"THE WORDS MAY CHANGE, BUT THE TUNE STAYS THE SAME"

2010 Presidential Address
RSM Section of Urology

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The RSM Sections' Office insisted I provided a title for this address when I still hadn't decided precisely what I wanted to say, so I came up with a title which struck me as being vague enough to encompass pretty much anything that I may say. I hope, by the end that I will have proved this thesis to be correct.

Rest assured, however, that this presentation will follow traditional lines for such talks. To paraphrase Gauguin "where do I come from?", "what am I?" and "where am I?"

So, to start at the beginning, I was born - as Gerard Hoffnung once said - at a very early age and have been growing uglier ever since. My paternal grandfather was a warehouseman packing carpets; my maternal grandfather read gas meters.

My parents met at the age of seven when my father was a Cub and my mother a Brownie. They grew up together performing in Church socials where Pa played the violin and my mother the accordion. My father later confessed to me that he had always wanted to be a doctor, but he was one of three children and my grandfather never earned enough to put him through medical school. So, having matriculated at eighteen, he found himself a clerk in an Insurance Company and then the war happened. He was invalided out, having been wounded in the push to Arnhem, and he subsequently returned to the Insurance Company and rose to Managing Director for the United Kingdom. He died in April 2010, aged 89.

Going through his photo album, my wife Vicky thought these might amuse you. At the age of nine I went down with a PUO – eventually diagnosed as glandular fever - characterised, once the temperature had settled, by prolonged and heavy nosebleeds. After a couple of weeks, I found myself in Great Ormond Street for investigation of what I later found out was thought to be leukaemia.

There I met nurses. You will remember the uniform in those days – starched aprons and black woollen stockings - and I fell in love. At this point, I vowed to become a doctor and the only time I deviated from that aim was for a couple of weeks when I was in the CCF and thought I might go into the army. Given my short stature, I am glad I didn't.

The year after I took O levels was the final year that the London Medical Schools had independent entry, so I filled in twelve application forms and got twelve rejections. I went to get advice from my headmaster as to what other medical schools I should apply

to. He suggested that, as I had been in the fast stream and taken O levels a year early, I should put in for Oxbridge. No one in our family had ever been to university and that was something that hadn't entered my head. "Do you think I have a chance?" I asked. "Well, Philp, stranger things have happened", was his reply.

Cambridge was a real revelation because I discovered most other students were just as boring as I was. It was also full of real talent and more than its fair share of eccentricity. Who, for example, could forget physiology "so-called" supervisions with Giles Brindley playing his home-made electronic bassoon. In the 60's, of course, one applied to Oxbridge during a third year in the sixth form, and I was accepted in the January and, as a result, had six months or so to kill. So, I got myself a job as an *aide infirmier* in the Hôpital Cantonal in Geneva and was put to work in the paraplegic unit run by Alan Rosier, himself a paraplegic, who had been rehabilitated at Stoke Mandeville by Louis Guttmann.

He was mad keen on bowel and bladder rehabilitation, and my first task from day one at 6.30 a.m. was to do manual evacuations. This is what constituted bowel rehabilitation. On day two, I was taught how to do urethral catheterisation with a sterile technique, which we did two-hourly on both male and female paraplegics during their initial period of spinal shock. As an 18-year-old from a single sex school, this was something of a baptism of fire ...

While I was there, Rosier got rid of his red rubber tubes & smoked drum, and acquired his first four-channel ink jet recorder. As I had just passed physics A level, I was put to work setting up his new urodynamic system – my first encounter with urology.

St Thomas's had a poor reputation amongst academics at Cambridge, but they had written me a very nice letter when I got into Cambridge, and I went there to do clinical medicine. Despite its reputation, I still think it was an excellent clinical training ground, mainly because of the emphasis on clerking patients and a constant hammering home of the importance of skills in history taking and clinical examination.

As a result, we all qualified being able to recognise when a patient was truly ill. We may not have known what it was but at least we recognised when something was wrong and we knew where to go to look up the diagnosis. There was also an expectation that medical students did other things. Nobody was more surprised than me when, one October, I was thrown off Brian Creamer's consultant teaching ward round before it started. He fixed me with a gimlet eye and asked whether I was producing the Christmas Show? As it happens, I was. "Well, you'd better go and get on with it", he said. "It's much more important to produce a decent show than to appear on my ward round".

