

Reference #7504

Microaggressions mitigation training is lacking in urological education.
A Review of Validated Teaching Tools to interrupt microaggressions.

Lauren Hekman¹, James Swanson¹, Denise Asafu-Adjei², Larissa Bresler²

¹Loyola University Chicago, ²Department of Urology, Loyola University Medical Center, Hines VA Medical Center

INTRODUCTION

Microaggression interruption training is lacking in urological education. We present a review of the literature assessing validated workshops on mitigation of microaggressions.

METHODS

Database search of PubMed and MedEdPortal with terms “urology” and “microaggressions” failed to produce any results. Broadened search including for “microaggressions” to filter for all existing teaching methods, specialties, and tools of all English language articles from founding to June 10, 2022 yielded 529 articles that matched our search terms. All articles pertaining to validated teaching methods, curriculum development, or educational toolkits that were specifically related to addressing microaggressions were reviewed and analyzed. Replies to the editor and papers that did not report statistical results were excluded from our analysis. The workshops and toolkits validated by statistical analysis were comprehensively reviewed. Significance was defined by a p-value of <0.05 or >65% of participants reporting positive impact and improved confidence when addressing microaggressions.

RESULTS

Six validated workshops and toolkits that specifically addressed microaggressions and provided statistical analysis fit the criteria of this investigation. Table 1 summarizes relevant outcomes. All workshops evaluated their programming with pre and post surveys. We found that all the reviewed workshops were significant in their post-assessments in increasing confidence in practically addressing microaggressions.

CONCLUSION

Microaggressions is a widely acknowledged and detrimental occurrence in the professional medical setting mirroring our society. Urological practice is not immune to this affliction. This review demonstrates a knowledge gap in urological education addressing microaggressions and highlights validated teaching tools developed for other specialties improving real-life confidence in mitigating microaggressions. As it stands, there is a paucity of formal microaggressions training in urology for practicing urologists and trainees, emphasizing the need for curriculum development.

Table 1. Summary of microaggressions-focused workshops and toolkits					
Workshop	Teaching Modalities	Population	Evaluation Method	Results	Acronym or toolkit utilized
Interrupting Microaggressions in Health Care Settings	Lecture, problem-based learning with case studies, pair and share, and facilitated small- and large-group debriefs	Third-year medical students during a clerkship intercession	Pre and post surveys	98% felt confident in identifying microaggressions at the end of the workshop	PEARLS (partnership, empathy, apology, respect, legitimation, and support)
Addressing Microaggressions & Discrimination in the Wards	Large group didactic session with PowerPoint, small group discussion, 2 case studies	First-year medical and dental students	Pre and post surveys	Reduction in perceived difficulty in identifying microaggressions ($p < .001$)	Stop, talk, Roll
Bystander Training: Creating a Safer Clinical Learning Environment	Review of the terminology, review of behavioral response framework, example cases of bias in the workplace	Second year medical students	Pre and post surveys	Respondents' confidence in addressing both personally experienced and witnessed incidents of bias and microaggressions improved significantly both immediately after the workshop ($p < .05$) 8 months postworkshop ($p < .05$)	5D'amodel (direct, distract, delegate, delay, and display discomfort)
Microaggression Response Toolkit (MRT) and Workshop	Fifty-minute workshop including case scenarios and role-play	Internal medicine residents	Pre-workshop survey and post-workshop survey	Increased comfort with identifying microaggressions (29% pre-survey vs 89% post-survey selected "comfortable" or "very comfortable")	Microaggression Response Toolkit (MRT)
Workshop for Inclusive Excellence	Presentation, cases in the health professions education environment, and discussion and facilitator guides	Students and employees including faculty, staff, and leadership in the nursing and medical professions from three universities	Pre-test and posttest, pre-workshop survey and post-workshop survey	Participants' confidence in their ability to respond to microaggressions increased by 24, Increased overall confidence ($V = 79.5, p < .001$)	Microaggressions Triangle Model Framework; ACTION - ARISE - ASSIST
Taking the V.I.T.A.L.S. to Interrupt Microaggressions	60-minute workshop. Large didactic session, small group sessions, and discussion with practicing VITALS.	Medical students and pediatric trainees	Pre and postworkshop surveys	Comfort with initiating difficult conversations to counteract microaggressions committed by their peers or those in power rose to 68% in the postsurvey ($P < .001$)	VITALS (validate, inquire, take time, assume, leave opportunities, speak up)

