CANADIAN JOURNAL
OF UROLOGY

Tech Science Press

Doi:10.32604/cju.2026.081440

LEGENDS IN UROLOGY

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"To be a legend, you've either got
be dead or excessively old!"
Sir Christopher Lee

Since I am still breathing and upright, it must make me excessively old! It's odd as to how we regard and even define the concept of a legend. I look at sports and entertainment and the names of individuals who we thought would live on in perpetuity, yet they have become less, or insignificant, with the passage of time. Ask a youngster today who Jackie Robinson or Jimmy Cagney, Johnny Carson or Burt Bacharach were, and the majority are clueless. In medicine, and in particular in our specialty, we have had our own icons or legends. With the passage of time, they become flickering memories to subsequent generations of budding urologists. To me, my dad was the ultimate legend, despite never being famous. He was wise, generous, thought outside of the box, and really had a strong moral-ethical compass, which have impacted me throughout my personal and professional life. Hence, I am who I am, because I am product of the influence of my father and of so many others who have impacted me along my journey in and outside of my career.

I have been fortunate to have enjoyed a career in academic surgery, that although at least to me is far from legendary, has entered its fifth decade. During that period, I have had the opportunity to increasingly be stimulated, learn new techniques, interact with amazing colleagues globally, many of whom have become wonderful friends. All of us suffer during down times and are plagued by unexpected and bad outcomes, but at the end of the day, when we balance the fruits of our endeavors, positive experiences have outweighed many of the negatives. As I enter my next chapter in life, I do so 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 peers from near and far, medical students, residents, and fellows with whom I interacted during that time.

In the era when I commenced my medical education in my hometown of Winnipeg, Canada, I for one, and I doubt if anybody entering medical school at that time, made an early career decision to become a urologist, or even knew what a urologist did. In fact, in 1976 when graduating, the only match for surgical residencies was for general surgery, with most systems being based on a highly competitive pyramidal track, where after a few years as junior residents, only a select group were offered positions to advance in general surgery through completion of a 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. Having had no overt exposure to urology, I only gained true knowledge of the specialty after graduation, following three years of surgical training. I did however meet some urologists along the way, who seemed genuinely happy with their choice of profession. I decided to take time off to work as a full-time emergency room doctor, at that time emergency medicine being a nascent, growing specialty. It was serendipitous

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that I was inspired by one who I would consider as a true legend, Dr. Paul Peters, who opened my eyes to urology when I heard him lecture on renovascular hypertension at surgical grand rounds at UT Southwestern. I was fortunate compared to today's students who must decide early in medical school which specialty they might intend to pursue, in that I was able to have broad surgical experience and training and to make a final career decision with my eyes wide open and with the mentorship of Dr. Peters to help guide me in my career choice. In our discussions, and to his chagrin, I told him I preferred putting things back together rather than taking them out, and really, only transplantation and pediatric urology seemed to appeal to these desires. After exploring options, the Harvard Program in Urology under Ben Gittes offered a new a program where one entering new resident would be chosen by Dr. Alan Retik and colleagues Drs. Arnold Colodny and Stuart Bauer and follow a more pediatric oriented training program, where more time would be spent at Boston Children's than the other residents. Since the residency was 4 years after the general surgical training, the second year was to be a research year. I negotiated with Drs Retik and Gittes that if offered the residency position, that I would do a transplant fellowship rather than go in the basic science lab that year. I was the one and only Brigham resident who was accepted into this pediatric track, as there wasn't yet a fellowship program in the cards at Boston Childrens. In the Brigham program, I would learn with and from some wonderful co-residents, including some who more deserving than me of being considered legends including: Kevin Loughlin, Arie Belldegrun, Gerry Andriole and Larry Levine. In a way, I feel sorry for today's medical students, who by their second year of medical school must start thinking about choosing a postgraduate career of choice, and the best route to ultimately match in that specialty. After competing to be accepted to university, then medical school, the stress of competing so early for postgraduate training is further accentuated. 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 200 transurethral resections of the prostate yet only sweated through eight radical prostatectomies, half being post-radiation (NOT FUN). The digital rectal exam and acid phosphatase were the guides to prostate cancer management and the IVP our primary diagnostic imaging tool. In fact within five years of completing my training, I had become a dinosaur in general urology, considering the advent of prostate-specific antigen, nerve-sparing radical prostatectomy, ESWL and endourology replacing the techniques and strategies I had been schooled in.

