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Platinum Opinion

On Having Grey Hair

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I recently received the Frans Debruyne Lifetime Achievement Award and the Hugh Hampton Young Award from the European Association of Urology and the American Urological Association, respectively [1,2].

In both cases, the principal reason for these awards was to recognise my work as an educator and my dedication in creating a team and helping the younger colleagues to follow the principles of scientific integrity and intellectual honesty. Mentorship and global leadership in academic urology were also recognised.

These awards have together been the most significant honours related to my professional life and have indeed been extremely rewarding for me. This being said, I think that they represent level 1 evidence that both the European and the American members of the award committees make mistakes, as there were dozens of individuals who would have deserved these recognitions more than myself.

I have grey hair and tend to reflect much more now than I did in the past about the reasons and the meaning of things. Owing to this, I thought it might be useful to share a few considerations with the readers of *European Urology*, the platinum journal.

1. In my opinion, the majority of urologists unfortunately do not devote enough time to reading scientific articles published in peer-reviewed journals, and this is particularly true for those who have been practising for a number of years. Unfortunately, this is also the case with individuals who have reached important professional positions: they are often excellent surgeons or clinicians, but they still make statements that clearly show that they are ignoring what has extensively been published in prestigious journals. I recently attended a conference where a well-recognised expert in the field of genitourinary oncologic surgery discussed a case study, making the point that nothing was known about the best management for that particular case. He operated on the patient, obtaining a final unsatisfactory result. It was very clear to me that this negative outcome could have been avoided, as many published articles indicate the most appropriate way to solve that specific problem successfully. I think that residency programme directors should invest most of their time in making their disciples understand the importance of staying updated with the latest advances in urology. I am a strong supporter of the rule that every resident and practising urologist should read one new scientific article per day. The Internet provides many apps that allow one to receive the lists of all the scientific articles published in various topics of interest. These services are typically free of charge and easy to obtain. Unfortunately, as most of us learn by example, if the boss is not enough interested in reading these articles, both senior and junior staff members under him or her will not read either. Perhaps, the top scientific associations and scientific journals should optimise actions directed towards their members and readers underlying the essential importance of remaining updated with the latest advances in science.
2. Many urologists are not completely honest when presenting their results at scientific meetings. It is part of a surgeon's life to look for better surgical solutions to improve the health conditions of his or her patients [3]. Clearly, one can report on results and complications only if he or she has organised a system allowing assessment of the short- and long-term health conditions of his or her patients [4]. Typically, this implies having either data managers or medical students, residents, or fellows taking care of the patients' follow-up. I often hear top-class surgeons describing spectacular results obtained following a particular procedure; however, in many of these cases, it is known that in their specific institutions most of the patients are lost to follow-up right after their

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discharge from the hospital. Sometimes, it seems to me that many urologists are like fishermen confronting each other by describing the size of their last catch conquered after an exhausting fight. In my personal experience, listening to conference talks devoted to complications and unpleasant sequelae of a surgical procedure is now unfortunately very rare. Indeed, chasing the complications experienced by patients after an operation implies having an organisation able to detect them, which, first of all, costs a lot of money. Secondly, nobody is happy to publicly discuss his or her own bad results and failures, even though this honest approach to what each one of us sees in our clinical experience would be appreciated. In my clinical practice, I have learned that providing patients with booklets that exhaustively detail the limitations and possible complications of a surgical procedure is the first step towards having a large number of them on the waiting list for that specific procedure. Patients appreciate and trust the surgeon who clearly talks to them about the major issues that may arise intra- and postoperatively.

3. The concept of the learning curve represents a hot topic in urology, and it has been well discussed by a number of prestigious authors [5–7]. This being said, I believe that talking about the learning curve makes sense only for those surgeons who carefully follow their patients and are aware of their personal results. By doing so, one can identify, for example, a critical step of a surgical procedure that is causing a specific complication: once this is known, the surgical technique can be changed, thus improving results. In my opinion, this is the correct application of the learning curve concept, and as a consequence, for surgeons who are largely unaware of their surgical results, the concept of a "learning curve" does not make sense. They will probably continue to include minor changes in the surgical technique of a specific operation every now and then, but quite often they will never be able to demonstrate the real efficacy of what they have proposed.
4. Urologists should do all they can to optimise the collaboration with the specialists who often are pillars of the best patient management [8,9]. Obvious examples include medical and radiation oncologists, pathologists, genetic medicine experts, gynaecologists, nutritionists, internists, radiologists, and nuclear medicine physicians. When considering genitourinary diseases, we as urologists are very often those who see the patient first, and this happens because most patients consider ourselves the principal referral specialists. I am convinced that the responsibility of building up an efficient multidisciplinary team is totally in the hands of the urologists who should take advantage of the will of the colleagues from other specialities to work together. Clearly, the more prestigious the scientific and clinical profile of the referring urologist is, the more attractive it will be for the colleagues of other disciplines to establish a solid collaboration.

Finally, we are all aware that the future of us urologists and of our patients is in the hands of our younger colleagues, who are expected to have the will and the intellect to identify the topical clinical and research questions that are still unanswered and design the ideal studies aimed at finding the answers [10]. Prospective randomised studies are not by definition based on thousands of patients; there are easy-to-organise randomised trials aimed at answering surgical questions that can be completed by a single institution, and there are excellent examples in urology!

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