Funding: N/A

Reference #7554

PREDICTORS OF SURGICAL RISK AND OUTCOMES IN GENDER-AFFIRMING PHALLOPLASTIES AND VAGINOPLASTIES

Kerith Wang, Rishabh Simhal, Yash Shah, Paul Chung, MD

Department of Urology, Sidney Kimmel Medical College, Thomas Jefferson University, Philadelphia, PA

Introduction: Gender affirming surgery (GAS) has seen dramatic advances in phalloplasty and vaginoplasty. However, there is still need for better characterization of patient demographics and surgical outcomes. Recent interest has emerged in predictors of post-surgical complications, such as patient frailty and comorbidities for preoperative risk assessment. Better understanding of these can help with patient selection, patient counseling, and quality improvement.

Objective: To evaluate phalloplasty and vaginoplasty outcomes and predictors of complications utilizing the National Surgical Quality Improvement Program (NSQIP) database.

Methods: All phalloplasties and vaginoplasties performed from 2006-2020 in NSQIP were identified, and descriptive statistics were calculated. Frailty was calculated using the modified frailty index (NSQIP-mFI-5), a validated score including points for diabetes, impaired functional status, COPD, CHF, and hypertension. Pre-operative morbidity probabilities were derived from the NSQIP morbidity probability, which uses hierarchical regression analysis on patient-specific factors. Univariate logistic regression, ANOVA, and t-test analyses were performed to identify predictors of surgical complications, operative time, and hospital length of stay (LOS).

Results: 58 phalloplasties and 485 vaginoplasties were reported in NSQIP. For phalloplasty and vaginoplasty, the mean patient age was 38.4 ± 11.8 and 36.6 ± 12.6 years, respectively. The average operative time for phalloplasty and vaginoplasty was 331 minutes and 263 minutes respectively, and the average LOS was 5.1 days and 4.3 days, respectively. The overall 30-day complication rate for phalloplasty was 26%, with 17% of all patients experiencing minor complications, and 16% of all patients experiencing major complications shown in Table 1. The overall, minor, and major complications rates for vaginoplasties were 14%, 7%, and 9%. Unplanned readmissions and reoperations each occurred in 7% phalloplasty and 5% vaginoplasty patients. No deaths occurred within 30 days post-operation in either cohort.

Upon logistic regression, NSQIP-mFI-5 scores ≥ 0.2 versus a score of 0 did not affect the odds of 30-day complications, operative time, or LOS for either procedure. Notably, for vaginoplasties, higher NSQIP-mFI-5 scores were numerically associated with higher complication rates (OR 2.02, 95% CI 0.94-4.09, $p=0.072$ [RS1]). When comparing NSQIP preoperative morbidity probabilities of $\geq 10\%$ versus $<10\%$, this score was predictive of 30-day complications for both phalloplasties (OR 4.0, 95% CI 1.1-19.6, $p=0.038$) and vaginoplasties (OR 2.46, 95% CI 1.4-4.3, $p<0.001$)[PC2] [RS3] [PC4] . NSQIP morbidity probability $\geq 10\%$ was also predictive of extended LOS for phalloplasty patients (6.3 ± 1.3 vs. 2.9 ± 0.8 , $p=0.03$).

Conclusions: The NSQIP preoperative morbidity probability is an effective predictor of surgical complications and is a better predictor than the modified NSQIP frailty index.

Table 1. Patient characteristics and complication rates following phalloplasty and vaginoplasty

