# LEGENDS IN UROLOGY

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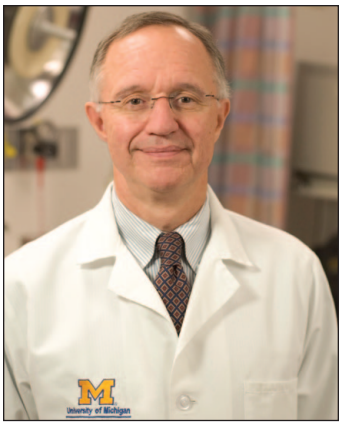

It is clearly an awkward assignment to contribute to this Legends Column. One generally doesn't perceive oneself as a legend and I certainly don't. Individuals previously selected by the CJU for the Legends Column have made important contributions to urology. In my case, I jumped on the bandwagon with new surgical techniques early, a few of which turned out to work. In some areas, I have steered our group towards desirable goals.

## Journeys

I grew up in the 1950s in Ecorse, a working-class suburb of Detroit that sat on the Detroit River nestled between Great Lakes Steel Corporation and a Wyandotte Chemicals plant. The air and water were not pure, to say the least. I attended University of Detroit Jesuit High School, an experience that profoundly altered my academic and metaphysical perspectives and for which I am forever grateful. I went to college at the University of Notre Dame and my only distinction there was being one of the founders of the Notre Dame Rowing Club in 1964 (it still exists). I was fortunate to attend the University of Michigan Medical School where I had a great education and made some lifelong friends. After 2 years in Seattle at Virginia Mason Hospital, where I had the good luck to train under Bob Gibbons, I headed to the Cleveland Clinic for urology, drawn by the highly accomplished team of Ralph Straffon and Bruce Stewart and the fact that my brother Joe did his urology residency there. I wanted to do renal transplant surgery and Lynn Banowsky was an outstanding role model. After an excellent experience for two years at the Air Force teaching hospital Wilford Hall in San Antonio, I made probably the most important professional decision in my career and decided to spend a year at Memorial Sloan-Kettering Cancer Center with Dr. Willet Whitmore learning urologic oncology. He had a profound influence on my career and taught me how to think about cancer, the patient, and what our treatments realistically accomplish. It was an exciting time to be at MSKCC with excellent clinicians as Alan Yagoda, Harry Grabstald, Pram Sogani, and Harry Herr.

I returned to the Cleveland Clinic in 1979 to head the newly created (I was the sole member) Section of Urologic Oncology. I quickly became very busy clinically with a diverse oncology practice but with a special interest in cystectomy. I started doing Koch pouch urinary diversions, working with the colon and rectal surgery group, who had a large experience in continent ileostomies. In addition to all the trials and tribulations of trying to get cystectomy patients safely out of the hospital, the new diversion was fraught with problems and many revisions. I remember once when Dr. Straffon walked into the operating room where I was struggling with one of these. He looked over my shoulder, and said, "You are going to be taking these down in 10 years." He was prophetic. In 1984, I did the first orthotopic neobladder at the Cleveland Clinic and believed from the outset that this was a far better option for both men and women than even a well-functioning continent cutaneous diversion. At that time, many new diversions were being introduced, usually named after a person, university, or city, in an attempt to establish a niche. I started experimenting with a reservoir made with absorbable staples in an effort to make reservoir creation easier and faster. It apparently worked so I published a paper on the first 15 cases or so. As time went on, it became clear to me that the results were inconsistent and thus I wrote probably the first, if not the only article, to say the reservoir I previously described was no good. This experience taught me a valuable lesson: sometimes the average results from a group of patients (in this circumstance average capacity of the reservoir) may look reasonable and yet individual patients at the extremes may have an inferior outcome. It reminded me of the story of the man who had one leg in the oven

and the other in the freezer---on average he felt quite comfortable. In retrospect, it is also quite sobering to recognize how inadequate clinical research methodology in urology was at the time. It is remarkable that we reached any appropriate judgments about operative techniques given the sorry state of the design and analysis methods.

In 1983, at age 37 years, I was named Chairman of the Department of Urology at the Cleveland Clinic after Ralph Straffon moved on to be Chief of Surgery. It turned out I was too young and unseasoned to balance both the professional and personal demands and so I stepped down after two years to the great relief of my family. In 1988, we moved to the start-up Cleveland Clinic Florida in Fort Lauderdale as part of the grand new adventure there. By 1991, it was clear that the medical environment in South Florida was different than northeast Ohio (duh!) and I wanted to get back into academic medicine. I took a position as Head of Urologic Oncology at Wayne State University with my good friend Edson Pontes. In 1995, I had an opportunity to return to Ann Arbor in the Section of Urology under the new Head, Joe Oesterling. Like many in our field, I was mesmerized by Joe's enthusiasm, energy and vision. Suddenly in 1997, Oesterling was asked to leave the University because of very public academic and financial violations and I was appointed interim and then permanent Head of the Section of Urology. I was fortunate that we had a great Dean at the UM Medical School then, Allen Lichter, the current CEO of ASCO. Under his guidance, Urology became a Department in 2001. Rapid growth in the Department ensued over the next 13 years under my and David Bloom's tenures and we went from a full-time faculty of 6 to currently more than 30, with a heavy emphasis on subspecialization. In 2007, after a pre-agreed upon 10 years of service, I stepped down to continue my clinical care and clinical research activities and David Bloom took over as Chairman.

