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# LEGENDS IN UROLOGY

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When I first received the invitation from *The Canadian Journal of Urology* to contribute an editorial to their 'Legends in Urology' section, my mind initially raced to consider about whom I might write. As I read on, I realized that I was being asked to write about myself and, while extremely proud, I was equally terrified. I looked up 'legend' in The Collins English Dictionary and discovered that it describes "*a person whose fame or notoriety makes him a source of exaggerated or romanticized tales or exploits*". This made me feel less intimidated!

The stated intent was to have the honoree describe accomplishments and contributions of which he or she is particularly proud and which might best serve to inspire future generations of young urologists. I take this wording literally and so, rather than chronicle my career and successes, as might be found in my CV, I would like to present a series of events on which others may reflect and perhaps from which they could learn.

Mine is indeed a very simple tale to tell with my personal success as much a result of opportunism, and the support of mentors, as the chasing of a dream.

### **It doesn't matter where you came from or where you trained.**

I grew up and was schooled in what was then Rhodesia, receiving a classical British style education. I had never personally committed to a career in medicine although my mother constantly told me that was my future. Acceptance of this came in 12<sup>th</sup> Grade when, on the first day of class, the Chemistry teacher went around the classroom asking our future plans. It came to the Ws and all I could think to say was 'medicine Sir'. The die was cast!

In the British system one entered medical school from high school for a 6 year curriculum. I had the opportunity to attend medical school in South Africa and England but elected to be one of the first intake class at the new Godfrey Huggins School of Medicine in Rhodesia, a college of the University of Birmingham in England and with which degree I graduated with honors in 1968. Internship and surgical residency followed at that teaching hospital through 1973 when a move to Britain was necessary to accomplish the FRCS.

### **Take advantage of good fortune and establish mentors.**

My good fortune started here. I was appointed as a resident at the Institute of Urology in London aided by the late Prof J. P. Blandy whom I had met on a visit he made to Rhodesia in 1971. I had the opportunity to escort him on rounds through the hospital filled with third world medical problems and have him join me in the operating room. I took the opportunity to tell him of my interest in training in urology at the Institute! Some years later I learned from Richard Turner-Warwick (RTW) that although I was appointed I was the 'compromise candidate'. Who cares, I had my foot in the door! I worked with men who were at the time the giants in the field of Urology, Prof John Blandy, Richard Turner-Warwick, Geoff Chisholm, Howard Hanley, Peter Riddle, J. D. Ferguson and John Wickham. I learned voraciously and acquitted myself well, I believe. The Institute was a British invention to focus the best minds in a particular field under one roof (really four separate small hospitals in Covent Garden in London) where they could practice sub-specialty Urology surrounded by sub-specialty pathologists, radiologists and other services. At the time this was a unique concept that had not yet traveled to the USA. It was after 2 years and with little chance of progress in what was then a stagnant British healthcare system (particularly for one from 'the colonies'), that RTW suggested: 'Go to America boy'. This he organized in a single phone call with Dr. James F. Glenn of Duke University, during a stricture clinic!

I left for America with a unique skill-set of a urology experience taught by the best, an extensive general surgery training and few other aspirations than to enjoy urology, my life and my family.

### **Match your personality and skill-set to your chosen specialty**

It was while at the Institute that I developed my enthusiasm for reconstructive urology, female urology and urodynamics. To a large degree this was a result of my recognition that I did not have the personality to deal with an oncology practice. In that era, cancer surgery was somewhat crude and cure was uncommon. By comparison, reconstructive surgery seemed elegant, particularly as demonstrated by RTW, and it favored the artistic skill-set I felt that I possessed. I was excited by the challenge of 'building' something or 'fixing it'. RTW worked with a simplistic surgical philosophy that he called TITBAPIT or 'take it to bits and put it together'. Whenever asked, before a complex case, what the plan might be, this would usually be his answer. I have used this same approach throughout my career, as my trainees all well know. It seems so logical.

### **Letting setbacks become opportunities**

The year as a Fellow with Jim Glenn was a foundation for my future. I was able to bring to him a functional and reconstructive approach to Urology uncommon in the USA at that time and certainly at Duke, and in the process I established a strong mentor and supporter. That year the program lost a resident to illness and so my fellowship became more residency-oriented. As unhappy as I was at the time it became an important key to facilitate my later return to the USA for I became fully incorporated in the, quite different, American system of health care delivery, and it taught me some humility.

I was in the USA on a limited visa and so at the end of the year I had to leave. These were difficult times, having a young family and having moved countries twice already, but like military personnel, one must do it with a smile. My options were to go to Holland or to Scotland but I elected to return to what was then a very troubled Rhodesia. It turned out to be an excellent decision, for over a 2 year period I honed surgical techniques and did a tremendous amount of good work in the teaching hospital. Urethroplasties of all kinds abounded. Bilharzia required upper tract and bladder reconstruction and endemic squamous cell bladder cancer required cystectomy and non appliance diversions. So many of the techniques upon which I built my surgical career had their beginnings here.

