

*Overcoming Challenges in Programmatic Leadership
without Compromising Resident Education:*

Optimizing the Ambulatory Clinic

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Learning in the Ambulatory Setting

- Learning surgical skills is critical for the urology resident in training, but for most urologists, the majority of their time will be spent in the clinic
- Residents want to be in the OR
- It is important to make the experience in the outpatient clinic fruitful



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Challenges in the Clinic

- Time
- Work space
- Number of learners
- Patient privacy
- Examining the patient
- Number of people in the room
- Procedures
- Proper billing of services

A Great Experience for the Resident

- Independent patient evaluation
- Formulation of a treatment plan
- Evaluation of that treatment plan with positive and negative feedback from faculty member
- Counseling the patient

A Great Experience for the Faculty

- Finish all notes and be home in time for dinner

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Empowering trainees through understanding learning theory and changes in medical education [version 1; peer review: 2 approved]

MedEdPublish 2022, 12:30 Last updated: 20 JUN 2022

Parag Singhal¹, Stephen Craig¹, Grace Boyd¹, Davinder Sandhu²

¹Internal Medicine, University Hospitals Bristol and Weston NHS Foundation Trust, Weston-super-Mare, Somerset, BS23 4TG, UK
²Clinical Medicine, American University of Antigua, Coolidge, Antigua and Barbuda

- Empowering trainees to think critically about decision making should result in the NHS being more efficient and cost effective
 - Reducing the wastage of NHS resources on unnecessary investigations, treatment, and consequently putting patients at risk
- A survey of 100 postgraduate trainees from the Severn Deanery was conducted on SurveyMonkey
 - 8 questions focusing on trainee responses to participation in clinical decision-making in the inpatient setting
 - Additional question on communication with the patient was included in the second iteration

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- Only 35% of trainees had finding regularly verified by consultants
 - 1/3 reported that decisions were made without asking their opinions on investigation or management
- The poor consultant trainee interaction represents a serious lost opportunity for experiential learning with real time feedback
 - Training programs should support trainees being given opportunities to nurture analytical, problem-solving skills, dealing with uncertainty among other attributes of patient management
- Trainees need to become competent through the art of critical thinking and develop a professional identity

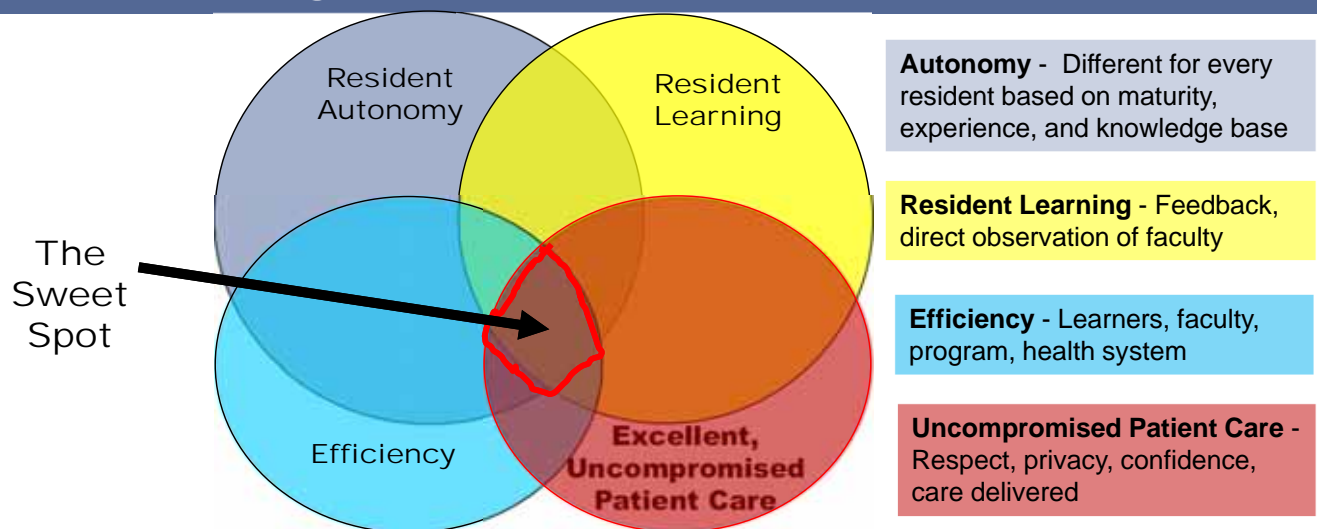


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Challenge: “Hit the Sweet Spot”



