LEGENDS IN UROLOGY

William L. Parry, MD
Professor Emeritus, Past Chairman
Department of Urology
University of Oklahoma
College of Medicine
Oklahoma City, Oklahoma, USA

At the invitation of *The Canadian Journal of Urology*, I am writing about some of my career history that may have meaningful value for readers. It is an enjoyable honor and challenge. Recently, I gave presentations on the living legend of Dr. Richards Lyon. His book "The Process Mind" is one urologists would enjoy reading. Its message here is the value of keeping a regular journal, especially of the "busy" years of one's practice. The pictures on my office walls, I feel, are windows through which my mentors are checking on me. Favorite scenes of my past also evoke helpful interchanges with my patients. I would suggest these tools may be helpful to young urologists starting their practice.

I urge candidates to provide background information on their applications and at interviews. My youth was spent in Elmira, New York in a setting where Mark Twain wrote his famous books. During the depression, my parents raised three children on as low as $1800 per school year; they managed our summers by living on my grandfather's farm. I encountered the adverse effects of medical costs as our family had hospitalizations for 15 years until Blue Cross Insurance was introduced in 1939. I also was introduced to good actions of doctors. They kept records but never billed my parents beyond a limited amount of charges. From such experiences, I always turned billing over to others.

I backed into medicine. My father, a science teacher/principal, urged me to take a "no longer required" course in biology that he deemed important. I took it to prove him wrong, but of course, he was right. A medical career appealed to me but appeared overwhelming. However, by driving up the mountainous road gradually, it proved possible to attend the University of Rochester through scholarships and enlistment in its Army Reserve.

The projected need of physicians during WWII accelerated my acceptance into medical school as one of four freshmen. I was called to active duty for the Army's Africa/Italy campaign. My orders were revoked and I was returned to the Reserve to complete premedical requirements. I spent only 1¼ years on campus and never caught up from missing a liberal education. Excused from English composition, I still need help in professional writing. These inadequacies may have been a hidden factor in my declining two medical deanship opportunities. Still college gave me life-long friends. For examples, I roomed between Drs. Carleton Gajdusek, Nobel Prize Laureate, and John Kanwisher, Investigator at Woods Hole Oceanographic Institute. One professor asked "is it the 'journey' or the 'goal' in life?" I knew I was a "journey" man and handled detours well. In contrast, my roommate, a "goal" man limiting his experiences became highly successful. Dr. Frank Hinman, Jr. invited me to talk at his retirement and was pleased that I brought out both features in his career.

My fascination with Urology began in medical school. I found technically I could insert a catheter easily into a ureteral orifice. Other attractions were dealing with "below the belt" problems and being able to accomplish more for older patients. Dr. Winfield Scott, Chairman at Rochester, was pleased to have one in our class interested in Urology. He accepted me into his residency program and became a valued mentor.

At some point I became aware of university missions. When Harvard became a university, its mission was to train leaders for the country, i.e. JFK's Think Tank. Columbia's mission was to solve problems for the country, i.e. FDR's Think Tank. Johns Hopkins and the University of Chicago took on the mission of new knowledge, i.e. research. Cornell's mission was to educate the public, i.e. Carl Sagan's Cosmos Series.

In retrospect, research paralleled each step of my medical education at Rochester with a faculty milieu related to Johns Hopkins. In its mission every student participated in "hands on" procedures with patients in the same curriculum. Research was institutional with the new cyclotron and the medical part of the Manhattan Project on campus.

Yale had a leadership mission. Passing the National Medical Boards was the requirement for graduation. Students could vary clinical rotations. Their patient contact would differ on service choices. Because I was the only outside graduate of the 12 surgical interns, my "hands on" experience was initially conspicuous. I helped students gain clinical confidence if they asked. Dr. William Anlyan, Dean at Duke, said I had been one of his mentors. Two peer interns demonstrate Yale's leadership milieu. Drs. Robert Chase became Head of the National Medical Boards and Arnold Relman the Editor of the New England Journal of Medicine.

I found later I had recruited key faculty in Oklahoma, a state school, representing the engendered four missions. The concept also has added understanding to the workings of colleagues. Another learned message has been to interview sufficiently. If your choices don't prove right, you can place individuals with known abilities in another position rather than dismissing them.

Returning to Rochester, I was advanced a year and made senior to earlier peers in a residency expanded for returning veterans. Rather than perform the surgery to improve my skills, I supervised talented individuals, learned from them and developed a pattern of training.

In my first year of Urology Dr. Hobart Boyd as Chief had regular informal evening sessions at his home, privileges residents do not have today. Dr. Arthur Paine said always sit in the front row at meetings to be in a position to 2nd motions. The officers will recognize you and select you for committees. This is how I was appointed to the American Joint Committee for Cancer Staging.

During my final two years of residency I worked under Drs. Winfield Scott for adult urology and John Benjamin in pediatric urology. Years later, I would work with Dr. Robert Pfaff, my Chief Resident, in Dubuque, IA. after Dr. Russell Scott had to withdraw my sabbatical with him in Saudi Arabia.

