

A Call to Action: The Case for Surgical Log Credit for International Rotations and Further Action by the Academic Urology Leadership

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A Call to Action

Important international initiatives have brought attention to providing surgical care to 5 billion people worldwide who lack access. As one of many opportunities to help, given vast resident interest in international rotations, the urological community is ideally positioned to harness this interest and foster the next generation of global surgery leaders needed to meet this challenge. Unfortunately, barriers such as lack of institutional support, time off and funding impede trainee participation and, perhaps, an educational experience that might stimulate a career-long interest in global surgery. Notably, the lack of case log credit for international surgeries serves as an important message to devalue the importance of these international experiences. Allowing international cases to be counted for surgical log credit exists as an immediate action that the urological leadership should take to demonstrate its commitment to this global effort and its trainees.

Background

In 2015, the Lancet Commission on Global Surgery was purposed to promote widespread access to safe and high-quality surgical care.¹ The Commission reported that, in contrast to other notable gains seen across other health care initiatives, the development of surgical care infrastructure in low and middle income countries (LMICs) had received little attention. And, as

a result, LMICs were unable to meet the significant and growing burden of surgical disease. Specifically, the Commission concluded that 5 billion people lack access to safe and affordable surgical care and that 143 million additional surgeries are needed to save lives and prevent disability due to surgical disease. Further, it noted that “surgical and anesthesia care should be an integral component of a national health system in countries at all levels of development.”

Fortunately, the urological community is well positioned to help lead within this global effort. This is critical given the significant portion of the global surgical burden that is urological and the cost-effective nature of providing surgical care.² Specific to the United States, numerous organizations have created robust infrastructure to help provide urological and urogynecologic care in LMICs. Such nongovernmental organizations (NGOs) include GSE (Global Surgical Expedition), IVUmed and IOWD (International Organization for Women and Development). These and other efforts are supported by many additional organizations focused on funding and advocacy, including the GPC (Global Philanthropic Committee), the G4 Alliance and, more recently, the Urology Care Foundation.

Most importantly, resident interest for international training is vast and growing. Numerous studies demonstrate a significant interest in global surgery experience in the majority of residents across varied surgical subspecialties.^{3–7} This interest is notable across urology trainees, who perceive international

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training as being of significant importance to their education and report a commitment to volunteer not only during residency but throughout their career.^{4,6,7} This is arguably the most critical component of the global surgery movement as we must seek to identify not just urologists willing to participate sporadically on a week-long surgical trip, but rather to foster the next generation of global surgery leadership.

Certainly, there are many steps needed to support the development of a formalized and robust training effort for international global urological surgery. Present barriers include the lack of formal curricula to provide global surgery training and the absence of organized platforms to help trainees identify international opportunities, as well as the lack of institutional support or the need to use personal funding and vacation time to pursue global surgery training.^{4,7} Much like global efforts to combat surgical disease, such steps will take time, leadership and commitment. However, allowing international cases to be counted for surgical log credit exists as an immediate action that the urological leadership can take to demonstrate its commitment to this global effort and its trainees.

The Case for Surgical Log Credit

Critics may emphasize the lack of standardization across international sites necessary to ensure the quality of international experiences. Such criticism is problematic for several reasons.

Foremost, such criticism suggests that operative skill education obtained when participating in surgeries in LMIC is somehow inferior to that gained in the U.S. This suggestion is underscored by case log restrictions, with Miller and colleagues opining that the institutionalized withholding of surgical log credit “discredits the value of the experiences and skills that can be attained in nonindustrialized nations.”⁸ The U.S.-centric message sent by this restriction is also inconsistent with important inclusivity and diversity initiatives throughout the urology and the health care community at large.

The inference that surgical education in LMICs is inferior, intended or not, is inconsistent with formal experience to date. For example, in a comparative analysis of operative log experience between general surgery rotations in the U.S. versus international (India), Kolkman et al found that, when compared with the parent (U.S.) institution, international case logs demonstrated greater number and diversity across disease categories.⁹ Beyond case number and diversity, multiple additional benefits are attributed to international training, including a greater emphasis on honing examination skills and surgical exposure to unique or advanced disease.^{8,10} Further, such experiences require participants to provide surgical care in a cost-conscious fashion given the scarcity of resources typically available.^{8,10} Finally, international efforts facilitate the development of leadership skills given the need for

participants to collaborate with medical teams across various cultures and health care systems.^{8,10} Ironically, all of these skills are integral to both Accreditation Council for Graduate Medical Education (ACGME) and milestone specific core requirements and are also promoted through American Urological Association initiatives such as its international exchange programs or legislative fellowship program.

