# EDITORIAL

# Go gentle into that good night

*Martin A. Koyle, MD, MSc, FAAP, FACS, FRCSC, FRCS (Eng.)*

*Department of Surgery & Institute of Health Policy Management & Evaluation, University of Toronto, Toronto, ON, Canada; CUAJ Associate Editor*

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It is rare for an elite athlete's career to span decades. We have been amazed with the longevity of Satchel Page and Gordie Howe, and certainly with the comeback of Mohammed Ali in a sport such as boxing. Even golfers demonstrate declining skills with the progress of time. How do we judge ourselves and our abilities in high-risk careers like surgery, and make the personal decision when it is time to step away? I must admit I thought I would "…not go gentle into that good night" when the time to decide approached, but COVID-19 has been the final disrupter that has tipped the balance towards my leaving full-time practice.

I have reached the stage where I realize I have been fortunate to have enjoyed an almost four-decade-long career in academic surgery. During that period, I have had the opportunity to increasingly be stimulated, learn new techniques, interact with amazing colleagues, and gain new friends. I leave with what I hope is a legacy with respect to the outcomes in most of the patients I have treated, and that I have had a positive impact and influence on the medical students, residents, and fellows with whom I interacted during that time. Yes, there have been down times and bad outcomes, but at the end of the day, the fruits of my endeavors have outweighed most (but not all) negatives. Admittedly, I am haunted by errors of judgment I have made along the way, and the unintended consequences of surgeries that were incurred by patients and families.

In my era of medical education, I doubt if anybody entering medical school made an early decision to become a urologist. In fact, in 1976, the only match for surgical residencies was for general surgery, with most systems being based on a pyramidal track — after a few years as junior residents at the base of the pyramid, only a select group were offered positions to advance in general surgery through chief residency. The remaining residents, some of whom may have found a surgical subspecialty by then, had to scramble for slots in subspecialties like urology, or use the two-year core training as their base to be accepted into a non-surgical specialty.

I, for one, did not know what a urologist was while I was a medical student, and only gained true knowledge of our specialty following three years of surgical training, when I took time off to work as a full-time emergency room doctor. I feel I was fortunate in that I was able to have broad experience and training and to make a career decision with my eyes wide open. In a way, I feel sorry for today's medical students; by their second year of medical school, they must start thinking about how to find a mentor in order to write some pivotal papers and structure electives in "left great toe surgery" at the most elite programs, to ultimately match in that specialty in the spring of their fourth year. So, the competition of being accepted to university and then medical school is only accentuated by this process. What happens if somehow, later in medical school, they serendipitously are exposed to "right great toe surgery" and are enamored with it, or worse, after they have commenced their "left great toe" residency, they find it was the wrong choice? They are sunk compared to the path I had taken.

I had broad experience when I finished medical school, at a time when new knowledge was doubling every seven years. It is daunting that the doubling time of medical knowledge today is now less than seven months. When I finished my urology residency in 1984, 28% of the cases I had performed as a chief resident were open stone surgeries. I had performed close to 300 transurethral resections of the prostate yet only sweated through eight radical prostatectomies, all post-radiation. Not what this guy wanted to do for sure! The digital rectal exam and acid phosphatase were the guides to prostate cancer management. After commencing a practice limited to pediatric urology and transplantation, within five years I had become a dinosaur in general urology, as the nerve-sparing radical prostatectomy, the advent of prostate-specific antigen, and extracorporeal shockwave lithotripsy and endourology had replaced the techniques and strategies I had been schooled in. Further disruptive innovations have led to increasing numbers of open surgeries being replaced by minimally invasive techniques — first

laparoscopic and now robotic. The intravenous pyelogram, which was our cornerstone radiologic tool, has become a historical note, as ultrasound, computed tomography, and magnetic resonance imaging have become standards in everyday practice.

Today, with expanding knowledge in the various subsets within urology, subspecialty expertise and fellowship training have become the norm. Pediatric urology was the first subspecialty to be awarded a Certificate of Added Qualification (CAQ) by the American Board of Urology in 2007. The Royal College in Canada has awarded an Area of Focused Competency (AFC) in Pediatric Urology just this past year. I am proud that the SickKids fellowship has become the first Canadian center to be accredited by the Royal College for AFC training, and as such, Canadian and American fellowship trainees who are chosen to train in Toronto will be eligible for both the CAQ and AFC. Without a doubt, other urological subspecialties will follow this lead.

I have had the opportunity to observe and participate in medical training and practice in the U.S., Canada, and Great Britain, as well as around the globe to a lesser extent. It has allowed me to gain a unique perspective in comparing systems. My own character makeup has been to challenge dogma and always ask why or is there a better way. My 10 years in Toronto, with the support of my colleagues, has allowed me to channel this energy towards quality improvement, patient safety, and learning health systems at the Institute of Health Policy, Management, and Evaluation at the University of Toronto, where I hold an academic position.

I was honored, as an "older student," to be accepted into the International Masters in Healthcare Leadership at McGill's Desautel School of Management, where I was selected to receive the Michael Decter Scholarship in Health Policy. My participation in the McGill program, combined with the COVID pandemic, has led me to take a few moments each day to reflect on the previous day or some impactful memory from the past. I suppose that this new norm for me has become my form of meditation. Even though I feel that a surgeon should not operate forever, and that there is no magical age where one can, with certainty, assess when the scalpel be tempered, I feel that it is now my time to enjoy the next chapter of my life, knowing I still have the desire to contribute — and I believe most of my synapses remain in sync. I think we "oldsters" still have a lot to offer as mentors and coaches to the "youngsters."

I am thankful for the opportunity to have contributed to *CUAJ* as an associate editor over the last decade. In particular, Laurie (Klotz) deserves continued kudos for getting the journal rolling, and Rob Siemens and Adriana Modica have enhanced the quality of the journal during Rob's tenure as editor. Mike Leveridge, along with Adriana, have the vision to continue to take *CUAJ* to that next level.

It is with regrets that COVID-19 prevents my saying goodbye in person to those of you in Canadian urology who have impacted me so greatly, as I go gentle into that good night. May we all remain healthy and see one another again soon.

**Correspondence:** Dr. Martin A. Koyle, Department of Surgery & Institute of Health Policy Management & Evaluation, University of Toronto, Toronto, ON, Canada; Marty.koyle@gmail.com