### **Developing an academic career means taking direction from mentors and seizing opportunities and challenges that present**

Dr. Glenn invited me back to join the Duke faculty in 1977 and, of course, I accepted. He was a giant in urology, and he was an insightful and very forthright man. He was an excellent mentor, guiding me to areas that were my strengths and helping set my goals. He recognized the dearth of activity in the areas that were my interest and expertise and he helped me formulate these into packages and he put me on the road to speak on them. Tongue in cheek, he once told me that I could become well known in our local area - if I persevered. This became my challenge!

In 1982 he became Dean at Emory in Atlanta and David Paulson succeeded him as Chief of Urology. He became a strong supporter and a good friend and advocate. Very early on he appreciated the rapid diversification within urology and he embraced the idea of subspecialized practice as we had at The Institute in London. I believe we were the first to do this in the USA and it presented each faculty with an opportunity to develop within its field without partner competition. I developed The Section of Reconstructive Urology, Female Urology and Urodynamics and defined our area of expertise and started my own Fellowship in 1982. Dave Paulson supported and promoted this concept at every opportunity.

One of my earliest endeavors was to duplicate at Duke the unique clinical video-urodynamic lab RTW had established in London. Urodynamics was a fledgling science in the early 1980s and so it gave me a somewhat uncontested niche in which to start my academic career. It became the cornerstone for many of my earlier pursuits such as the development of strategies for management of neurogenic bladder particularly in children with spinal dysraphism, and the development of bladder reconstructive techniques. Indeed it remains the underpinning of reconstructive and female urology, stressing to us that function and not just form are important.

### **A chronology of my practice and academic achievements: changing times present new opportunities**

As I read through my bibliography of some 250 publications and view my podium presentations over the past 35 years, I realize how much our field evolved and how my focus and direction changed constantly as new clinical challenges emerged. I believe the lesson to the young urologist must be to expect rapid change and to be prepared to adapt to and grow with it, a process that requires constant re-education. The era when a good residency would be preparation for one's entire future is past!

What started out as loosely knit and somewhat related reconstructive pursuits became codified separately into female urology by SUFU (The Society for Female Urology and Urodynamics) and by the GURS (The Genitourinary Reconstructive Society), and I am proud to have been a part of this process and an office bearer in each group. Indeed each Society now oversees formal fellowships, the former with new board certification and the latter with a new matching fellowship program.

Review of one's bibliography is a good way to recall one's changing interests and accomplishments and I must say this was an enjoyable journey through the past for me.

I had brought an interest in pelvic fracture urethral injury with me from Rhodesia where the problem had been seemingly endemic. While there I had performed many delayed primary repairs through the perineum that were very successful. Indeed this approach serendipitously led me to develop the progressive perineal repair for pelvic fracture urethral distraction defects when operated on months after injury. One of my early manuscripts in this area was in 1983 and examined the current management of these injuries and offered our new rational approach. This became one of the most cited manuscripts in the field. Over the next two decades I followed with many publications regarding the further development of this procedure and its outcomes.

In the 1980s I was the urologist to the Duke Myelodysplasia Clinic serving some 200 children. This was fertile ground for neurogenic bladder investigation and management. I developed and published on urodynamic hostility scores to predict upper tract damage and need for change in management. These many bad bladders ushered in the era of bladder reconstruction using enterocystoplasty leading to many publications debating indications, techniques and outcomes. In tandem with this group were the many undiversions using similar surgeries. This truly was the golden era for innovative bowel use in urology. At the same time continent urinary diversion was also just being introduced as a more desirable alternative to appliance dependent urostomies. Once again, many years of debate and publications about bowel selection, to detubularize or not, to create anti reflux mechanisms or not and how to construct the continent stoma, ensued.

Perhaps my most fertile area of clinical practice over the past 30 years has been the management of male incontinence primarily using the artificial urinary sphincter. My first publication on its use was in 1984 and there followed some 30 or more over the next three decades on various aspects on its use. In the 1990s I developed the transcervical approach to its implantation which completely changed the device's usability in complex cases. Running parallel with the artificial urinary sphincter practice was the management of the devastated bladder outlet in men who had undergone surgical or radiation treatment for prostate cancer. We developed techniques and strategies for managing the recurrent obstruction or the obliteration. This continues to be a hotly debated topic still today.