My recall to Air Force Service during the Korean Conflict as Chief of Urology in Cheyenne, WY was a pivotal detour. Due to circumstances outside my control, I was unable to be the Chairman of the new Medical School in North Carolina, the Chief of Urology at the NIH, a Fellow with Dr. Charles Huggins, Nobel Prize Laureate or the Chairman at the University of Colorado. Still I had the privilege of working with the noted Streptococcus Laboratory on Base that identified the strain associated with nephritis and established guidelines to prevent post-infection complications.

Then I became the first full-time faculty member in Urology at the new Upstate Medical Center of New York taken over from Syracuse University. With support from the clinical chairman, I established an approved training program. In trials with residents, I learned to follow a loose rather than a strict approach of supervision. (See Numa versus Lycurgus in Plutarch's Parallel Lives).

Dr. Clifford Straehley had trained in Surgery at the Massachusetts General Hospital and I had fellowship electrolyte studies with Dr. Jorgen Schlegel in Rochester. Together we mastered doing radical exenterative surgeries yielding palliation for patients with advanced malignancies of the abdomen. This work included devising a pelvic diaphragm using rectus muscle. All urologists would benefit from case experiences requiring extensive measurements of fluid balance, blood and urine chemistries and weight changes. Special also was doing urology cases with Dr. Lawrence Pickett, pediatric surgeon trained in Boston.

The most stimulating figure to me in medicine has been Dr. C. Barber Mueller. He arrived in Syracuse as the first full-time Chief of Surgery. He had visualized the glomerulus of the kidney with the new electron microscope and needed a model to study its tubules. Using rats, I was able to produce lethal acute renal failure with methaemoglobin blocking the tubules. The significant discovery was they survived by giving mannitol, an osmotic diuretic. Dr. Mueller photographed the clearance of the pigment in the tubules. We paid the Journal of Urology $1,000 to have these as its first colored pictures. Dr. Reed Nesbit, a pioneer of TUR use, knighted me at an AUA meeting saying "This young man has solved the problem which I've been working on for some time". Nephrologist Homer Smith had us reverse "white renal failure" caused by globin alone. Our findings were confirmed in dog models with Dr. Gerald Murphy at the Walter Reed Army Laboratory. The clinical effectiveness of mannitol was proven by teleconference with Dr. Thomas Starzl in Denver during kidney transplant cases. Mannitol is still a standard preventive measure especially in organ vascular procedures.

Clinically, I became responsible for bringing the transsacral prostatectomy to national attention for a period. Dr. Willard Goodwin, Urology Chairman at UCLA, invited a select group to watch me perform this surgery for

benign disease. Observers were suspended in a cage over the operating table. Dr. Wyland Leadbetter came to Syracuse to observe a total prostatectomy for his use. This technique needs to be remembered as an excellent approach for lesions in the seminal vesicle region.

I was a co-investigator in the founding of the VA Cooperative Urology Research Group. The initial project was studying estrogen therapy of carcinoma of the prostate. The Group found a 5 mgm estrogen dose caused a significant increase in cardiovascular problems compared to the placebo enrollees. This Study promoted the value of placebo controls and the importance of multisites for accumulation of statistical data. One fond memory was staying in Dr. Donald Gleason's home and being asked to review his famous Pattern Score before its initial presentation.

Research at Syracuse included using reverse sero-muscular grafts to enlarge bladder capacity and performing partial nephrectomies without occluding the renal arteries. Drs. Thomas Stamey with his differential studies and Eugene Poutasse, a leader in surgical treatment, personally aroused my interest in renal vascular hypertension. I learned to do percutaneous needle aortography and needle biopsies of the kidney plus demonstrating the latter to residents at Harvard.

Dr. Scott had forewarned me that academia grinds hard and slow. I expected to be appointed as Chairman in Syracuse. Awaiting this, I turned down re-offers from North Carolina and the NIH plus positions at Tulane and Minnesota. I learned the importance of visiting even if you doubt making a move. Both you and the site members benefit. Then Dr. Oliver Stonington called about returning to Colorado to be Co-Chairman with him and Dr. Donald McDonald, Division Chairman, proposed my return to the University of Rochester. The difference was salary/benefits offered by a private institution versus a state funded setting.

During my 1 ¼ years in Rochester, my renal dialysis service started for acute care in Syracuse needed to be expanded for chronic care. Dr. Charles Rob with extensive experience for finding vascular accesses arrived from England as Chairman of Surgery. He provided training for the placement of shunts for repeated dialyses. His arrival raised the question of which service was to do the renal vascular surgery for hypertension. The compromise was that Dr. Rob would train me to do the surgery and subsequently such cases would belong to Urology. I also began a trial of placing radioactive gold seeds in the prostate.

Shortly, I had three chairmanship offers. Initially I pursued the new school in Kentucky. Visits then to Oklahoma offered more potential. Dr. Stewart Wolf's charisma and goals for moving the clinical medical college to a full-time faculty center challenged me. Dr. Monte DuVal's points about a Department in Oklahoma versus a Division in Kentucky also provided a deciding factor.

