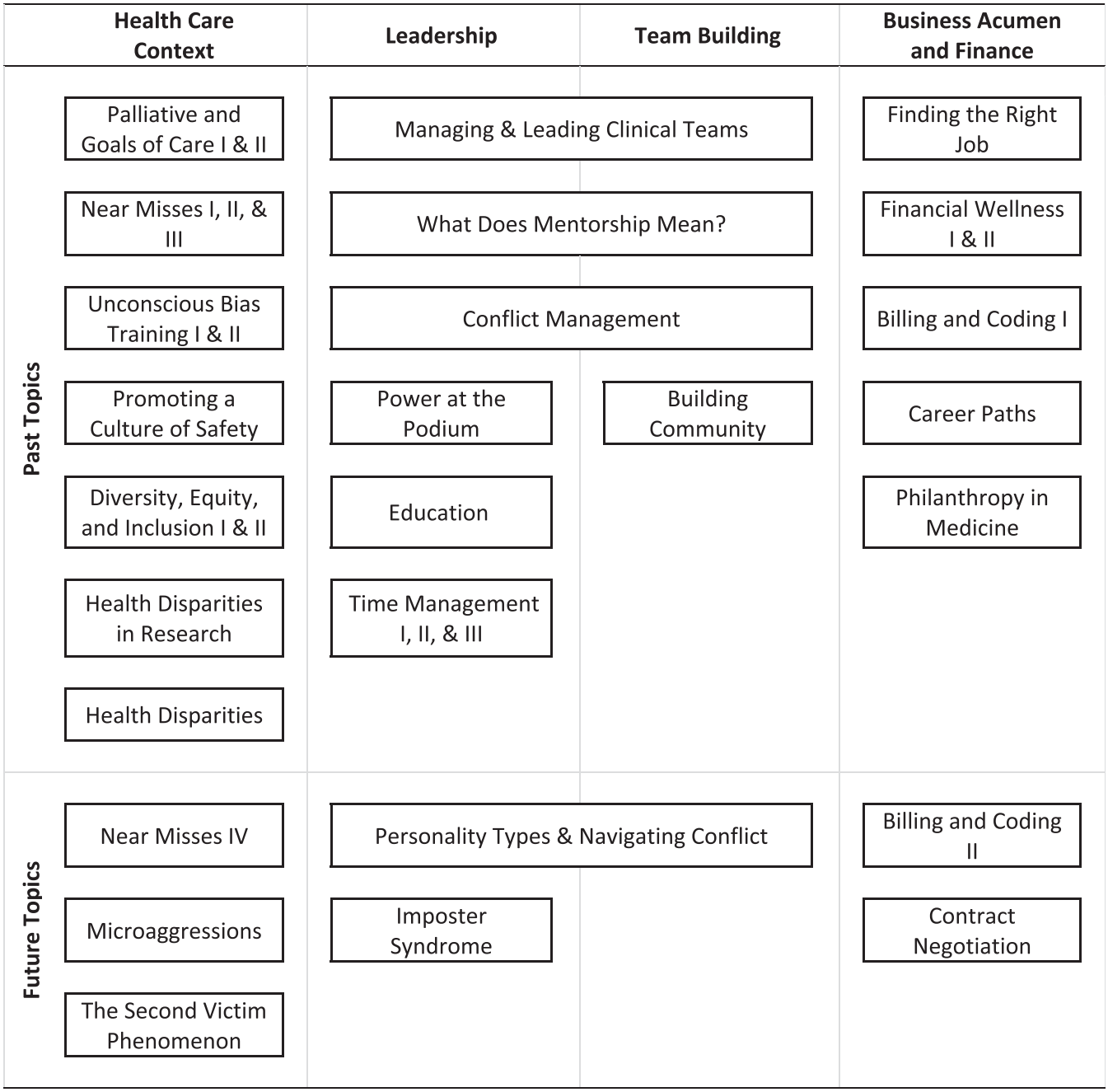

Figure. Leadership curriculum by domain July 2020 to June 2023 (top) and future topics planned (bottom).

Results

During the study, 67 evaluations were collected for the series, with 20 pertaining to journal clubs and 47 to didactic lectures. The sessions were rated above average or excellent by 85.1% for relevancy, 92.5% for instructor knowledge, 86.5% for instructor effectiveness, and 82.1% for usefulness. The median answer was "excellent" for all.

Among the 47 didactic evaluations, 93.6% would include the topic again and 95.7% would select the same instructor. Written feedback from the series included a general sense of appreciation for these topics and calls to continue the series in future sessions. There was also an emphasis on the importance of keeping lectures relevant and timely.

Discussion

The process of implementing a comprehensive training curriculum taught us several important lessons. Overall, we found that residents received sessions readily and felt they complemented their clinical training. Some of the most successful topics were those that addressed immediate and

relevant needs for the residents, such as lectures on financial wellness, how to lead a clinical team, and job seeking strategies. The rubric in the Figure reflects the final version of subjects incorporated into our curriculum based on longitudinal resident feedback.