My first urology job was my first post pre-registration job, working for Wyndham Lloyd-Davis and Ken Shuttleworth – equivalent to today's FY2. In my six months, I did fourteen open Millin prostatectomies, at least half of which were unsupervised. I had my own unsupervised Saturday morning list, when on call 1:2, doing inguino-scrotal surgery. I leave it to you to determine whether you think this was good training or simply foolhardy. In today's climate, this would be unthinkable but then, I felt ready for it - I wanted the challenge and it was hellishly good fun.

Peri-fellowship training was at Northampton in general surgery and urology under John Fergus and John Chapman. Great fun but then I had my first encounter with St Peter's and the Institute of Urology. As a result, that was the year I nailed my colours to the mast to become a full time Urologist.

I was then lucky enough to be taken on by Joe Smith and moved to Oxford to do, what turned out to be two and a half years of research, continuing the Oxford theme of that time - to find an effective treatment for the unstable bladder.

I think it is fair to say that the place of research in the training of a surgeon is still a contentious issue, with some strongly held views both for and against. What do I feel? Well - during my two and a half years did I advance medical science? I think that is hard to say. To try and preferentially alter bladder sensation to modify the micturition reflex and thereby ameliorate the symptoms of an overactive bladder is still, I think, a valid idea. My predecessor, Roger Higson, showed that when it is suitably ionised, local anaesthetic will cross the urethral barrier and temporarily increase bladder capacity. To induce more permanent damage by cooling the bladder to 5°C, in other words to try and induce nerve damage akin to trench foot in the bladder, seemed to work in the rabbit but no one subsequently took it on into larger mammals or humans.

I did find the wonderful Alison Brading, who volunteered to help me in analysing what I did to these bladders. She was getting bored with guinea pig taenia coli and, in introducing her to bladder smooth muscle, perhaps sparked the line of research that has been so productive in bladder physiology since.

However, I did have one good idea. Acupuncture alters perception and so I tried that in some Oxford women with long standing instability who had gone through all the treatments on offer - and it worked. The first time I presented it, I was met with general scepticism, and comments from the floor included a description of its use in anaesthesia for dogs. It was turned down for publication. I did, though, persist with it and indeed took it down to the Institute when I was appointed as Senior Registrar.

It was eventually published, and it remains the first paper in the urological literature on the use of acupuncture. Marshall Stoller in San Francisco subsequently took it up. He had the resources and the money to investigate electro-acupuncture, and this has subsequently metamorphosed into neuromodulation using posterior tibial nerve stimulators and undoubtedly has a place in the treatment of moderate bladder instability. At Whipps Cross, we continued to run an acupuncture clinic for bladder instability with a response rate of 70%.

Lord Adrian, the eminent neurophysiologist, had an aphorism that the only papers worth reading on a subject were the first and the last ones. As mine is the first, perhaps I have contributed.

What did I get out of research? The opportunity and time to read deeply into one subject and around that subject is, I think, a great privilege. To get back to the source material, to read it critically, not relying on subsequent, often inaccurate, précis. Correcting the mistakes which get passed on teaches valuable lesions. Designing, performing analysing, correcting and re-performing and presenting your experiments teaches you more about

research methodology than any number of lectures. The practical difficulties, the mundane things that can destroy an experiment, give invaluable experience when reviewing or evaluating other people's work. It taught me scepticism, self-discipline and honesty.

What did I learn from research? Well, I can anaesthetise, blindly intubate, operate on and recover New Zealand white rabbits and, if necessary, repeat the exercise several times. That, I can tell you, is no mean feat. I know what a cystogram of an awake, unrestrained rabbit looks like. With the University vet, I got to operate on several rhesus monkeys. My triumph was to do a commando operation on a tumour in the neck of a monkey called Neeskyne. His cure was so complete, he subsequently impregnated all the females of the colony resulting in a healthy profit for the Department of Experimental Psychology from the sale of the unwanted offspring.

I also became medical officer for Oxford United. Robert Maxwell took it over during my second season. What I learnt from him was that I could never be a bastard like he was.

To supplement my income, I, like many other research registrars in Oxford, worked sessions in the Elliot-Smith Vasectomy Clinic. This produced two papers on the complications of vasectomy – still quoted, and the source of a medicolegal income for me for years.

