

## Groundhog clinic

Who could forget the excellent *Growing Pains* episode when Mike Seaver's hapless friend Boner Stabone overcame his school-play stage fright by playing a recorded version of his lines from a tape recorder in his trench coat pocket? The answer is "everyone," but still. It doesn't go so well but I think of it now and again in clinic, when I realize that my actual job seems to be saying the same things to patients, verbatim, over and over and over again, and wonder if there is room for automation.

The meat of so many conversations is, in essence, [Ctrl+V]ing lines and paragraphs of my own boilerplate copy. Not just a suite of analogies or definitions, but whole lines of reasoning and entire arcs, from pathophysiology to consent. Like Bill Murray in *Groundhog Day*, it's the same day played on repeat. We read the consult, check the labs and images, and enter the room ready to unspool a well-rehearsed script. Is this face-to-face doctor-patient time really just the patient pressing play on Dr. Teddy Ruxpin?

*"It's technically cancer. The pathologists know what they're looking at. But it doesn't behave like a cancer. It doesn't eat through linings and spread and do the things cancer does."*

Let's go deeper. Common things really are common, and most patients cluster in a modest number of familiar presentations. We write guidelines about these things because "the index patient" is your next consult, and guideline-concordant management will carry the day most of the time. The Pareto (aka 80:20) Principle is iron-clad for good reason. A small number of inputs will serve the majority of outputs and it's wise to exploit this. It is smart to reserve precious cognitive bandwidth and fuel for the zebras and your red-flag radar. Defaults, routines, and scripts are, in fact, efficient ways of optimizing clinic flow and patient care.

*"...it sets up an immune reaction in your bladder that [\*hands making chomping motions\*] eats up cancer cells too small to see."*

Is standardization through scripts enough though? In business, they'd call the lack of automation of recurring tasks *inefficient*. In the quality improvement world of lean processes, they'd call it *waste*. Any repeating task is ripe for delegation or automation. Indeed, there are many who direct patients to our excellent CUA patient information pamphlets *before* the consultation, and even services to stack and collate videos of you describing disease states and therapies so you can mime a subtle "shhh" motion and direct patients to the YouTube version of your spiel, then leave to chip away at the full hopper of consults and provide more net care. Online check-in offloads consequential logistical work to the consumer, but the airport experience is significantly improved. Why not in healthcare? Work through the nocturia module to unlock the appointment booking page! Light sarcasm aside, there is room for some calculation at a system level. Where would the curves cross between somewhat less personalized discussion for some and improved specialist access for all? Throughput does not define quality, but it factors.

*"It's like when you turn the hose off at the wall. No more water's coming out, but if you lift the hose, the water trapped in there spills out."*

Who am I kidding here? My licence plate says C4NM3D5 and I write "intrinsic roles" with hearts instead of dots on the *i*'s. One might argue that the boring act of rote recitation is another straw added to the heavy wellness bale, but repetition is valuable. At the least, developing scripts ensures us as physicians that we have covered the bases with the depth we intend. I've riffed on Van Halen's brown M&Ms tour rider parable here before, but it is an evergreen lesson that standardization is an insurance policy.<sup>1</sup> Having your always-approach assures you that you have mentioned this adverse effect or that recovery time expectation. It is a checklist disguised as a riff.

*"...in this case, the bladder is asking 'does that mean I'm full?' and because of the short-circuit, the*

Michael  
Leveridge

Editor-in-Chief

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*brain stays silent, and the bladder is like 'I'll take that as a yes!'"*

I'm going to suggest that what we perceive as identical swaths of discussion are, in fact, subtly different and evolving in real time. Performers of all types improve with time and practice, and these years and reps in clinic are just that, contributing to our "10 000 hours" as we develop expertise. We learn new data or update our own priors regarding the expected outcomes of our treatment and feed that back into our conversations, an evolving and updating training set for your personal "GPT." We also "read the room" while conducting our visits; we respond to patient cues about their engagement and understanding, whether at the broad strokes of health literacy or a surprised eyebrow raise when talking about "the nerves that run along the prostate like the seams on a baseball" or an upturned mouth that belies iffy prior experience with Cialis.

Every performance is different. We see the same musicals, bands, symphonies, even movies again and again because of the subtle differences in energy and expression, making new discoveries and feeling new vibes despite the objective repetition. We internalize that 7% of communication is carried through words and 55% through non-verbal cues the way children learn "Ring Around the Rosie" — a cultural meme seemingly without origin but taken to be true. Delegating large chunks of knowledge translation to a video or a blog post on a website a) disables updating without having to re-shoot and b) fixes any body language or non-verbal cues to a single iteration, unable to flex to current needs. Having a consultable record of your key points is great but is best as an adjunct or memory aid for use before or after the encounter, not in lieu of it.

*"These aren't miracle drugs; you won't pee like a 20 year-old again. But somewhere between here now [\*spreads arms, flicks right wrist\*] and perfection [\*flicks left wrist\*] is a line where you feel like you have some control over your peeing, not the other way around."*

I've outed myself as a CanMEDS Communicator evangelist. Rather than a wellness leak, plying one's

trade expertly in the clinic with good data, fun analogies, and assured comprehension is the opposite. Well-articulated lines, communications that land effectively, and some levity are energizing, and are hedges against both formal complaints (it is well-described that much escalation to colleges or patient relations boards is based on fractured communication) and frustrating, high-friction interactions. Even those whose LUTS or pain or new recurrences are beyond our ability to cure, our honed and practiced elocution can be a balm of shared understanding and acceptance. These interactions are the puffs of flame that help keep the balloon afloat.

*"Mr. Smith? Hi, Mike Leveridge, urologist. I'm hearing tell of betrayal by foreskin."*

Is there a balance to find? Need I deploy all my monologues while the clinic heaves like a bus station with waiting patients? I could probably get away with a bit less in my attempts to provide physiology lessons, and round numbers are probably sufficient when articulating outcome expectations. I have many times baffled people through over-explanation of hypothetical reasons why PSA might escape into the bloodstream. But for explanations of surgery and its expectations and for articulating the rationale and expectations around medications, a polished script is an unimpeachable good. I find it fun as well, and perhaps it is intended to cement my status as the expert in the room to be trusted. My job then becomes to iterate and optimize, to build adaptable scripts full of wheat and low on chaff. And recall the movie again — despite his suffering, Bill Murray's Phil Connors comes to use his endless repetition and expertise to become a source of good in Punxsutawney.

## REFERENCE

1. Leveridge M. RoCo riffing: Thoughts on the qualifying exam. *Can Urol Assoc J* 2022;16:239-40. <https://doi.org/10.5489/cuaj.8040>

CORRESPONDENCE: Dr. Michael Leveridge, Department of Urology, Queen's University, Kingston, ON, Canada; [Michael.Leveridge@kingstonhsc.ca](mailto:Michael.Leveridge@kingstonhsc.ca)