Second, standardization of international experiences generally places surgical characteristics (such as case type) as the primary educational objective. Although seeking to standardize surgical characteristics may appear helpful, this focus contradicts the foundation of appropriate global surgery initiatives. That is, effective global surgery outreach must place focus on the needs of the host site. These needs, whether case type or training efforts, can commonly change. Effective outreach thus relies on helping to address present surgical needs and focusing on sustainable, scalable and cost-effective approaches. In contrast, short-term surgical trips primarily focusing on visiting team priorities (fulfilling personal surgical goals or self-aggrandizement) are often criticized and commonly ineffective.

Despite the varied qualities inherent to international trips, insofar as oversight of surgical experience is an important consideration, numerous opportunities exist to also achieve this goal. Foremost, ACGME and Residency Review Committee (RRC) leadership should act to create a more comprehensive and defined set of requirements and accreditation standards surrounding international programs. Indeed, at present, common program requirements fail to address international programs. Because of this, related oversight is left to individual specialty RRCs. In their multispecialty review of RRC standards for international electives, Miller et al noted great variability across surgical specialties.⁸ These authors found that, in contrast to urology, other surgical specialties (general, plastic, neurological) have a formal international application process and guidelines. Further, both general and plastic surgery allow credit for cases performed during international experiences. In the absence of broad action by the ACGME, the urology RRC should lead the creation of standards and requirements for international urology experiences.

A second opportunity for oversight exists in the creation of the electives themselves. Numerous reports detail experience successfully developing international surgical rotations and formally incorporating these rotations into residency programs.^{11,12} As such, successful existing urological programs can serve as templates, with their directors helping to guide the academic urological community at large. Further, as detailed previously, the urological community has the benefit of several well-established NGOs that have long-standing experience supporting quality international trips that often include residents. To the extent that programs across many

individual academic institutions may be criticized as decentralized, the urological NGOs offer another option for establishing an organized program open to all urology trainees.

Conclusion

A global surgery movement is underway and the academic urological leadership is well positioned to help. An immediate action that it should take to demonstrate its commitment to the global surgery effort and to its trainees is allowing international cases to be counted for surgical log credit.

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Editorial Commentary on A Call to Action: The Case for Surgical Log Credit for International Rotations and Further Action by the Academic Urology Leadership. Not So Fast!

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Dr. Rapp in his article in this issue makes the case that the inability for urology residents to log international cases on their surgical logs is a significant barrier to wider adoption of global electives.¹ He also states that not counting these cases is insulting to the host countries, sending the message that we don't value that experience. He calls for changing this policy as the first step toward expanding the participation of urologists in these experiences.

Global medical missions to provide surgical care for patients in the developing world have been undertaken for decades in all surgical specialties. These have largely been funded by non-governmental organizations and together have provided critical services across the globe. Urology is well represented among these volunteer programs. IVUmed was started by pediatric urologist Dr. Catherine deVries in 1995 and has organized well over 200 resident trips since then. They have been perceived as extremely valuable to the trainees.² A number of other groups sponsor urology trips, often focusing on pediatrics, reconstruction, female urology, stone disease and oncology. Most of these organizations have at least 2 goals: to provide expert urological care to as many patients as possible when such care is not available locally, and equally important, to provide education to the host medical providers so they may be able to provide those services to more patients once the group has left.

Plastics, general surgery and neurosurgery, among others, have incorporated these trips into their residencies as electives

in many programs.³ Plastics, general surgery and obstetrics/gynecology do allow the cases for international rotations to be counted on resident case logs with preapproval. Orthopedics allows them to be logged only if the rotation is at least 4 weeks and the resident is supervised by a core faculty member in the home program. Neurosurgery has a detailed process to approve electives but does not allow logging of cases. Several other programs, including urology, provide some guidelines for these rotations but do not require approval or allow the residents to count those cases on their surgical logs.

Although most residents express true altruism when planning international trips, they often are also hoping to do a large volume of complex cases to augment their surgical experience at home.⁴ However, this resident goal may conflict directly with the goal to provide surgical education to the host physicians. A U.S. resident operating with a U.S. faculty volunteer may provide much less educational benefit to the host medical team than if the faculty were working with the host residents and faculty directly. A number of authors have discussed this conflict of interest and noted on surveys that that the host team may be acutely aware of it as well.^{5,6}

Cloyd and Wren noted that in fact some of the most important lessons residents gain from going on these trips come from learning to practice without the imaging, lab tests, medications and equipment (including laparoscopy and robotics) that we have learned to depend on at home.⁷ The

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patients' diseases are often advanced and involve complex infections and injuries that we rarely see here. The economics of health care in some countries require the patients and their families to come up with funding to receive care, and by necessity there may be rationing of scarce resources to only treat those most likely to benefit. Experience for the resident seeing all this firsthand is invaluable and might certainly make them better doctors, but that may have little to do with the number of surgical cases performed while there.

