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Washing down a couple of ballpark franks means a trip to the gents after the home half of the sixth inning. Bladder bursting, I find myself at the wall of urinals with 31 fellow Jays fans (and one burly Minnesotan with a well-worn Kirby Puckett jersey). Easy enough, 700cc's on deck, but then the familiar feeling. *There's not a chance on this earth I'm peeing here.* A shuffle of the feet, eyes dead ahead, a centering breath, some imagined pelvic floor relaxation. Nothing. A flush nearby means go time, valsalva time! All this produces is a tiny, sour bleat and inguinal canals straining like Dizzy Gillespie's cheeks. The Ballad of the Shy Bladder is sung again as the crowd attenuates and the dam finally bursts.

This is a glib paruresis anecdote, but it is the thin edge of the wedge of a glaring care gap in the urology clinic. The impact of cognition, mood, anxiety, and mental health in the etiology and treatment of our patients' problems is enormous, and the median urologist is, at best, marginally trained to stickhandle these issues.

Anxiety and adjustment disorders are woven into oncology; we are trained to break bad news and to empathize with time, tone, and tissues. Social workers stand ready in cancer centers. Multidisciplinary pain clinics have long brought psychologists into the public system; sure, we recognize the impact of coping and catastrophizing, but we rely on expert colleagues to help tackle that part. In these cases, the issue may become that the *expected* psychological reactions to cancer and pain reach escape velocity and wreak havoc.

Where we are lacking is most conspicuous when disordered thinking may be *etiologic*, as so often in patients with voiding or sexual dysfunction. A social life addled by the prospect of incontinence. Elaborate rituals and mantras to find the peace to empty one's bladder. An urge and ache to void that never abates. A 40-year-old athlete in knots about erections that simply stopped working. Urine normal. Anatomy normal. Cystoscopy normal. It's here we see our patients ensnared in cognitive short-circuits, an answer to the diagnostic puzzle resolving. We've written about it and even named it. "Uropsychiatry" first showed up in 1964, and dozens of low-fidelity expositions on "neuroses" and "psychosomatics" followed, but these buds never bloomed into a therapeutic field.<sup>1</sup> We know of the Hinman "non-neurogenic neurogenic bladder" in kids,<sup>2</sup> but when we reach back into our clinical toolkit, we find only a crude glossary of terms and a list of care providers, who are not us, best suited to help. And so, we deploy the tools we have. Manage your fluids and triggers, a  $\beta 3$  or PDE-5i, hoping to start a positive cascade or exploit a placebo effect, rooting in earnest and feeling impotent ourselves. Sometimes we shrug and dig up a card or number for a colleague psychologist, social worker, or physiotherapist outside of the public system.

We silo our specialties in medicine as a means of categorizing disorders and to provide some order in how to train ourselves to manage them. Diseases, though, don't care about our taxonomies as they smatter themselves about our bodies and minds. This leaves urologists as gatekeepers for vexing pain, voiding and sexual issues that have often *already* eluded our toolkits before we've laid eyes. Patients have taken their concerns to their primary care team, and when referred to us, have every reason to believe we are the experts in their issue; however pridefully we cling (or fall back?) to our status as surgeons of the genital and urinary tract, we are also the medical doctors for the same (remember your personal letter and interviews? ;). You may think this is not a problem, or at least not *our* problem, but that's a shortcut to unburdening ourselves of the care of our patients. If you believe undermanagement of the cognitive and psychological aspects of urologic disease is a real issue, how might we tackle it?

I'm not about to suggest a year of psychiatry training woven into urology residency. Stay cool. Here are some practical and some pie-in-the-sky ideas. You may have your own and should spread the word.

- Level up your current counselling skill set. At the very least, compile a local contacts list for available psychological services. Better yet, include psychologists and other experts in your CME calendar. Seek out how to ease patients into the idea that their mind is a conspirator in their problem. This can dramatically decrease the activation energy of steering patients to their best chances of help. Training programs, seek out these experts for your half-day.
- Look to your colleagues who have built these skills already. Every "I can't help you [there's nothing a drug or operation will fix]" is a reminder of the gap, and an opportunity to do a bit better.
- Advocate for (and participate in) multidisciplinary clinics. Learn from the closest pain clinic, and work to get psychologists and social workers into the fold for zero added patient dollars. Proximity and access will collapse barriers to care.
- Bake psychological skills development into andrology fellowships. Surgical management of ED is highly specialized (and hardly the only aspect of the subspecialty), but why not a 360° approach to comprehensive care of the ED patient? Our andrology colleagues are perhaps best situated for the multidisciplinary clinics noted above.
- Build urologic care into psychiatry and clinical psychology training. There is an entire untapped space for clinical and academic leadership in treating these issues. From co-management of the mood and anxiety disorders that so commonly involve urinary and sexual effects to deploying the skills of counselling and cognitive behavioral therapy, there is *already a specialty* that is expert in this, but the practitioners and patients remain largely ships in the night.
- Develop a primary care niche in urologic health or men's health (more to come in this space some months hence). Our family medicine colleagues also have an established psychotherapy armamentarium. A post-CCFP year of training that includes comprehensive management of GU disorders seems another under-surveyed area of highly valuable terrain.

Step one is recognizing that patients are piling into our clinics with hopes and expectations of our expertise that we are underprepared to meet. As keepers of GU health, it feels right and important to bridge this gulf. Let's assemble some skills and teammates and get to work on step two.

## References

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