During my residency, pediatric urology fellowships began growing and while I was away in San Francisco doing my transplant fellowship, Dr. Retik instituted a fellowship at Boston Childrens. At that time Hardy Hendren also moved from the Mass General to Boston Childrens. Upon returning to Boston to complete the last 2 years of training, despite ups and downs regarding my special resident status and now unexpectedly having a fellow, there was still plenty of experience offered. I realized that in order to be a card-carrying pediatric urologist, that I would have to do further training. Having done my general surgery at LA County-USC medical center, I had hopes of returning to California on completion of my residency. I thus, upon graduation, could not have been more fortunate than to be offered a faculty position at UCLA, where I would resurrect the transplant program at Harbor UCLA Medical Center. While at UCLA, 2 individuals changed my life in many ways. Jake Rajfer and Richard Ehrlich became mentors, colleagues, and lifelong friends. Ehrlich offered me a fellowship in pediatric urology while Rajfer, who had trained at Hopkins under Pat Walsh, had a tremendous research interest in endocrine aspects of urology and inspired me to do basic research with him. He had contributed the most recent chapter on cryptorchidism to Campbell's textbook. Of significant importance was that the two of them were innovators and out of the box thinkers (like my father) who challenged dogma, very unlike the structured approach during residency training where one generally was expected to conform. Ehrlich used to always quote Stewart Brand, "Once a new technology rolls over you, if you're not part of the steamroller, you're part of the road." During my UCLA tenure, I was extremely fortunate to meet Dr. Richard Hurwitz, a pediatric urologist at Kaiser-Permanente, who has become one of my dearest friends and with whom I have enjoyed a long-term personal and professional relationship. In an era where there weren't cell phones or even emails, learning and practice change occurred not only by attending the AUA, Society of Pediatric Urology (SPU), and American Academy of Pediatrics, Section on Urology (AAP/SOU) meetings, but also smaller gatherings which allowed interchange in informal environments with social formats that encouraged the development of friendships. Stephen Shapiro, who practiced in Sacramento, who was a founding member of Wee Willies, also formed the Pacific Rim Association of Pediatric Urologists (PRIAPUS), whose members included all pediatric urologists in the Western USA and Canada. As pediatric urology and especially subspecialty fellowship training grew, David Roth (Houston) and Mark Zaontz (Chicago at that time) conceived a similar meeting for newly minted pediatric urologists. That group, initially the Society for Young Pediatric Urologists (SYPU) composed of

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12 charter members, met in Palm Springs. As we aged and membership grew in number, the group became what is now the American Association of Pediatric Urologists (AAPU), became more political in its mission, and was a major force in the ultimate decision by the American Board of Urology to grant a separate Certificate of Added Qualification (CAQ) in Pediatric Urology in 2007. Leadership wise, I believe I am the only pediatric urologist who has held position as president of both the SPU and AAPU, as well as recently been elected chairperson of AAP/SOU. During my SPU and AAPU presidencies, I was also deeply involved as a member of the Coordinating Council that met with the ABU, ultimately leading to the granting of the CAQ.

In 1988, I reached a liminal phase in my career. Immunosuppression for transplantation had evolved so that the field was expanding rapidly as patient successes increased. I believed that urologists, if they were to continue to be involved in transplantation, had to learn to engraft other organs and be well versed in understanding immunobiology and the new pharmacology of transplantation. I felt the best structure of a transplant program would be a mixture of general surgical trained and urologically trained surgeons with their medical colleagues. I was fortunate to lead the team that did the first pancreas transplant at UCLA, but realized my vision of a collaborative team was just not in the tea leaves. I thus felt that although I would continue my academic and clinical interest in this field, it would be secondary to my main focus of pediatric urology. This led to moves to Colorado, Seattle, and Toronto where I was given opportunities to lead their pediatric urology programs. This was a different era, preceding IRB requirements and strict policies, and where we often could operate with and learn from one another. I was able to perform the first laparoscopic nephrectomy in an infant, introduce the Malone ACE procedure to North America, after being taught the procedure by Philip Ransley. The incised urethral plate or Snodgrass repair became interesting to me and along with Warren and other colleagues, we published some of the first multicenter experiences of this technique, which ultimately led to its popularity worldwide. I then exported it by teaching it to colleagues in UK and mainland Europe and Asia. I also became more involved with global surgery, where a friendship with Tony Caldamone began and blossomed. In addition, I became an annual visitor to the Midlands of the United Kingdom where I helped establish the pediatric urology program in Leicester, and developed long-enduring relationships with Tim Terry, Pat Malone, Tony Manzoni, SuAnna Boddy, and John Hutson, amongst many others. This led to my participation annually at BAPU (British Association of Pediatric Urology) meetings where I was honored to be awarded lifetime membership. For me as an academic surgeon, my greatest joy has been impacting and educating others. I have been rewarded by being elected a Fellow of Royal College of Surgeons (2010), receiving the 2022 Progress Medal by the Asian Society for Paediatric Urology (ASPU) and the Indian Society for Paediatric Urology (ASPU), and in 2023 the AUA Resident and Fellows Committee of the American Urological Association (AUA). In 2023, I also received the University of Minnesota School of Medicine Excellence in Teaching Award and in 2025, the Rocky Mountain Urological Society (RMUS) awarded me the RMUS Donahue Lifetime Achievement Award for teaching excellence. I was to receive the 41st Wee Willies Award in Washington DC in 2020, a true honor awarded by one's peers. COVID however led to postponement of that meeting for a year. This led to an even greater celebration, when Richard Hurwitz, the 42nd honoree and I were roasted jointly in Miami in 2021 by Tony Caldamone, Tony Manzoni, and Philip Ransley in person, and virtually by Stu Bauer, Tim Terry and Pat Malone.

During my 10 years in Toronto, I channeled my energy towards quality improvement and patient safety (QIPS), and learning health systems at the Institute of Health Policy, Management, and Evaluation at the University of Toronto Dalla Lana School of Public Health, where I received an MSc focused on QIPS. I subsequently was accepted into the International Masters in Healthcare Leadership at McGill's Desautel School of Management, where I received the Michael Decter Scholarship in Health Policy in 2019, subsequently completing a MMgmt (Master's in Management) in 2021 at which time I retired clinically. I continue to actively teach in the Desautel Faculty of Management. After returning home to Denver from Toronto, I was approached to resume my clinical career on a part time basis at the University of Minnesota. I feel that a surgeon can (should) not operate forever, although there is no magical age where one can, with certainty, assess when the scalpel should be tempered. For me, it is now my time to enjoy the next chapter of my life, knowing I still have the desire to contribute while I believe most of my synapses remain in sync. I think we who are "excessively old" still have a lot to offer as mentors and coaches, rather than as operating surgeons, to the next generation(s).

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