I would argue that providing credit is perhaps the last step rather than the first if we are considering expanding global surgical rotations for our urology residents. For general surgery, the ACGME (Accreditation Council for Graduate Medical Education) and American Board of Surgery several years ago outlined the many critical elements that need to be in place before receiving approval for an international rotation, including the following key topics, among others:

- Established a solid relationship with a host institution with clear goals and expectations.
- Assurance that the resident's salary, benefits, health and malpractice insurance (including evacuation insurance), travel expenses and housing will be covered by the home institution during the rotation.
- Provide careful attention to the local physical environment (housing, transportation, safety, communication) and establish mechanisms for insuring the health and safety of the participating residents.
- Provide a formal description of the rotation including educational rationale, competency-based goals and objectives, describe the qualifications of supervising faculty and available educational resources such as libraries, and a plan for resident performance evaluation.

While the high-income institutions often focus on cost and logistics when trying to organize an international elective, the

first bullet above is probably the most important. It may be very difficult to form a solid collaboration if teams come for just a few weeks per year. Mulenga and colleagues surveyed host institution staff and providers and described common perceptions of racism, lack of respect for their knowledge and skills, being sidelined by the visiting team, and lack of willingness to accommodate the local medical and social customs.⁸ Some felt the relationship was 1-way, and noted that local faculty and residents had never been similarly invited to visit the U.S. institutions. Certainly, knowledge that the residents are there to "pad their case logs" would not do anything to address these concerns.

Powell et al reported in 2009 that over 90% of 562 surgical residents who responded to a survey expressed interest in an international rotation if it were offered, regardless of whether they received case log credit for the surgeries performed.⁴ The response rate on that survey was only 11%, perhaps suggesting a bias in who chose to respond. In reality, many institutions offering elective international rotations report that participation among their residents has been well under 50%, and in some cases much lower. Residents and faculty both have many competing priorities that are barriers to participation in such trips, including family and call responsibilities, and financial and safety concerns, among others.

In summary, there are many challenges to developing and running a successful global urology elective for residents. Spreading the word about well-organized trips would certainly be valuable, and institutions that have the resources to support such trips should be encouraged to do so. However, it is premature and likely not critical that residents who go on these trips must be able to count surgeries performed on these electives on their ACGME case logs.

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Editorial Commentary on A Call to Action: The Case for Surgical Log Credit for International Rotations and Further Action by the Academic Urology Leadership

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The article by Rapp in this issue of *Urology Practice*® makes several well-founded points regarding the need for surgical care in low-income countries and acknowledges that the United States urological community is ideally positioned to meet this need.¹ There is also no doubt that, due to a residents' desire to help humanity combined with an interest in how an international surgical rotation could enhance their education, many urology residents would be interested in pursuing these opportunities. This article, however, suggests that the first step in establishing international rotations during urology residency training is to allow a resident's surgical experience to be counted for surgical credit during their residency.

A robust contrary argument to this latter point exists. Before allowing a resident to count surgical cases during an international rotation toward their surgical training log, it would be imperative to have the appropriate foundations of surgical education in place. This point is especially critical during an international rotation since both the mentor and the resident become *de facto* ambassadors for the United States and U.S. medical educational institutions.

The initial step in allowing a resident's surgical cases during international rotations to be counted as part of their training log is to acknowledge that their mentor for this rotation is a competent urologist. The supervising individual should be appropriately certified by an acknowledged certifying agency. The U.S. Accreditation Council for

Graduate Medical Education should also recognize the mentor as an academic faculty member. These key points enable the foreign countries and medical facilities participating in these endeavors to recognize that their fellow citizens are receiving the top echelon of medical care from the visiting foreign physicians. It also helps to verify the educational value of the resident's experience—the next critical step is to establish guidelines for patient care that the resident will need to follow during these rotations.

Once these basic foundations for resident education are in place, it is imperative that we seek appropriate authorization and approval from the foreign countries involved. It must be recognized by the foreign governments, the site of patient care and the patients undergoing treatment that U.S. medical trainees will be part of the visiting medical team. Failure for us to inform the foreign government, facility and patient that trainees will be participating in their medical care breaches ethical restraints and fails to respect the foreign government's and citizens' rights. Without the foreign governments and their citizens being fully informed that U.S. surgical residents will participate in mentored, supervised care of patients, we open ourselves up to a possible quagmire of problems and misconceptions regarding our intent regarding allowing U.S. residents to train in foreign countries.

Although I wholeheartedly support the concept that residents should be able to participate in international

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rotations, I would strongly disagree that allowing the resident to log surgical cases for these voluntary experiences is the first step. Instead, we must first establish appropriate, well-recognized mentors, develop guidelines for patient care by surgical residents during these rotations and obtain appropriate authorization from the foreign government, medical institution involved and patients undergoing care. It is imperative that everyone involved recognize that supervised U.S. surgical residents will participate in their

medical care. Only after fully informed consent of all parties involved can we proceed with allowing surgical cases performed during international rotations to count toward residency training.

