LEGENDS IN UROLOGY

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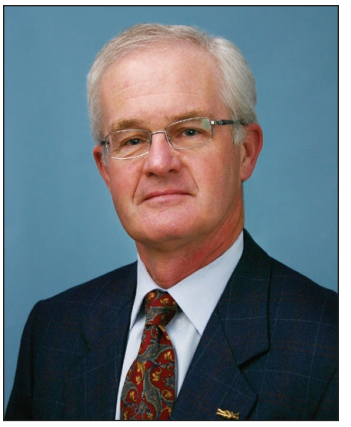

"I've had a great career and loved what I have done but with all the changes in health care and the way medicine is heading, I can't see that a career in medicine will be as rewarding in the future".

These were my father's words to me in the early 70's when, after 7 years of post-secondary education, heading to a career as a research chemist, I realized that I was not cut out to be a lab based professional and should seek an alternative career. My father was an old school physician-surgeon who practiced where he grew up in Port Colborne, a small Ontario industrial town. He graduated from medical school in 1942 with the intention of a surgical residency, but duty to his country got in the way and by the time he was demobilized, he was married and my older brother was in the picture. A surgical residency for a married man with a child was not realistic in the 1940's, so he hung out his shingle in his home town. Fortunately for him, there was a trained surgeon there, who took him under his wing and he was able to learn the craft and practice of a broad range of surgery. I had the opportunity to scrub in with him and recognized that he had "good hands", but more importantly he knew his limits. However he recognized the implementation of specialist credentialing and knew the end was nigh for general physician-surgeons like him. He struggled to keep up with the innumerable developments in the broad range of medicine and surgery he practiced, as he believed it was a professional obligation to remain current in all domains of his patients' problems. He lived through the controversial introduction of Medicare in Canada and was initially skeptical about government managed health care, primarily because of concerns related to the altered relationship between physician and patient. However he ultimately saw the advantages of a universal insurance plan, not the least of which, was that he got reimbursed for every service rendered. He no longer had to accept chickens, potatoes and cabbage rolls in lieu of payment to settle accounts.

I came along a few years after his return to civilian life and eventually there were four more children so our home was lively and loving. When it came time to choose a university program, I did not consider medicine. I enjoyed the certainties of the physical sciences and did an undergraduate degree, a MSc degree and started a PhD in inorganic chemistry before realizing this was not what I was going to be happy doing for the long haul. I missed the personal interactions. So despite my father's advice, I applied and was admitted to medical school at Queen's University. By current medical education standards, the curriculum would be regarded as pedagogically substandard being lecture dominated. However I had the benefit of a remarkable faculty of dedicated physicians and surgeons as exemplary role models in their clinical and academic practice. I was unsure of which specialty to choose on completion of the MD degree and initially spent my first post-graduate year doing an internship in Internal Medicine. A wise community based general surgeon I met during a medical student elective advised me to look at Urology. When one of the general internists also recommended Urology I did some further investigation and met with Said Awad who sold me. My father did not think much of Urology as a surgical specialty since he had quite a negative opinion towards endoscopic surgery. He thought that true surgeons made big incisions. Nevertheless, once again I did not heed his advice and entered the Urology program at Queen's. I was incredibly fortunate that the Department of Urology at Queen's in the late 70's had three giants of 20th century Urology on faculty – Andrew Bruce, Said Awad and Alvaro Morales. Residency was hard work with long hours, with significant personal disruptions along the way. However, with mentors such as these three, who were never satisfied with the status quo, I knew that I was going to be well prepared for a successful career. They were

always on the lookout for better management options for patient problems and knew how to go about assessing the options scientifically and appropriately. They maintained exceptionally high standards for patient care and would not accept anything that was less than best effort from the residents and themselves. Although each had very different ways of expressing their expectations, there was no excuse for failure. I was also fortunate to have terrific resident colleagues including Ian Davis who has remained a good friend.

Part way through residency, Said Awad took me aside and recommended I look at a fellowship in stone disease to take advantage of my chemistry background and consider a career in academic urology. Following a year at the Mayo Clinic in Lynwood Smith's lab doing urolithiasis research, where I met and became good friends with Denis Hosking, I was recruited back to Queen's by Al Morales. By that time Said Awad had been recruited to head up Urology at Dalhousie University in Halifax and Andrew Bruce was head in Toronto. Back at Queen's, I attempted to establish a basic science research program in renal stone disease and did obtain peer reviewed funding for a few years, but for a number of reasons the lab program was not sustainable. I was fully prepared to leave the academic life but with sage advice from Al Morales, I re-focused on medical education and administration role. Having Curtis Nickel as a colleague and friend join the department, Queen's Urology continued to build on its reputation as a productive academic program, initially established by Andrew Bruce and subsequently nurtured and developed by Al Morales.

During this time I was mentored by Duncan Sinclair who was Dean of the medical school as well as Bob Maudsley, the father of competency based medical education in Canada. I was appointed initially to a committee reviewing the faculty practice plan, then I got involved with the clinical teachers association and was a part of the negotiating team which established the first comprehensive faculty wide alternative funding plan in Canada. Subsequently, I was appointed Postgraduate Dean and got involved, and continue to be involved in the Royal College educational activities including examinations, credentials and accreditation. I served three terms as department head. The usual two term limit was extended since Curtis Nickel, the obvious successor, threatened to leave Kingston if he was required to be department head. During my tenure I recruited seven highly productive and collegial faculty, Rob Siemens, Darren Beiko, Steve Steele, Jun Kawakami (now in Calgary), Mike Leveridge, Naji Touma and Jason Izard. Now led by Rob Siemens, Urology continues to be the most academically productive clinical department at Queen's and a respected unit in Canadian Urology. One of the highlights of these years was being elected President of the Canadian Urological Association in 2002 and presiding over the meeting in St. John's Newfoundland which is remembered as one of the best attended and most enjoyable meetings in CUA history. The team in St. John's, Doug and Zoe Drover, Richard and Charlean Hewitt and Gavin Duffy, with little direct support from the association, went well beyond expectations to ensure a successful meeting. I also served as President of the Northeastern Section of the AUA and presided over the meeting in New Mexico which was a distinct honor. Since stepping down as department head I have been elected member of the Royal College council and chair the Education Committee. I have also become involved as a Medical Advisor for the College of Physicians and Surgeons of Ontario which has provided new challenges and opportunities since retiring from active surgical practice in 2013.

