

Results of the EBU Manpower Survey on office urology*

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The practice of urology is changing throughout the world. Increased efficacy and popularity of medical and minimally invasive treatment modalities are influencing urology, making it a more medical rather than surgical centred specialty (1). Some European countries, in response to this, are altering their training arrangements (2). The EBU Manpower Committee felt it very important to learn the present position and future plans of the EBU member countries in relation to urology training.

For many years certain European countries have had a large number of what are called office urologists but it has never been very clear what training such individuals have had and how they practise. The Manpower Committee of the European Board of Urology conducted a survey on the current situation of office urology in Europe.

A detailed questionnaire designed by the Manpower Committee of the EBU was e-mailed to the delegates of the 30 member countries. These delegates were asked to complete the questionnaire either personally or in consultation with their fellow delegates and send their replies by January 31st 2007. In addition to the questions about office urology, a few questions were included in relation to the prescribing habits of urologists and on restrictions in this area. A final question in relation to emigration of urologists from their training country was asked. The following is a summary of the finding from this survey.

Results were available from all countries except Slovenia and Croatia. As the populations of the countries in Europe vary widely and the urologist/population ratios were published in the previous survey of the Manpower Committee of the EBU, we concentrated on the age range of urologists. Fig 1 illustrates the age distribution of urologists. In most of the countries the majority of urologists are in the age group between 35-55, with Belgium and the UK having the highest proportion of younger urologists.

The ratio of residents to urologists in each country was calculated. These ratios may indicate the

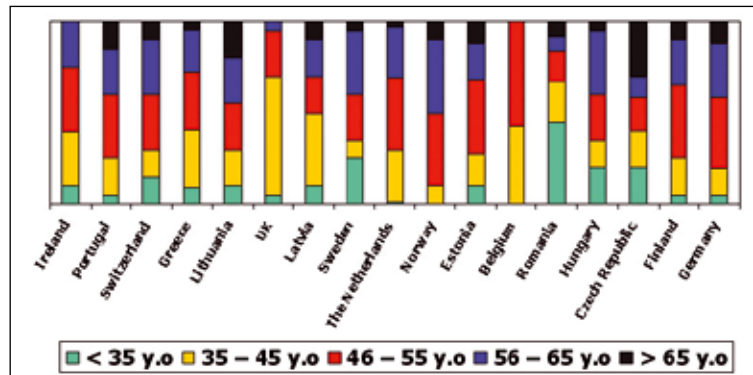


Fig. 1 The age distribution of urologists

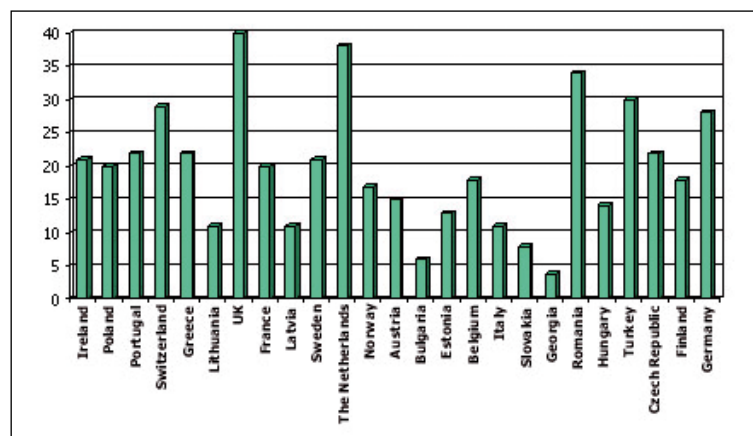


Fig. 2 Ratio of residents to urologist

potential for some urologists to work as “office urologists only” in the future. In this regard, UK, Germany, The Netherlands, Romania and Turkey have the highest ratios of resident/urologist -between 30 to 40% - among the countries responding to this question (Fig. 2).

According to the survey, in countries where office urology exists, its extent is almost equal. National societies, however, plan to develop the role of office urology in ten countries, including six countries (Switzerland, Greece, UK, The Netherlands, Georgia, and Turkey) where office urology does not at present exist. (Fig. 3)

The duration of training in urology is more or less similar amongst all countries (5 - 6 years) with the UK

Do national societies plan to develop the role of office urology?

YES

Switzerland
Greece
Lithuania*
UK
The Netherlands
Bulgaria*
Georgia
Romania*
Turkey
Czech Republic*

NO

Ireland
Poland*
Portugal
France
Latvia
Sweden*
Norway
Austria*
Estonia*
Belgium*
Italy*
Hungary*
Finland*
Germany*

* Office urology does exist

Fig. 3 Do national societies plan to develop the role of office urology

(10 years) and Finland (3 years), being two opposites. The next question is, “is there a specific residency programme to become an office urologist”?