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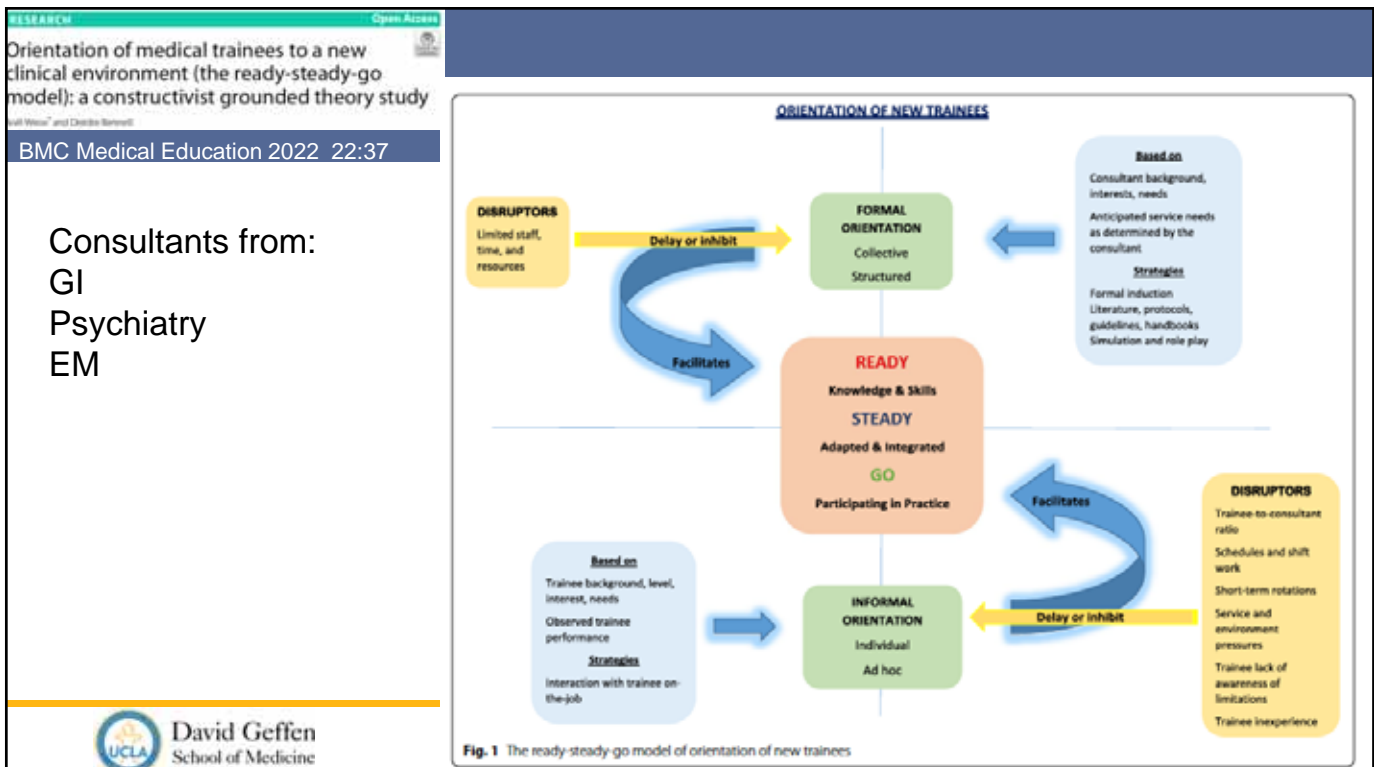
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Maximizing the Ambulatory Clinic Experience: Preparation

- Preparation by the resident regarding commonly seen conditions in a given clinic
- Advanced materials provided to the resident
- Preceptorship model
 - Having the same resident in clinic for multiple sessions / weeks enhances the learning experience and efficiency