	Phalloplasty (n=58)	Vaginoplasty (n=485)
Mean age (years)	38.4 ± 11.8	36.6 ± 12.6
RACE		
White	33 (56.9%)	331 (68.3%)
Black	14 (24.1%)	87 (17.9%)
Asian	4 (6.9%)	24 (5.0%)
Native American	1 (1.7%)	4 (0.8%)
Unknown	6 (10.3%)	39 (8.0%)
COMORBIDITIES*		
Diabetes mellitus	0 (0.0%)	14 (2.9%)
Dependent functional status	0 (0.0%)	0 (0.0%)
COPD	0 (0.0%)	2 (0.2%)
CHF	0 (0.0%)	0 (0.0%)
Hypertension	5 (8.6%)	35 (7.2%)
Smoking	9 (15.5%)	49 (10.1%)
Chronic steroid use	0 (0.0%)	7 (1.4%)
Bleeding disorder	0 (0.0%)	2 (0.4%)
Open wounds	0 (0.0%)	7 (1.4%)
SURGICAL MEASURES		
Mean operative time (minutes)	330.9 ± 232.8	262.6 ± 112.1
Mean length of hospital stay (days)	5.1 ± 6.4	4.3 ± 3.4
Readmissions	4 (6.9%)	23 (4.7%)
Reoperations	4 (6.9%)	24 (5.0%)
30-DAY COMPLICATIONS		
Overall complications	15 (25.9%)	70 (14.4%)
Minor complications	10 (17.2%)	32 (6.6%)
Major complications**	9 (16.4%)	43 (8.9%)
Specific complications		
Superficial SSIs	6 (10.3%)	10 (2.1%)
Deep SSIs	1 (1.7%)	0 (0.0%)
Organ Space SSIs	1 (1.7%)	0 (0.0%)
Sepsis	1 (1.7%)	2 (0.4%)
Urinary Tract Infection	2 (3.5%)	11 (2.3%)
Bleeding Req. Transfusion	4 (6.9%)	11 (2.3%)
Wound dehiscence	4 (6.9%)	39 (8.0%)

*Comorbidities not observed in any phalloplasty or vaginoplasty patients include the following: dyspnea, ascites, renal failure, dialysis, disseminated cancer, recent weight loss, and blood transfusions.

**Includes: sepsis, DVT, stroke, reintubation, renal failure, myocardial infarction, pulmonary embolism, septic shock, wound dehiscence, deep wound infections, and cardiac arrest

Funding: n/a

Reference #7561

OOCYTE CRYOPRESERVATION (EGG FREEZING) DURING GRADUATE MEDICAL TRAINING: A SWIU SURVEY OF UROLOGY RESIDENTS

Connie Wang¹, Jane Kurtzman¹, Rini Ratan², Paula Brady², Gina Badalato¹

¹Columbia University Irving Medical Center Department of Urology, New York, NY, ²Columbia University Irving Medical Center Department of Obstetrics and Gynecology, New York, NY

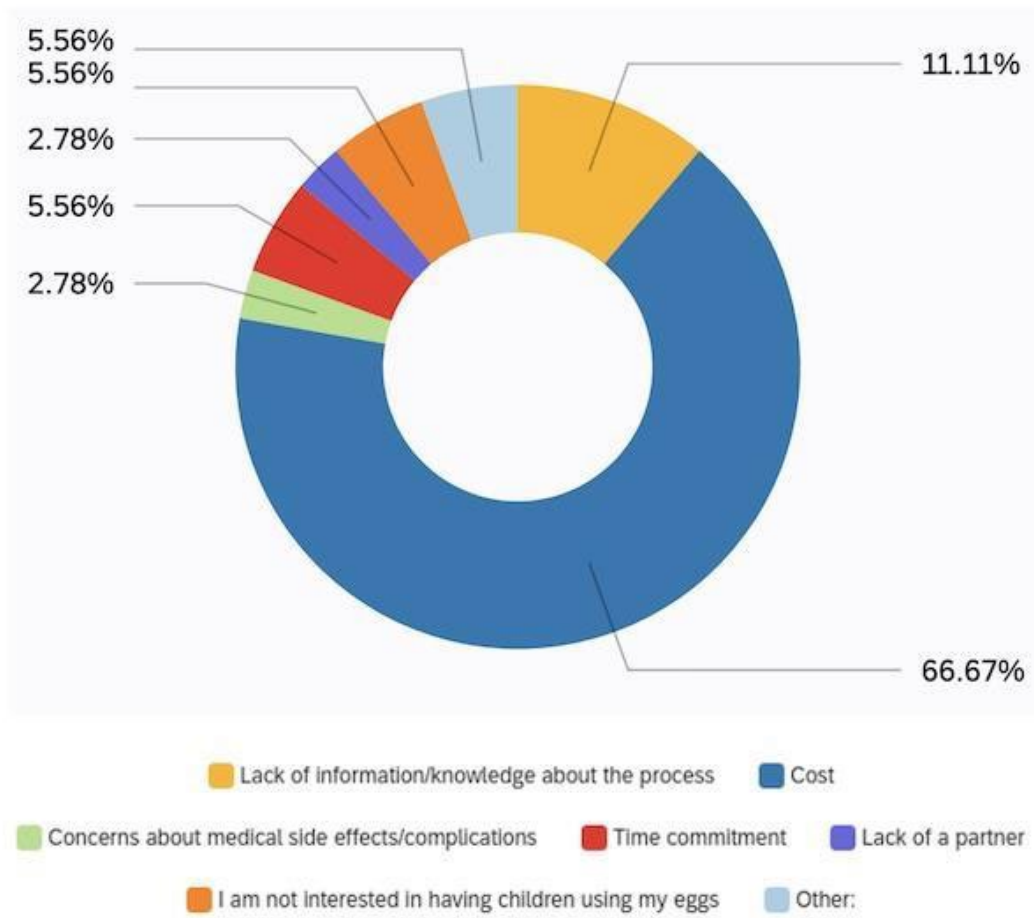
Introduction/Objective: To determine if female urology trainees are interested in egg freezing as a method of fertility preservation during graduate medical training and to identify barriers to egg freezing during this time.