So, in the debate on whether research should play any part in surgical training, I am firmly in the "yes" camp. Those in the "no" camp who argue that, because so few projects result in a thesis, research is a waste of time miss the point. Research should be seen as delivering so much more than a higher degree. It teaches critical thought, understanding and knowledge acquisition, self discipline, doggedness and perseverance, quicker and more thoroughly than anything else. It personifies team working *par excellence* and it is the serendipity of unexpected consequences which really leads to advances.

The problem with poor research is poor supervision, and the need for so-called research registrars to plug service gaps in departments. Guidance for the naïf is all, knowing what is achievable whilst keeping research-focused and on-track are fundamental. The development of academic fellowships and lectureships is probably a welcome corrective. My anxiety is that, in establishing a body of academic surgeons, an elitism will be created that will deny the majority of trainees the benefit to be gained from a period in research.

After Oxford, I had a wonderful eighteen months with Robert Morgan at the Whittington before finally becoming a Senior Registrar, again at St Peter's and the Institute. To go there and be polished by Philip Ransley, Peter Worth, John Pryor, John Blandy, Richard Turner-Warwick and John Wickham – not forgetting Mike Kellett, David Rickards and Connie Parkinson – was an ideal finishing school with some great experiences … not only in urology.

John Wickham was instrumental in sending me to Rudi Hohenfellner's unit in Mainz for three months. This gave me first-hand experience in how urological care is delivered in Europe and how patients there are treated. The University Department served a large population and, by having a system of private urologists based in the community and

polyclinic service by large numbers of junior urologists, the volume of major urological surgery was huge, though the clinical decision-making where everything relied on the whim of the chairman, was cumbersome. My impression at the time was that the NHS was cheaper and more efficient.

We designed a study to see whether JJ stents placed before lithotripsy helped stone passage. I asked Peter Alken how we should randomise it. He said "We will randomize by Professor: during the X-ray meeting, when he says lithotripsy we say – splint or *oder keine* splint. He will decide whether to stent or not and it will be quite random". When the data was subsequently analysed and we looked at the demographics, he was quite right.

Before my appointment as a consultant, courtesy of the Kings Fund, I spent a month in the USA with Pat Walsh to learn radical prostatectomy and with Don Skinner for continent diversion. Here again were big units, the direction of the department being dictated by the interests of the chairman, who attracted large volumes of work

So, in 1987, I was appointed to Whipps Cross with sessions at St Peter's. I joined Manmeet Singh in a department of two Consultants, one full time Clinical Assistant, one Registrar in a non-SAC approved post, and two SHOs.

In a year we performed close to 2,000 inpatient operations, 1,500 day-cases and saw in excess of 8,000 patients in clinics, of whom more than 2,000 were new patients.

At that time, the prevailing pattern for urological services within a DGH, as espoused in 1982 by Keith Yates, was for two Consultants with a Registrar and Houseman. The SAC at that time reinforced the pattern by approving registrar training posts based on one registrar to two whole-time equivalent consultants. I tried to ascertain what evidence there was to support this model of care but it didn't seem to take account of activity levels, service demands, on-call provision or training needs, and I was left with the feeling that it must have been that this model seemed to fit best the prevailing resources and seemed about right.

Five years into my consultant appointment, the service we were operating, despite the huge volumes of work we did, didn't seem to be getting any better. We had an enormous waiting list, a huge backlog of outpatient appointments and if often took up to a year to come to any management decision for patients with chronic problems.

It was then that Mike Pietroni, the Senior General Surgeon, invited the Council of the English College for a day visit to our unit and we were all told that we must give a paper.

I decided to air my growing belief that, to deliver a comprehensive urological service based on two consultants serving a population of 250,000, was impossible. To service the workload demands on Whipps Cross and surrounding districts effectively, we needed more resources in the form of new and expensive technologies, lithotripsy, ureteroscopy, laparoscopy and the like. We needed better provision for complex urological pelvic surgery and to take in the likely future developments in urology. The whole, informed by my experiences in Germany and the USA, made an irrefutable case, in my opinion, both professionally and economically … to merge units into one centre

servicing a population of 750,000 to 1 million. I thought it would need about 40 beds with some private provision, two operating theatres, a day-case theatre, a variety of procedure rooms and dedicated outpatient facilities. We would need eight Consultants, four Registrars, Specialist Nurses and so on. I spent a lot of time marshalling the evidence to make this into a paper and I finished by paraphrasing Martin Luther King … "I have a dream" … I sat down to polite applause. The call for questions was met with silence. John Blandy was asked, rather desperately I thought, for a comment. "Well, you just have too much work to do, Tim" he said. That was in 1993.