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Maximizing the Ambulatory Clinic Experience: Patient Selection

- Encourage
 - New patients
 - Follow-ups that the resident is familiar with
 - Post op patients that the resident is familiar with
- Avoid
 - Patients who request not to be seen by anyone other than a faculty member
 - Patients who can require a lot of time for non-urological, non-medical issues

Resident Productivity in the Emergency Department After Implementation of an Automated Patient Assignment System; a Brief Report

Archives of Academic Emergency Medicine. 2022; 10(1): e33

Christian Rosenow¹, Sophia Aguirre¹, Thomas Polveroni¹, Zachary Ginsberg¹, Jordan Pollock¹, Stephen Traub², Douglas Rappaport^{3*}

- Retrospective cross-sectional study of non-EM residents
- Resident productivity was measured as number of patient visits per hour and per 8.5-hour shift
- Before and after the implementation of an automated patient assignment system
- Automated-system assigned one patient at the start of the shift, another 30 minutes later, and one patient every hour thereafter

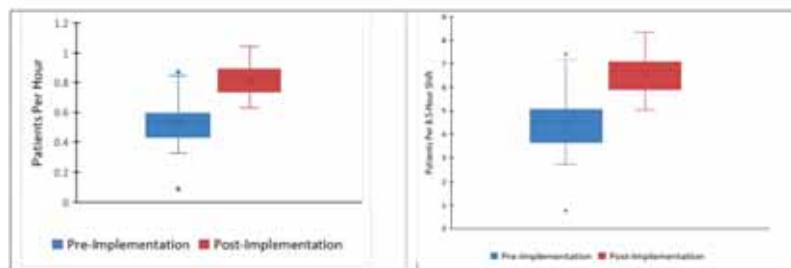


Figure 1. Box-and-whisker plots of the average patient visits per hour (left) and per 8.5-hour shifts (right) by residents in emergency department before and after implementing an automated patient assignment system.

Maximizing the Ambulatory Clinic Experience: Expectations

- Define what is expected from the resident
 - History taking
 - **Review of prior records**
 - Exam
 - Counseling
 - **Documentation**

For Me: Documentation of Assessment and Plan is Critical and Very Time-Consuming

- Initial assessment of the problem
- Further diagnostic testing and why if applicable
- Unanswered questions / missing information
- Initial plan – treatment, testing, or both
 - Include all options discussed with risks and benefits
- Potential additional plan depending on outcomes

For Me: Documentation of Assessment and Plan is Critical and Very Time-Consuming

- How issues unique to a particular patient affect the plan
- How results of further testing affect the plan
- Alternatives if initial plan needs to be revised
- Unique concerns of a particular patient

Dot Phrases: Female SUI

- We discussed urethral bulking for the treatment of stress urinary incontinence. There are several agents that can be used all of which are injected into the urethra. Urethral bulking can usually be done in the office setting with a local anesthetic in takes a few minutes. It has a relatively low complication rate, the main complications being bleeding and temporary difficulty voiding or urinary retention requiring catheterization usually for not more than 48 hours. Urethral bulking is effective in curing stress incontinence in 25% of patients, improving it in 50% of patients and does not work in 25% of patients. Sometimes more than 1 injection is necessary to get an initial result. Also, the the durability of urethral bulking injections is variable but in a good case scenario should be about a year at which time another injection may be necessary. Sometimes the duration of affect is shorter and more frequent injections may be required.
- We discussed surgical treatment of her stress incontinence and we talked about both synthetic mid urethral slings and pubovaginal slings. We discussed the pros and cons of each of these. This synthetic sling being less invasive, having excellent success rates, and a short convalescence. There are however the unique complications of mesh which are vaginal exposure in 1% of cases, pain requiring removal of the sling and less than 1% of cases, and erosion into the urethra or bladder which occurs in less than 1 in 1000 cases. All of these require surgical intervention. The risk of incomplete bladder emptying requiring loosening of the sling is 2% and this is not a unique complications of mesh. We also discussed pubovaginal sling. This would involve harvesting autologous tissue from the thigh or lower abdomen. It is a larger procedure with a longer convalescence. It avoids the unique complications of mesh. Overall however complication rates are higher and there is an increased risk of temporary voiding dysfunction requiring catheterization and in increased risk of permanent voiding dysfunction requiring loosening of the sling which is in about 6% of patients. Success rates are similar to the mid urethral sling.