Methods: An IRB-approved survey was distributed between January - May 2022 to current female urology residents and fellows through the Society of Women in Urology (SWIU) e-mail list-serv. Survey questions assessed a variety of demographic, training-specific and reproductive factors. Responses were saved without identifying information and analyzed with descriptive statistics.

Results: 39 complete responses from female urology trainees were analyzed. Mean age was 30.9 (27-37) years. 37 respondents (94.9%) were residents and 2 (5.1%) were fellows. 76.3% of respondents had chosen to intentionally delay pregnancy because of their training/career and 91.9% of respondents were concerned that their training would compromise their future fertility. Excluding respondents who had already undergone egg freezing (n = 3), 58.3% of respondents were interested in pursuing fertility preservation with egg freezing during training. Of respondents interested in egg freezing, barriers to doing so, in order of greatest impact, included: 1) cost, 2) lack of information/knowledge about the process, and 3) time commitment required (**Figure 1**). 65.7% of respondents interested in egg freezing would be willing to pursue this process at a total out-of-pocket cost of \$1000-\$2000. 69.2% of respondents expressed interest in obtaining a no interest or very-low interest loan during training to pursue egg freezing. 79.5% of respondents believed that graduate medical education should provide both education and financial support for egg freezing during post-graduate medical training and 84.6% of respondents would prefer to be employed by an employer offering egg freezing as part of a benefits package.

Conclusions: The majority of female urology trainees in our cohort had intentionally delayed pregnancy plans during post-graduate training and were concerned their training would compromise future fertility. More than half of female trainees in our cohort expressed interest in pursuing egg freezing as a method of fertility preservation during training; but high cost was cited as the most impactful barrier to doing so. Nearly all respondents expressed interest in increased education and financial aid to pursue egg freezing during training. Understanding the interests and concerns of trainees and the challenges they face in achieving their fertility goals can inform institutional policies on the recruitment and retention of female trainees.

Figure 1: Most impactful barrier to pursuing egg freezing cited by respondents.



Funding: N/A

Reference #7586

WOMEN IN MEDICINE: CAREER VS FAMILY. CAN WE HAVE BOTH?

Niki Parikh, MD, MBA, MSBA, Manaf Alom, MBBS, Mohamed Ahmed, MB, B.CH, Maraika Robinson, MD, Sarah McGriff, Elizabeth Olive, Sevann Helo
Mayo Clinic- Rochester

Introduction: Women in healthcare are faced with unique challenges that may increase the risk of infertility including irregular work hours, occupational hazards due to radiation or chemicals, and advanced maternal age.

Objective: We therefore sought to investigate live birth rates of female healthcare workers presenting with infertility compared to their non-healthcare counterparts.

Methods: After obtaining IRB approval, a retrospective review of hospital employees and partners presenting for fertility evaluation between 2013-2019 was conducted. Patient age, BMI, history of previous live birth, occupation, use of assisted reproductive technology, and female fertility factor were recorded. Couples with at least 12 months of follow up and documented semen analysis were included in the study. Normal semen parameters were defined by World Health Organization 2010 criteria. Logistic regression analysis was conducted to identify factors associated with increased likelihood of live birth.