I delayed my move to finish my work as a Board Member and Program Chairman for the Northeastern Section of the AUA. Dr. Kenneth MacKinnon at McGill University and I planned a resident exchange between Montreal and Oklahoma City.

In 1962 I became the first academic full-time Chairman and Professor of Urology at the OU College of Medicine, a position I held for 32 years. Oklahoma was going to be different as it was deemed "out in the wilderness" by respected colleagues. Having no full-time faculty, I visited community urologists and learned what each might like to do in the Department. I also followed Dr. Rob's advice "to use the rubber on my car tires" to go to their conferences. Further, I expanded the residency to include urologic experience in local hospitals. A psychiatrist, part-time funded, helped residents weekly to deal with patient problems and the "sexuality issues of the 60's". No program attention was given to preparation for the Boards. Residents instead were encouraged to find specialty interests. All passed Boards on first testing. At graduation, my charge simply was to practice their best Urology and to keep up with its progress.

I was appointed to the original NIH Committee for awarding research grants in Urology, representing the Southwest. I also had the privilege of being the chairman of a group of national figures who appeared before a House of Representatives Health Sub-Committee headed by an Oklahoman. The bill was to initiate the funding of renal transplantation through the Regional Medical Program. It passed Congress with only one dissenting vote.

Another opportunity was participating in "million dollar" studies of abrupt deceleration by the Civil Aeromedic Institute (CAMI) of the FAA. Results were seat and lap belts and the air bag plus a plastic that diffused ground impact in helicopter accidents. These projects were revisited when 120 academic urologists and our spouses were

involved in a crash landing without injury in South Africa. The CAMI/FAA work brought membership in the Rocky Mountain Trauma Society with its contributions to outdoor safety and bringing Outward Bound Survival to America. I led seven wilderness treks around the world to define problems for future travelers.

Christine Jorgeson, the first recipient of sexual change, chose to have "modifications" done in our Transgender Program. I had a cryosurgery unit to remove prostatic obstruction without general anesthesia. The Army had me on call twice to perform the procedure on President Eisenhower if needed after his heart attacks.

My most influential position in Urology was being the first elected Secretary-Treasurer, the operating officer, of the Society of University Urologists (SUU). This involved contacts with the leadership and the two representatives of each academic program. The SUU became the first surgical specialty society to hold meetings in conjunction with the Association of American Medical Colleges (AAMC). After my SUU Presidency, I was appointed a member of the Council of Academic Societies of the AAMC. My hope is that the Chairmen's Society of the SUU will re-unite with the AAMC. The SUU led to my serving as Co-Chairman of the Genito-Urinary Group for developing part of the new TNM Classification of Malignancies introduced at a World Health Organization Conference held in Geneva, Switzerland.

Community practice in Hornell, Cheyenne and Dubuque provided several insights. In academia every day was different, residents provided support and one didn't consider taking time off each week. In community practice, I experienced the need for physicians to take breaks. The multidiscipline clinics provided a good pattern for me to advocate for future practice change. I made house calls because I could sense home situations not recognized in an office setting. My patients today like home visits to discuss various source materials they have obtained.

Some points may be of interest. Dr. Willard Goodwin would write me that chairmen should step down for new leadership after a period of 15 years. I engaged in the proposition that urology's academic components would grow faster and more Divisions would become Departments, if chairmen with years of experience would move to fill openings. Thus, I visited three institutions in that capacity. Early in coming to Oklahoma I was able to resolve issues relative to renal transplantation and pelvic procedures with General Surgery and Gynecology. With current struggles, I wish Urology and Gynecology could be combined into one specialty for doing retroperitoneal surgery. Obstetrics could become a part of Pediatrics.

Attending conferences has been a valuable part of my urological life. They covered the need for sabbatical leaves or missionary trips. The involvement as Historian for four medical organizations and as a member of the AUA History Committee has kept me attending meetings. I sense the value of conferences and for whom they are intended is a new situation for the younger generation of urologists to resolve.

I have had a positive relationship with the VAMC for over 40 years. The VA has the potential to advance clinical medicine when outcome studies to which I belonged earlier can be resumed. Its system can access follow up data of treatments no matter the changes of patient location. I have missed belonging to such studies by not taking the VAMC as a semi-retirement option.

Memorable events for me were being elected first Chief of Staff of the Hospitals of the University of Oklahoma College of Medicine, becoming President of the American Association of Genito-Urinary Surgeons, receiving the Gold Cane Award from the AUA, handling guest arrangements for Dr. Hans Marburger's seminar gathering in Innsbruck, Austria, being an officer of the Aspen Urological Association and going to China on a NIH Study where I worked with Dr Wu, later head of the Congress of China.

I gratefully cherish my career in Urology. The joys continue by keeping in contact with colleagues and by following the accomplishments of my Faculty, Staff, Residents and Students.

William L. Parry, MD
Oklahoma City, Oklahoma, USA