Dot Phrases: Male SUI

- We discussed the full spectrum of management for postprostatectomy stress urinary incontinence. We started with conservative management which revolves around pelvic floor exercises. These can be done by the patient himself or in conjunction with a physical therapist. For postprostatectomy incontinence, pelvic floor exercises have the most benefit in the 1st year after prostatectomy helping patients get to their final level of continence quicker. There is less data on the use of pelvic floor exercises to treat significant postprostatectomy stress incontinence after 1 year but some studies suggest that there can be some improvement.

We discussed medications for the treatment of post prostatectomy stress incontinence. There are no FDA approved medications for the condition. The medication that has been studied the most is duloxetine. It would be an off-label indication for the treatment of post prostatectomy stress incontinence though some studies have shown benefits. It does have central effects as its main approved indications are for depression and diabetic neuropathy. Anecdotally, the best results have been seen in patients with milder degrees of incontinence.

We discussed surgical procedures for stress incontinence in men. First we discussed a sling procedure. Sling procedures involved placement of mesh under the urethra pulling tension to elevate and compress the urethra. The surgical procedure was described to the patient. Sling procedures in general do not work well in patients with high-grade stress incontinence or in those who have been radiated. In a well selected patient with mild to moderate stress incontinence and no radiation sling procedures are successful about 70-70% of the time with about half of the patient's achieving pad free status. After sling procedures patients need to be careful for 6 weeks not to do excessive abduction or adduction at the hips to prevent dislodgement of the sling. After sling procedures, a catheter is usually left for 24 hours and removed on postoperative day 1 either in the office setting or by the patient himself. Lastly we discussed the artificial urinary sphincter. This is the gold standard for the treatment of stress incontinence. It works well for all levels of stress incontinence and works well in radiated patients. It is a 3 piece mechanical device. I showed the device to the patient and explained how it is implanted and how it works. We went over the 90+ % patient's satisfaction rates with about 50% of patients achieving pad free status and the rest of successful patient is wearing usually 1 small pad per day. We discussed the 4-5% per year reoperation rate for urethral atrophy, mechanical failure, infection, and erosion. Revisions may involve revision or replacement of 1 part of the device or a complete replacement of the device depending on the type of malfunction and age of the device. In cases of urethral erosion, the cuff (and sometimes the whole device if infected) need to be removed and a healing process of at least 3 months is necessary before the device can be replaced. It is important that if a patient has an artificial urinary sphincter that he is not catheterized without deactivation of the device.



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What About Scribes?

Implementation of medical scribes in an academic urology practice: an analysis of productivity, revenue, and satisfaction

Benjamin J. McCormick¹ · Allison Deal² · Kristy M. Borawski¹ · Mathew C. Raynor¹ · Davis Viprakasit¹ · Eric M. Wallen¹ · Michael E. Woods¹ · Raj S. Pruthi¹

World Journal of Urology (2018) 36:1691–1697

- Over a 3 month period scribes: increased productivity, revenue, and provider satisfaction while maintaining high patient satisfaction
- ROI >6:1
- No mention of effect, if any on trainees



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What About Scribes? Effects on Residents

- Can efficiencies gained from utilization of scribes in a academic practice be reproduced for residents
- In academic dermatology clinic, residents could potentially increase their volume and clinical experience by 50% by seeing three patients hourly instead of two*
- In urology this could mean a larger experience and potentially more procedures and surgical cases



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*Healey B, et al. Clinics in Dermatology 2022; 40: 402-4

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Procedures in the Ambulatory Clinic

Discussion



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Resident Education: Optimizing the Ambulatory Clinic

- There are many opportunities for resident education in the ambulatory clinic setting
- It takes a well thought out plan to maximize education AND improve efficiency
- With continuing challenges in the delivery of health care, especially in the academic setting, we will need to continually adopt models for learning in the clinic