Results: Of 934 female partners identified, 445 were healthcare workers and 489 non-healthcare workers. Female age, BMI, smoking status, and history of previous live birth were not statistically significant between groups. No differences in male partner age, BMI, semen parameters and presence of male factor were noted. As an overall group, female age, male age, and abnormal concentration were noted to impact live birth rates ($p < 0.016$). Live birth rates were higher in female health care workers compared to non-healthcare workers, 76.1 vs. 69.6%, respectively, $p = 0.042$. The cohort was further analyzed to determine differences in females holding a Doctor of Medicine (MD) and other medical occupations (91 MDs vs 357 other occupations). Live birth rates, pregnancy complications, and preterm labor were not statistically significant, however MDs were found to have higher rates of assisted reproductive technology use (IUI or IVF) and were more likely to be older at time of evaluation ($p = 0.0015$). After controlling for age at delivery, female physicians were still more likely to utilize ARTs, but this was no longer statistically significant ($p = 0.0806$).

Conclusion: In this cohort of hospital employees, female healthcare workers had a higher live birth rate despite no differences in age, BMI, female factor infertility, use of ART, or male partner factors. However, when the subgroup of female hospital employees was further analyzed, MDs were noted to have higher use of assisted reproductive technologies and older age. This indicates increased difficulty achieving pregnancy, likely a reflection of advanced maternal age. Further research is needed to identify subgroups within the healthcare population that may be at greater risk for infertility.

Funding: N/A

Reference #7587

DOES RURAL RESIDENCY IMPACT THE TREATMENT AND OUTCOMES OF LOCALLY INVASIVE AND LOCALLY ADVANCED BLADDER CANCER IN LOUISIANA?

Megan Escott¹, TingTing Li², Mei-Chin Hsieh², Scott Delacroix Jr³, Jessie Gills³, Xiao-Cheng Wu⁴, Mary E Westerman³

¹*School of Medicine, LSU Health Sciences Center - New Orleans, New Orleans, Louisiana,* ²*LSU Health Sciences Center New Orleans, New Orleans, LA.,* ³*Department of Urology, LSU Health Sciences Center - New Orleans, New Orleans, Louisiana,* ⁴*School of Public Health, Louisiana State University Health Sciences Center, New Orleans, LA, USA*

Introduction and Objectives

Bladder cancer (BCa) will be newly diagnosed in 81,000 people this year, making it the sixth most common cancer in the United States. It is well-established that stage at diagnosis, gender, and race are independent predictors of cancer-specific outcomes. There remains a need, however, to characterize additional factors that influence BCa treatment and outcomes. We investigated the effect of urban and rural residency status on a patient's likelihood of receiving standard of care in Louisiana and its impact on survival outcomes in patients with locally invasive or locally advanced BCa.

Methods

Using the Louisiana Tumor Registry, we identified American Joint Committee on Cancer (AJCC) stage II or III, microscopically confirmed BCa diagnoses in Louisiana residents between 2014 and 2018. Standard of care was defined as transurethral resection of bladder tumor (TURBT) followed by radiation and chemotherapy, radical cystectomy and chemotherapy, or radical cystectomy (for stage II disease only). Multivariable logistic regression analyses were performed to assess the impact of independent variables on receiving standard care. Kaplan-Meier method was used for survival analysis. Multivariate Cox proportional hazard analysis was performed to identify independent predictors of overall and cancer-specific mortality. All analyses were performed using SAS statistical software (version 9.4; SAS Institute Inc). All statistical tests were 2-sided, with a P value <.05 used to identify statistical significance.