Through the 30 years I was in active clinical practice I was busy. Although focused on stone disease and rehab urology I also provided a general urological consultation service to Prince Edward County – a pastoral community about an hour's drive west of Kingston. For 30 years, twice a month I would head down the road to the hospital in Picton. I always thought that I was able to provide better consultations there since I knew the family physicians well. They would drop by the clinic to talk, ask questions and provide the additional details about patients that can make practice in smaller communities so rewarding. When I finally retired from this aspect of practice, these family physicians honored me by donating a rank of pipes to the organ that I enjoyed playing at the church we attend.

My career was enhanced by terrific colleagues and a superb group of residents who now practice throughout Canada from Newfoundland to British Columbia as well several who practice in the United States. They were and are a remarkable group of individuals and I was particularly touched when many of them came back to Kingston in October 2014 for a surprise "festschrift" celebration for me. Being involved with residency education has been very fulfilling – the daily challenges, the quest to stay ahead of their inquisitive minds certainly stimulated my own ongoing learning. The only problem with being involved in medical education is that the students and residents as a group remain the same age, whereas I have become progressively older.

Change – my father warned me about change and indeed there have been significant changes over my career but what a spectacular time to be a urologist. The last 30 years have been a most exciting time in the history of our

specialty. When I think back to what I learned as a resident and what I am doing at the end of my career, change is an inadequate term to describe what has happened. We all know that technological advances – ureteroscopy and percutaneous surgery, laparoscopy and lasers, ultrasonic and shockwave lithotripsy – have changed how we care for patients. However the advances in imaging means that there are many fewer surprises when doing any surgery. No longer are there "exploratory" operations. Our rigid surveillance cystoscopies that required a hospital stay are now done with flexible scopes with much better visualization. We used to consider a middle third open ureterolithotomy as a junior resident case. We have a urological pharmacopeia to treat patients' problems when in years past there were few prescriptions to write. Similarly, we have seen change in medical education. The undergraduate curriculum used to be dominated by lectures; now, small group interactive teaching is the norm and there is earlier and more intensive clinical involvement. We are currently in the process of transitioning to competency based residency education programs, perhaps the most significant change in postgraduate medical education in the last 100 years. We can certainly improve our residency education processes and it is an exciting time to be involved in medical education.

I have also witnessed the less desirable changes – the ever increasing patient expectations in the face of insufficient resources to meet all patient needs, let alone patient demands; the rise of the concept of wait time as a means of rationing medical services; the increasing super-specialization and the ongoing challenges for generalists like me who are being marginalized. Our increasing dependency on technology means that a fully active urological practice requires a continual capital investment to stay current which is beyond the means of many smaller hospitals. I see the demise of smaller community general urologists and the rise of alternative care providers for patients presenting with urological problems. Urologic oncology used to be the heart of a general urology practice with a significant fraction of surgery being cancer related. Major GU oncology, is best managed by multidisciplinary teams, which inevitably means consolidation of services to larger centers. With the loss of much pediatric surgery as well, there is not much left for the general urologist beyond benign prostatic surgery (which also seems to be in jeopardy), non-invasive bladder tumors, ureteral stones and scrotal procedures. Do we really need 5 years to prepare a resident for such a limited practice? I would suggest that the answer is no. There certainly is demand for urological expertise with the increasing deferral and referral of minor urological problems to urologists by insecure primary care physicians. It will be an interesting process as we define the competencies required for the general urologist of the future supplemented by optional additional training for those entering a focused area of practice.

Through it all I have been supported by my wife Jean who has indulged my work habits – the voluntary as well as the obligatory. She kept the home fires burning, mothered our two children and managed domestic crises. I would not have been able to do what I have done without her support and recognize and acknowledge that we have been and continue to be a team.

So indeed as my father warned me, there has been change and certainly my experience has been quite different compared to his. When my own son came to me asking about a career in medicine after 7 years of post-secondary education (and a "gap year" in Hawaii!), one of the justifications he offered was that he had observed that I had clearly enjoyed my career and he thought that he too would find a career in medicine rewarding. I recalled my father's words to me 35 years previously; however I did not discourage my son from applying. I warned him about the changes that he could anticipate – and not all of them would be for the better – but I also advised him that the most rewarding aspect of clinical practice are the patients who present with problems that we can diagnose commonly, cure infrequently in this era of chronic disease management but care for always.

It has always struck me that it is appropriate that the term for the ability to practice medicine in a hospital is "privilege" as indeed it has been a privilege to practice medicine and specifically urology. I thank my family, my mentors, my colleagues and especially my patients for the privilege of being able to work in such a rewarding discipline.

It has also been a privilege to be asked to submit to the "Legends in Urology" series and thanks to Lena Georgieff for her ongoing support for the series and her commitment to *The Canadian Journal of Urology.*

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