Having trained with Turner Warwick the management of urethral stricture was one of my favorite pursuits. For three decades I performed urethroplasties, constantly tweaking the techniques as outcomes dictated, and debating and publishing data. Like all of the other areas of reconstruction this was one where communication between surgeons led to constant variations in technique. A particularly rewarding association was with Dr. Guido Barbagli of Florence, Italy who developed the dorsal onlay graft approach.

Female urology started to become a significant component off our reconstruction practice around 1990 and it increased exponentially by year 2000. The management of women with incontinence was in constant flux with techniques having short half-lives. Competing philosophies and techniques made it an exciting field, filled with lively debate and opinion. I introduced the pubo vaginal sling technique using cadaveric fascia lata which in some form is still used today. I had a strong interest in the management of the patient with a bad outcome from incontinence surgery and established a practice of salvage for this group and presented and published extensively on their management. Together with the incontinence practice the 1990s saw an increased involvement by urologists in vaginal prolapse repair and other reconstructions. I developed a technique for vaginal repair for this vesicovaginal fistula by vaginal cuff excision which was published and presented extensively.

Around year 2000 I established a collaborative practice with Duke Urogynecology, and specifically with Dr. Cindy Amundsen. This was a unique endeavor in the field. It seemed better not to have turf battles over the practice but rather to share our different expertise to the patients' advantage. It was remarkably successful and it also significantly enhanced the education of our fellows and residents. This is now a codified collaborative approach with the introduction of the combined Urology/Urogynecology fellowship program 'Female Pelvic Medicine and Reconstructive Surgery' (FPMRS).

In the decade following the year 2000 we identified new initiatives including an entry into the use of neuromodulation and Botox for bladder overactivity, and an exciting collaboration with biomedical engineers using electrical stimulation in the treatment of neurogenic bladder. Collaboration with psychiatry using nocturnal cystometry and polysomnography led to new philosophies regarding nocturia.

### **Developing a legacy**

I trained 32 fellows in consecutive years starting in 1982. They were the backbone of my practice, both clinical and academic, and all became and remain good personal friends. They brought the enthusiasm that led to the diverse pursuits that I have presented above. They have all gone on to very successful careers in the same field and many now have fellowships of their own to continue the legacy that really started with Richard Turner Warwick. Without their efforts and support my success would never have occurred.

### **Don't seek out honors. Let them find you**

I have never sought honors nor lectureships and always felt undeserving when I received one. Nonetheless I am extremely grateful for the recognition. Once again these honors are generally the work of a mentor or colleague with whom one has a good relationship, and I can read such a person into each of mine. I list my important honors below not for self-aggrandizement but for completion.

In 1996 I was inducted into the prestigious Association of Genitourinary Surgeons and in 2003 the British Association of Urologic Surgeons awarded me the St. Paul's Medal. The latter honors international contributions to urology. The Society for Urodynamics and Female Urology honored me in 2003 with the Zimskin Award and again in 2006 with their Lifetime Achievement award. In 2011 the American Urological Association awarded me the Politano Award, a lifetime achievement award for the field of which I now write.

### **Personal aphorisms**

There are some personal attributes that lead to success in the medical and academic workplace. Some of these I do possess and some I work to achieve. However each I try to teach and it is without embarrassment that I lay some of these out primarily for the young urologist to whom I was informed this personal statement is directed.

- Always be congenial (my mother told me always to smile).
- Make all who come into contact with you pleased that they did.
- Always credit others for their contributions and their support of you.
- Remember that being a doctor is about people and not about money.
- Remember that your patient is afraid, so be a good listener and be compassionate and learn to explain well.
- Be a perfectionist in everything that you do, but particularly in surgery.
- In surgery when something you've done does not look good, the comment "it will be okay" usually means you should redo it.
- Accept that you are the captain of the ship when you deliver healthcare.
- Take ownership even when you delegate.
- Remember your trainees are there to learn, not to be used or abused.
- Know everybody's name, particularly in the operating room and clinic. I never called anyone 'nurse' in my own workplace.
- Remember that bluster may get you your way but at a price.
- Learn to be collaborative with other services and not critical or territorial.
- Recognize the rights and feelings of other personnel particularly in the OR.
- "Slowly, slowly catch the monkey" (my fellows and residents know what this means).

### **Final thoughts**

I feel most fortunate to be able to say that I did achieved all of my professional life's goals, and to a large degree Duke University facilitated this. This made it easier for me to walk away from practice as I now have, leaving it to my many worthy followers. What I now know is that an exacting and strenuous career pre-empts so many of life's other pursuits and I now find myself able to extract great joy from these 'other' pursuits. As I look back on my career I realize that the most important rewards were always those where I touched the lives of others - be they patients, staff or trainees, and this I hope is a goal to which all physicians aspire.

Thank you for this opportunity to present these personal thoughts.

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