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Response to Editorial Commentaries on A Call to Action: The Case for Surgical Log Credit for International Rotations and Further Action by the Academic Urology Leadership

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I appreciate the thoughtful commentaries by Drs. Skinner and Husmann. Foremost, it is my belief that global surgery deserves far more attention within the urological community, and to the extent that my editorial helps stimulate this discussion, I am grateful.

Drs. Skinner and Husmann describe several challenges to establishing a successful urology elective. In doing so, I believe they conflate the difference between establishing a global surgery program with simply supporting residents' formal participation in these experiences. Certainly, establishing a visiting global surgery program is a vast undertaking and includes steps outlined by Dr. Skinner. As founder and president of a surgical nongovernmental organization, I would agree and clarify that these represent just the tip of the iceberg. There are countless more. These steps are taken not to facilitate resident electives, but rather in an effort to build a partnership with a host country and help deliver surgical care. Specific to Dr. Skinner's highlighted logistical considerations, vast efforts are carefully taken to address housing, transportation, financing, safety and health care as basic tenets of our programs because they are critical to the whole team—the visiting and local physicians, nurses, technicians, translators, volunteers and the patients themselves. To the extent that residents participate in these experiences, they benefit from the same efforts that are in place not based on a primary objective to create a resident elective, but rather based on a primary goal

to help provide safe, effective and accessible surgical care to a country in need.

Similarly, Dr. Husmann places focus on developing appropriate resident supervision, remarking that supervising mentors should be “competent ... appropriately certified by an acknowledged certifying agency.” I have several concerns regarding this messaging. Certainly, a urologist (or moreover physician of any specialty) who participates in international care delivery should be competent and certified (have a current medical license). We do this not because residents participate in these trips, but rather because it is a basic ethical principle of practicing medicine, be it in the U.S. or abroad. Whether a resident is involved or not, the idea of allowing uncertified, incompetent surgeons to travel abroad to deliver substandard care is unethical. In my experience, this standard is maintained not simply by the traveling team, but more importantly, the host countries that often have significant application processes to ensure appropriate certification of all team members, including nurses and technicians.

Dr. Husmann also states that supervising mentors should be recognized by the U.S. ACGME (Accreditation Council for Graduate Medical Education) “as an academic faculty member.” I have had the pleasure of enjoying careers in both academic and private practice urology. Certainly, academic medicine is filled with physicians skilled in complex surgery and teaching. That said, I have also encountered some of the most talented surgeons and teachers of my career in the

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private practice environment. Further, the majority of dedicated physicians involved in my organization's global surgery programs come from private practice. Indeed, these physicians have more knowledge and skill specific to global surgery than most academic physicians I know and they have spent years teaching these skills to residents. Intended or not, sending the message that global surgery teachers should be academic faculty members or certified by the ACGME as such is problematic.

Dr. Skinner highlights the over 200 resident trips organized by IVUmed, serving as support of my stated position. Both the logistical and teaching foundations detailed by Drs. Skinner and Husmann have been in place for these trips for over 20 years, and advocating that these experiences should now be associated with log credit is unrelated. Simply, are we suggesting that resident experiences over the last 20 years (and approved by program directors nationwide) have been done so without having in place the basic tenets of safety or education detailed by Dr. Skinner? And that we should incorporate these only now because of case log credit? Certainly, this is not the case, as if it were this would represent a major breach in the ethics of resident mentorship.

Fortunately, it is not necessary (and likely less effective) for isolated urological faculty or departments to create this infrastructure. The urological community is benefited by the presence of several well-established private organizations with decades of experience developing safe and sustainable surgical outreach programs internationally. In addition, the

logistical and educational infrastructure is also quite developed at various global surgery centers across specific universities. They have already taken the first step(s). And also fortunately, these same organizations happen to support resident education through related programs allowing resident participation in these trips.

That said, much of this infrastructure has been created privately and without substantial nor formal support from the greater urological academic community. Ideally, the future is one in which we see the U.S. urological leadership and academic community place more formal efforts toward global surgery outreach and training, beginning with widespread support of existing organizations that have paved the way. Resident training is one small part of this initiative. Importantly, to the extent that focus is placed on international resident electives, these should be supported not simply as an isolated experience, but rather as part of a wider initiative to truly foster the next generation of global surgery leaders. Such an effort should include formal training programs and curricula focused on global health and surgery. The development of such programs would not be dissimilar to other areas of recent focus, including diversity/inclusion (AUA Diversity and Inclusion Task Force), health care policy (Health Policy Scholar Program) or leadership (AUA Institute for Leadership and Business).

I am excited by the prospect of this future. Until then, I reiterate my opinion that the urological leadership should seek to support these efforts in a small way by allowing international cases to be counted for surgical log credit.