In 1995, my Trust decided that it would explore the merging of the Whipps Cross Urology Department with that of Barking, Havering and Redbridge. My time had come. We had several amicable meetings between the five and, later, six urology consultants. We all agreed that merging the then three departments was desirable. We accepted that there would be no new build, but we felt that working on a hub and spoke model with all the major surgery and administrative backup at the hub would work well, and we were all prepared to sign up for it.

The results of our discussion were sent back to the respective Trust Boards, and nothing happened. Two years later we were urged to go through the same process again, and again we came to the same conclusion. At the time, you may recall that Mike Bailey and John Boyd did a similar, detailed and comprehensive exercise in Southwest Thames where, again, all the consultants came to an agreement to concentrate major work in two centres with the rest being spokes. I got hold of this report and distributed it widely in Northeast London with the comment that the Southwest Thames findings could equally be applied locally. And the result? Nothing happened. We subsequently had informal talks with Bart's and the London, again with Harlow, and again, as in Southwest Thames, the result has been complete inertia. Given that all Consultants were fully behind this move to centralise, why did it never happen?

The answer I think lies in the incessant tinkering with NHS by successive governments. A recent editorial in the BMJ highlighted that there had been 15 reorganisations of the NHS in the last 30 years. Since I was appointed a consultant, by my reckoning, there have been 16 Acts of Parliament and 12 reorganisations of the NHS affecting hospital care. I have listed the major ones here.

In addition, over the last 20 years, there have been 29 major policy papers impacting on the function of the NHS. With all this going on, is it any wonder that the administration had no time to listen to the views of those of us at the coal face?

In 1997, the Standing Medical Advisory Committee (SMAC), in response to reports from the Royal College of Physicians on future patterns of care and the Royal College of Surgeons on Consultant Practice and Training in the UK and Provision of Emergency Surgical Services, themselves published a policy and guidance document on future patterns of secondary care services, concentrating on DGHs and how to configure them for maximum benefit.
Their conclusions were based on evidence, as opposed to the rhetoric of government policy documents. It noted that the formation of Trusts had been an obstacle to efficient and effective delivery of specialist care. Competition discouraged collaboration and encouraged inappropriate developments to meet unsustainable ambitions. It promoted

the concept of systems of care between primary, secondary and tertiary centres – in other words, "hub and spoke" and it cited urology as a specific example of a specialty that could benefit from such a pattern of care provision. In the absence of the funding to produce a large building labelled Urology, hub and spoke is clearly the next best thing. The SMAC concluded that training and service was best served by concentrating in small numbers of centres.

In Northeast London we got "Fit for the Future" in 2006, an exercise to effectively close one of three acute hospitals, downsizing it to ambulatory care - they called this modernisation. Then along came Lord Darzi. For his vision of a few large centres delivering specialised care with peripheral polyclinics, why can't we simply read "hub & spoke"? Sir George Alberti was invited in 2007 to review the Northeast London plans.

In essence, he endorsed the idea, but interestingly identified in his conclusion, there was inadequate leadership, no enthusiasm for integration (but he didn't ask the urologists), a lack of capacity to carry out the changes and indifference among GPs. He also felt that there was some doubt that Northeast London was a natural "health economy", whatever that means, and that Whipps Cross rather more naturally inclined towards Bart's and the London. So now what has happened? Whipps Cross management is now exploring a merger with Homerton and Newham, the putative "Olympic Trust" - God help us!

So, after 23 years, my belief that units should merge to produce economies of scale, to improve services and allow more specialisation with a benefit to training, are no closer to fruition.

Might this occur in the future? The proposed model of care for London Cancer Services might just force the issue in its bid to centralise to concentrate complex pelvic and nephrological surgery in centres. My anxiety, however, is that without the investment and resources to provide centres with the capacity to encompass all the urological specialisms, the effect will be to cherry-pick major surgery into what, in effect, is the old teaching hospitals, to purloin the lion's share of money and resources, to treat politically sensitive cancer and thereby deprive the satellite units of resources, turning them into second class service deliverers.

But will it happen? Who knows? With equity and excellence now coming along to muddy the waters still further, I remain sceptical that anything will change. Put another way, "the words may change but the tune stays the same".