## Research

As Chairman, I gained a deep appreciation of the value of translational laboratory research, particularly in oncology, but in other areas as well. Under Ken Pienta's leadership in Medical Oncology, U of M was awarded a Specialized Program of Research Excellence (SPORE) grant from the NCI that has for more than 15 years supported innovative prostate cancer translational research. A particular honor for me was the opportunity to collaborate with Arul Chinnaiyan and his team. In 2007, this group won the first annual Team Science Award from the American Association of Cancer Research for the landmark discoveries of recurrent gene fusions in a majority of prostate cancer cases.

Probably the most valuable contribution I made to Michigan Urology while I was Chairman was the investment in the development of our Health Services Research (HSR) group. In 2000, John Wei had recently joined the faculty with an interest in outcomes research after completing a Robert Wood Johnson (RWJ) Fellowship at U of M. I fortuitously had the opportunity to care for Avedis Donabedian, PhD, of the U of M School of Public Health (SPH), who was viewed by many as the father of quality improvement (QI) methods in health care and the concept of structure, process, and outcomes as the means to evaluate quality of care. After long discussions with him, I became convinced that quality in the delivery of health care was not going to remain just a marketing tool, as it largely was then, but was going to become an extremely important factor in care delivery. At the same time, Dean Lichter encouraged the Department Chairs to read and implement aspects of "Good to Great" by Jim Collins. I thought that with John Wei's leadership, we could follow one of Collins' dictums and potentially develop the best HSR group in the world and be comparable with the outstanding team assembled by Mark Litwin in Urology at UCLA. We obtained a NIDDK T-32 grant to support protected research time in HSR for Residents and Fellows and Caleb Nelson, now at Boston Children's, was the first Fellow. Brent Hollenbeck was hired, we were fortunate to get exceptional trainees, and the program continued to gain momentum. We were particularly fortunate to be imbedded in a University with great expertise in HSR and, over time, collaboration with SPH, the RWJ Program, and the Department of Surgery was established. The current HSR Division in the Department of Urology is the largest and arguably the strongest HSR group in the country, with 9 faculty members including 3 PhDs, 4 analysts, 5 Fellows, and T-32 training grants from the NIDDK and the NCI. David Miller is the current Head of the HSR Division and our group is imbedded in the multidisciplinary Institute for Health Policy and Innovation at U of M.

When David Miller returned to join the faculty at U of M after a fellowship at UCLA, we approached Blue Cross Blue Shield of Michigan (BCBSM) with the concept of a practice-based, rather than hospital-based, urology collaborative that would initially focus on prostate cancer care. The Michigan Urological Surgery Improvement Collaborative (MUSIC) was formed in 2011 and began collecting data in 2012. MUSIC currently has > 12,000 patients in the registry and has

approximately 220 urologists participating from 43 practices in Michigan representing > 90% of all the urologists in the state. The collaborative is based on principles of collegiality, confidentiality, and transparency; a key tenet is that there are "no billboards" using MUSIC data to seek a competitive advantage. BCBSM does not have access to any patient or practice level data and there have been no efforts to identify winners and losers in performance. Each practice knows its own data and how it compares to the rest of the collaborative and uses the rest of the collaborative as a benchmark. The goal is to identify and disseminate best practices so that we can learn from each other.

When I first started at U of M, the focus veered strongly toward translational research. Later, the pendulum swung toward health services research and the emphasis on translational research suffered. Now, there is considerably more balance on both aspects of research in our Department, as I believe it should be. We need to be striving for better treatments. We also need to understand how the US health care system can help or hinder actual delivery of better treatments that may come along. Health care is a financial behemoth in the US. Attempts to alter the status quo are resisted by extraordinarily successful insurance, hospital, pharmaceutical and device, and medical professional industries, to the point that one could despair that meaningful change to the profits of any of these is impossible without wreaking havoc in the US economy.

## Life

I have been deeply affected by many of my cancer patients. I never felt the need, as many medical oncologists express, to remain at arms-length with my patients, even when I knew the ultimate cancer outcome was likely to be poor. Many of the most meaningful interactions have come from patients at times when I and my colleagues could no longer offer them curative treatments. I came to greatly appreciate cancer palliative care and how important it can be for patients and families and how it is often underutilized. I became quite involved with the American Cancer Society (ACS) wherever we lived. Most recently, I was on the Board of Directors of the Great Lakes Division of the ACS for more than 10 years and found the experience remarkably rewarding.

The opportunity to work with Residents and Fellows has been a blessing. I have always thought that the only difference between Residents and the Faculty is age. Good residents are just as smart (if not smarter in this day) than we are, just as motivated to succeed, and truly as compelled to do what is right for patients. With such a philosophy, the interaction between the Residents and Faculty is based on mutual respect and trust. Day to day work can be challenging, fun, and stimulating, in spite of the stress we all endure. I knew it was time to stop my surgical career when my tolerance for rather minor delays in a case became a source of frustration rather than viewed as an opportunity for a teaching moment.

An avocation of mine outside of medicine has been competitive rowing, a sport I have been involved with since I was in the 8$^{th}$ grade. Most of the time I had to train quite early in the morning and travel good distances to a rowing club but the attraction has persisted. I still race competitively and sometimes win, but mostly I relish the sublime beauty of sculling on dead-calm water around sunrise.

The balance between the competing demands of professional and personal life remains a challenge for most of us. I believe that attempts to draw a hard line between professional and personal responsibilities often lead to frustration. For me, it was better to recognize that my family life and my academic life were on a continuum and that, although I needed to recalibrate my time commitments frequently, both facets were part of my passion and personality. A spirit of innovation and curiosity is at the heart of academic medicine and can be a source of energy and enthusiasm that is readily apparent to, and appreciated by, those we love. It is impossible to plan a career trajectory. Opportunities and life events come and go but in my experience, the most rewarding challenges could never have been predicted even a few years earlier.

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