We found residents tended to be more receptive when topics were taught by urologists as opposed to faculty in other specialties. Urologists may better understand our residents and their lived experience, thus making sessions feel more timely and pertinent. For many topics, however, we did not have experts among our own faculty and needed to solicit nonurologists to provide insight and expertise. Through this, we learned that pairing nonurological lecturers with our own (nonexpert) faculty helped contextualize lessons. This also allowed our faculty to become experts in these areas and go on to give lessons autonomously in subsequent years. Moreover, it has been shown that residents tend to model themselves after senior physicians, and developing our faculty as leaders allows them to serve as these role models for our trainees.[5]

In addition to recruiting nonurologists at our institution, we learned that lessons by urologists from other institutions provide additional expertise while facilitating valuable collaboration and networking. Nationally, there are myriad urologists with knowledge in various domains, and bringing them into our series helped overcome institutional barriers with enthusiasm from both residents and visiting faculty. By providing an opportunity to easily access information from national experts in a collaborative and customizable forum, this series serves as a meaningful adjunct to existing material available through the AUA Core Curriculum, which currently provides education on communication, business, and ethics. We found that through creating this space via discussion-based journal clubs, case-based lectures, and Q&A sessions, we were able to satisfy residents' desire for information that is both personalized and interactive.

Finally, we found that using dedicated educational time to implement this series helped weave it into our training. In the first year, we extended our didactic time for the curriculum and received feedback from faculty and trainees that the extra time conflicted too much with clinical responsibilities. Subsequently, we integrated the series into existing protected didactic time and this was better received overall.

Immediate future directions of this initiative include accruing more evaluation data for the series as more residents are exposed to it with the goal of validating and further improving the curriculum. Furthermore, we recognize the topics at hand are applicable to residents beyond urology, as well as to physicians who have completed training. From a long-term perspective, expansion of such a program to nonurology and nontrainee physicians would further fulfill the need for greater familiarity with these topics within the health care system at large.

Conclusion

Comprehensive training in skills that extend beyond clinical competencies is both needed and desired by residents. Implementation of these series can be done in academic urology departments by leveraging expertise within and outside of the department and utilizing existing educational time. This is most successful through using both local and national experts and emphasizing topics that residents see as relevant and timely. These lectures were well received, and most residents felt the series enhanced their training. As we continue to refine and develop the curriculum, it may prove to be a valuable resource for residents in the future.

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Editorial Commentaries

The authors describe their experience with creating a nonclinical didactic series that was centered around leadership, business, and general health care.[1] The majority of evaluations were noted to be "above average" or "excellent" in relevancy, effectiveness, and usefulness. I find that the residents in our department share a similar and strong desire

to complement their clinical skills with the "real-world" education of an attending practice. We instituted similar curricular changes 2 years ago and resident opinion has been equally positive.

As practicing urologists, we can remember the steep transition from training to our life as a junior attending. Much of that stress and anxiety centered around nonclinical issues including those in the above-noted curriculum. I personally wonder how much smoother my transition would have been if I'd had more knowledge in these areas.

The authors highlighted the need to seek experts in these topics and noted that some practiced outside their institution. Over the last few years, interacting across specialties and the country has never been easier due to the explosion of virtual meetings. Integrating resident education needs in these areas could be implemented across other programs using this format.

We, in urology, are not the only ones grappling with the question of whether or not to add this nontraditional component to resident education.[2,3,4] I would argue that our responsibility, as attendings at teaching institutions, is to train competent and confident young urologists—and that includes arming them with nonclinical skills. With the existing rigor and requirements of residency, the addition of more education can seem daunting. However, it is filling a gap in knowledge and the authors demonstrate ease of integration into the existing didactic schedule. I appreciate the authors' description of their curriculum and hope to see an update of their results over time.

Jyoti D. Chouhan[1,2]
[1]*Department of Urology*
Oregon Health & Science University
Portland, Oregon

[2]*Editorial Committee, Urology Practice®*

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Although the authors frame their pilot curriculum as relating to leadership and practice management training, it essentially comprises a series of value-added nonclinical lectures directed at urology trainees.[1] Feedback and future plans for this curriculum were directed from resident evaluations and suggestions, which were, all in all, positive.

With limited work hours, and in our current training program models, (perhaps too) many formal conference times are directed to more practice-related clinical issues and to learning endeavors that gear residents to ultimate success in scoring well on their in-service and then passing their American Board of Urology board exams. Given time constraints, it is challenging to carve out additional time within their schedules for novel-learning educational efforts such as these. In addition, are all the topics presented in this brief communication as relevant to more junior level residents, as opposed to those who might require leadership and administrative preparation training before they become chief residents, or those chief residents and fellows who are entering practice? Might the sections within the AUA either virtually or at regional subsection meetings present even more ideal venues to promote such learnings in a more informal, but more personalized, fashion directed more to the resident's level of training and needs? Such a cooperative training model that is supported by the training institutions and their respective AUA sections would also increase the cadre of experienced, qualified, and committed urologists (which residents seemed to prefer over invited nonurologist lecturers) from multiple institutions to most appropriately impact the "gaps in education" that future practitioners face. The practice of medicine is increasingly complex and hierarchal, and, as the authors have attempted to do, filling in relevant gaps for our trainees should be an iterative process where faculty and trainees can gain knowledge of the increasing nonclinical challenges that will be faced throughout training and beyond.

Martin A. Koyle[1,2]
[1]*University of Minnesota Faculty of Medicine*
Minneapolis, Minnesota

[2]*University of Toronto*
Temerty Faculty of Medicine & Institute of Health Policy Management & Evaluation
Toronto, Ontario

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