What has changed, undoubtedly, is training, but has it? Undoubtedly training has been reformed. It is 17 years since the Calman report came out. Since then, there seems to have been continual discussion, argument, reform and modification to training, which as an active member of the Specialist Training Committee for North Thames ever since it was set up, I have been party to. Calman of course was the result of a belief that training in the UK took too long, needed to be shortened and structured to produce Consultants in half the time and prevent a pyramidal career structure leaving half trained doctors on the shelf with nowhere to go – a laudable aim. This has led to a curriculum, examinations, more regulatory bodies, and huge power to the Deanery, not only over trainees but increasingly more demands of trainers to the point where those wish to train may well have to take that on a sub-specialty itself.

But have these training reforms worked? In my experience the acquisition of consultant level experience has not occurred any quicker for most trainees. Kieran O'Flynn recently went through the logbooks of trainees he was signing off for their CCTs and discovered that the numbers of individual operations being performed by the trainees varied widely; the balance of procedures was likewise hugely variable, so that hasn't changed at all. Neither do I have to point out the negative impact that the European Working Time Directive has had on the training opportunities of all surgeons.

Can training be speeded up though? Sir John Temple, charged with reviewing training in relation to the EWTD, reported in May. To comply with EWTD, he concluded that service needs to be delivered primarily by consultants. This, of course, implies a huge expansion in consultant numbers producing a split into senior and junior Consultants. The seniors would need time in their job plans for mentoring of juniors and, implicit in that, is that the juniors will need mentoring. Call me old fashioned – but does that sound like Consultants and Senior Registrars to the more mature of us here?

Temple also concluded that to deliver training adequate to ensure competency amongst the trainees, services had to be reconfigured into larger units, so that specialisation, economies of scale and training could be better delivered. Where have we heard that before?

One of Temple's introductory remarks was that the aim of training is to produce professionals who are both competent and confident. But the one point I think everybody would accept, but seems to ignore, is that the acquisition of knowledge and competency does not equal experience and wisdom. Having now counselled lots of trainees, wearing my various hats of regional advisor, programme director and STC Chairman, it is quite clear their anxieties are all around the gaining of experience and wisdom to give them the ability to perform at the higher level of a consultant. Acquiring experience and wisdom takes time, is best delivered with an apprenticeship scheme, and the only way to speed this up would be to train them in units large enough to have a consistent throughput of the same cases, so they are not reliant on the haphazard presentation of patients with the less common problems.

But if you think that training is quicker in Europe or America, don't be fooled. While you may get your ticket earlier, you certainly don't have the experience, which is then gained by sitting around for a long time waiting for dead men's shoes. Getting to the equivalent of an English consultant is no quicker anywhere.

So, will training change and can the delivery of urological services change? Surely this needs political will. The first thing is to stop MPs trying to preserve their small District General Hospitals against closure. Of course, they are going to fight that corner; now there is no money to build the large units that will be required. Your guess is as good as mine as to whether it will ever change. "Words may change but the tune stays the same."

By this, do I give the impression that I have had a frustrating and disappointing career as a consultant – by no means. The one thing that has not changed and will not change, the core business of doctoring and indeed the thing I love, is building that relationship between the surgeon and his patient. The patients and their illnesses are the same, the

anxieties are the same, and to be able to manage that, to improve the lot of the patient, to leave a patient happy and satisfied is the whole *raison d'etre* of the profession.

Therefore, strive to impose different models of care for the running of the health service. I suspect, in the long run, it doesn't make much difference which way we do it but those who wish to impose change need to consider why things have evolved as they have. I strongly believe that the way things work has more to do with the geography of the buildings and the resources one has available, than with any imposed patterns of working. What is most important is to ensure that medical students qualify with skill in history taking and clinical examination, a reasonable level of skill in diagnosis but a deep-seated enthusiasm to discover more.

Once they have qualified, train them thoroughly in technical skills and how to manage patients, and listen to what they have to say. We are dealing here with highly intelligent people - they should know for themselves what they need to do to grow and mature. Why impose artificial time constraints on them?

So, concentrate more on teaching and maintaining a good urinary stream

Ladies and gentlemen – I am truly touched by your entrusting this Section to me for the coming year and before I become any more pompous, I would like to leave you with a quote from Nietzsche …

Finally, as John Edmunds used to say on Monday mornings on Radio 4, "**If you have been, thanks for listening**".