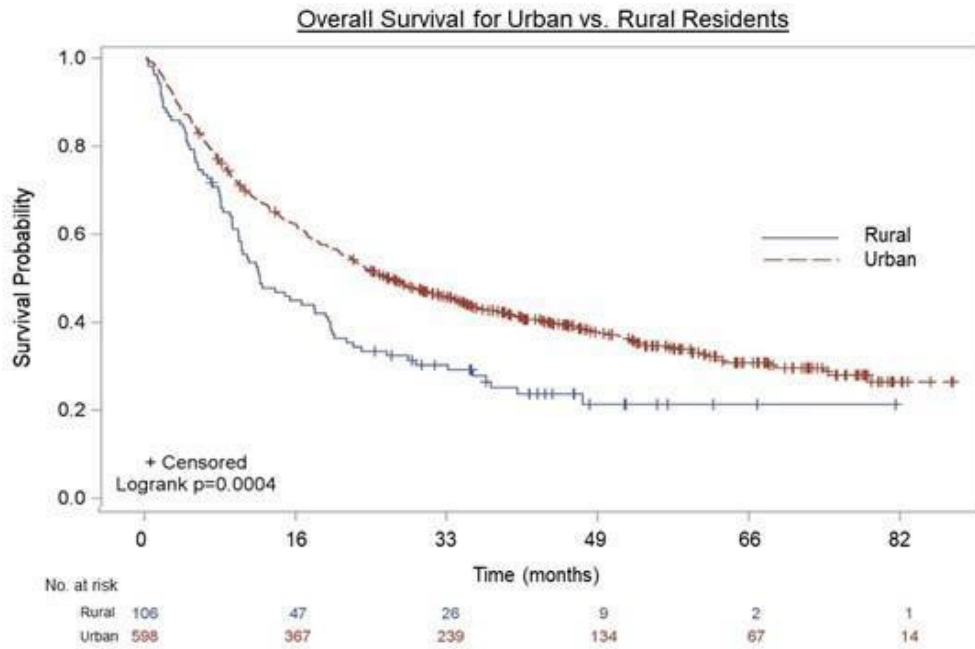
Results

704 patients met inclusion criteria, with 598 (85%) living in urban and 106 (15%) living in rural settings. After controlling for race, socioeconomic status (SES), and insurance coverage, there was no significant difference in the probability of urban and rural residents receiving the standard of care for definitive management. However, rural residency was independently associated with an increased risk of cancer-specific mortality (HR 1.60, p<0.02). Additionally, the median overall survival for rural residents was 13 months (95% CI [10, 20]) compared to 27 months (95% CI [23, 33]) for urban residents (Figure).

Conclusions

Prior studies using different statewide databases reported SES and insurance coverage, instead of rural residency alone, were associated with decreased cancer specific survival. A recent study using national census data, however, showed rural patients had significantly higher overall mortality and marginally increased cancer-specific mortality, calling for further epidemiologic investigations. Our work contributes to the body of evidence suggesting that rural residency may independently contribute to

cancer outcomes even when patients receive the standard of care, highlighting the need for continued investigation on the disparities in BCa outcomes.



Funding: NCI's Surveillance, Epidemiology, End Result (SEER): HHSN261201800007I/HHSN26100002.
CDC's National Program Cancer Registries (NPCR): NU58DP006332

Reference #7613

ATTITUDES AND PERCEPTIONS AMONG SWIU MEMBERS REGARDING *DOBBS V. JACKSON WOMEN'S HEALTH ORGANIZATION*

Chloe Peters, MD¹, Jenney Lee¹, Sarah Holt¹, Erika Wolff, PhD¹, John Gore, MD¹, Casey Seideman, MD²
¹University of Washington, ²Oregon Health Science University

Introduction: *Dobbs v. Jackson Women's Health Organization* was a June 2022 U.S. Supreme Court decision that ruled that the U.S. Constitution does not guarantee the right to an abortion, reversing *Roe v. Wade* and *Planned Parenthood v. Casey*. Multiple states have subsequently passed abortion restrictions up to and including total abortion bans. We surveyed members of the Society of Women in Urology (SWIU) to understand attitudes among urology trainees and practicing urologists following the *Dobbs* ruling regarding impact on their practices and professional decision-making.

Methods: An IRB-approved REDCap survey was distributed to SWIU members via list-serve email and social media on 9/2/2022. Participants included medical students, urology residents, urology fellows, and practicing and retired urologists over 18 years of age. Responses were anonymous and collected in aggregate. Participant responses were characterized with descriptive statistics.

Results: 300 respondents completed the survey. Demographic characteristics of respondents are shown in the Table. 89% (N=266) disagree or strongly disagree with the *Dobbs* decision and 25% (N=75) are not confident they could access abortion care where they live. With respect to professional decision-making, 45% of residents and fellows (N=41) may have changed the programs or rank order if current laws were in place at the time of their match. Among practicing urologists, 39% (N=74) reported that if *Dobbs* had happened when looking for their current position, they would have chosen a different job. 61% (N=184) of respondents reported the *Dobbs* ruling will impact future decisions where they choose their next job.

Of those who could get pregnant or have a partner get pregnant, 32% (N=76) stated that *Dobbs* has impacted their family planning decisions. The majority of respondents reported that if they lived in a state with restrictive laws, they would want their employer to cover costs related to out-of-state abortion care, if needed (82%, N=146).

Although only 12% (N=37) of responding SWIU members feel the *Dobbs* decision will reduce the number of women entering urology, 70% (N=202) express concern it will decrease the number of women entering residency programs in states with restrictive abortion laws.