Apart from in the U.K., where a new programme of residency has been instituted in 2005, there are no specific programmes of training for office urology. Even then, it is envisaged that the practice of these U.K. urologists will include limited surgery.

Another important aspect of this survey (practice) is the spectrum of the practice of office urology. These activities are: a) Non-surgical procedures (ultrasonography, uroflowmetry/urodynamics, transrectal ultrasonography+prostate biopsy, biofeedback, urethral dilatation, intra-cavernous injections and intravesical instillations) and b) Surgical interventions (circumcision, TUR-P, testicular biopsy, endoscopy). Figure 4 depicts some of the most commonly performed activities.

The most prominent reasons offered for the emergence of office urology were changes in treatment modalities towards a more medical approach, higher income in office urology and differences in costs of treating certain conditions in a clinic or office setting. Table 5 shows these and other reasons.

The migration of doctors from certain European countries to others has become a concern in recent years, as this might cause difficulties given the fact that residency programmes and the practice of urology including office urology varies between countries. However, almost all delegates who responded to the survey reported that the percentage of recently qualified urologists who emigrate from their native country is less than 10%. This should not be a major problem for the time being.

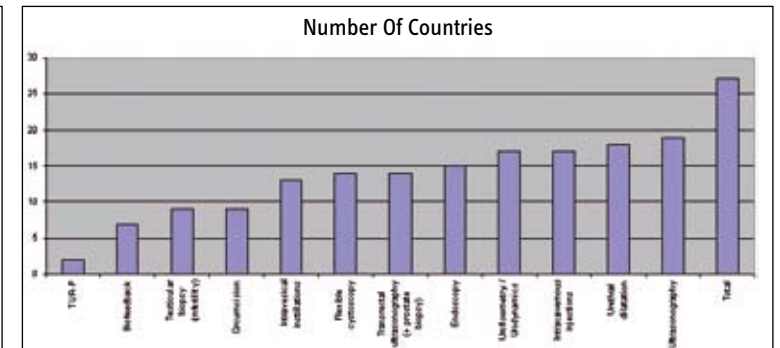


Fig. 4 Most commonly performed activities in the practice of office urology

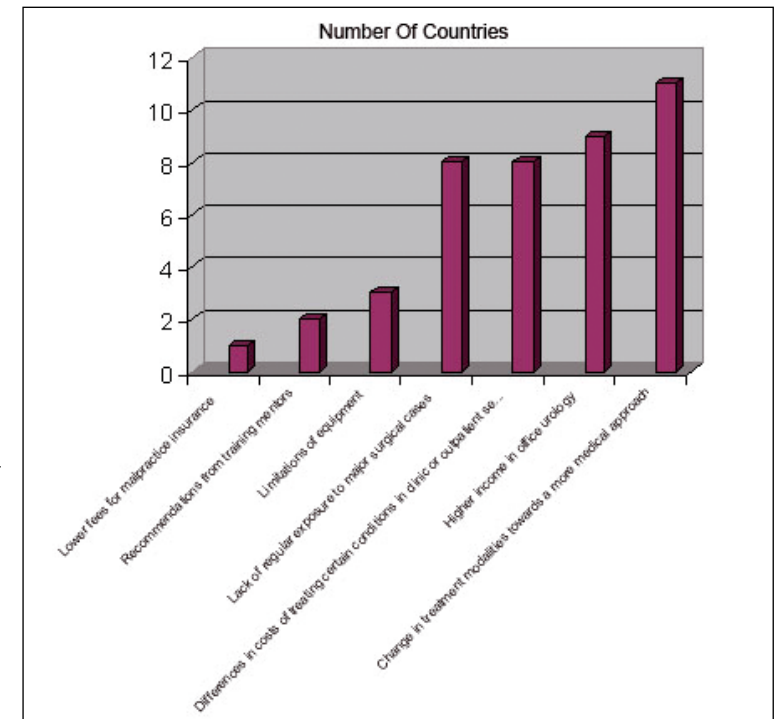


Fig.5 The reasons for the emergence of office urology

Limitations for prescribing medications: In certain countries, urologists are not allowed to prescribe systemic chemotherapy for urologic cancers (Switzerland, Lithuania, Slovakia, Romania, Hungary, Turkey and Czech Republic). In addition to this, urologists in Slovakia and Turkey cannot prescribe anti-depressants, while our Czech colleagues cannot prescribe LHRH agonists.

The role of office urology continues to grow and warrants more attention in terms of training, certification, and continuing medical education. It appears that this area of non-surgical urological practice has developed largely by default, and perhaps a more focussed approach to it is required by our national societies and training bodies.

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References:

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