Conclusion: The *Dobbs* ruling will have a significant impact on the urology workforce. Trainees may alter family planning goals and change how they rank programs in states with restrictive abortion laws. Practicing urologists will consider state laws on abortion when choosing jobs. Respondents strongly desire employers to provide financial and/or logistical assistance for employees requiring out-of-state abortion care.

Demographics	n (%)
Total Respondents	300
Level of Training	
Medical Student	22 (7.3)
Resident	65 (21.7)
Fellow	26 (8.7)
Practicing urologist	182 (60.6)
Retired urologist	5 (1.7)
Age	
18-24	5 (1.7)
25-34	112 (37.3)
35-49	132 (44)
50+	51 (17)
Race	
Asian	58 (19.3)
Black	11 (3.7)
Caucasian	209 (69.6)
Hispanic	8 (2.7)
Other	14 (4.7)
Gender	
Female	279 (93)
Male	19 (6.3)
Other	2 (0.7)
Relationship Status	
Single	50 (16.7)
Married/partnered	242 (80.6)
Separated/divorced/widowed	8 (2.7)

Funding: N/A

Reference #7625

DON'T SKIRT THE QUESTION: THE USE OF LEAD SKIRTS IN THE OR TO DECREASE RADIATION EXPOSURE

Katelyn Klimowich¹, Jacob Thatcher¹, Shawon Akanda¹, Thomas Mueller²

¹Jefferson NJ, ²NJ Urology

Introduction: Fluoroscopy is an important tool in endourology and is used often throughout urologic training. Extrapolated data collected from our OR using real time dosimeters showed that despite using low dose technology, leaded aprons, and thyroid shields, the standard dose a resident receives over one year is 11% over the annual radiation dose limit to the eyes and near the annual dose limit for the entire body. The aim of our study is to reduce radiation exposure to the primary surgeon when a lead skirt is installed around the operating table.

Methods: We placed lead skirts around the operating table and used Radex One Quarta Geiger dosimeters at the level of the eyes, buttocks, anesthesia outer chest pocket, and adjacent to the x-ray tube to collect radiation exposure levels during procedures. We compared these data with data collected using the same configuration without lead operating table skirts.

Results: Radiation exposure to various body parts during eighty-one endourologic procedures over a six-month period was tabulated. The highest amount of radiation received was to the eyes and buttocks. Installing a lead skirt around the table attenuated the radiation scatter to all areas. Most notably, radiation to the eyes and buttocks was reduced by nearly 500% and 200%, respectively. Though these data are preliminary, they reflect a potential intervention that is simple yet revolutionary in fluoroscopy.

	Without Skirt (µgy)	With Skirt (µgy)
Glasses	8.42	1.46
Buttocks	1.53	0.7
Anesthesia lead chest	---	1.35
X-ray tube	13.41	5.68

Table 1. Radiation to various parts of the body. Dosimeters were placed during various endourologic procedures and the average values recorded from each body part listed.

Conclusion: Residents and anesthesia personnel are exposed to high amounts of radiation during fluoroscopic procedures. A lead skirt around the operating table significantly reduces radiation scatter in the operating room. This represents a cheap and innovative improvement to operating room safety and can be used across multiple specialties. The effects of radiation to anesthesia personnel are largely disregarded and future aims of the study will look to reduce exposure to these staff members as well as to the eyes of the primary surgeon.

Funding: Osteopathic Heritage Fund

Reference #7629

UNDERSTANDING PATIENT EXPERIENCES WITH OVERACTIVE BLADDER

Hannah Sitto¹, Casey Brodsky², Daniela Wittmann², Lauren Wallner², Courtney Streur², Melissa DeJonckheere², John Stoffel², Aruna Sarma², J. Quentin Clemens², Giulia Lane²

¹Central Michigan University, ²University of Michigan

Introduction and Objectives: Overactive bladder (OAB) is highly prevalent, affecting millions of Americans, and poses a significant symptom burden. The purpose of this study was to understand lived patient experiences with OAB and the impact of these experiences on OAB treatment.

Methods: People with symptoms of OAB were recruited from a tertiary care clinic and from an online health research portal to complete semi-structured interviews. The interviews were recorded, transcribed and inductively coded by two researchers. Excerpts were then analyzed and discussed to build themes by three researchers.

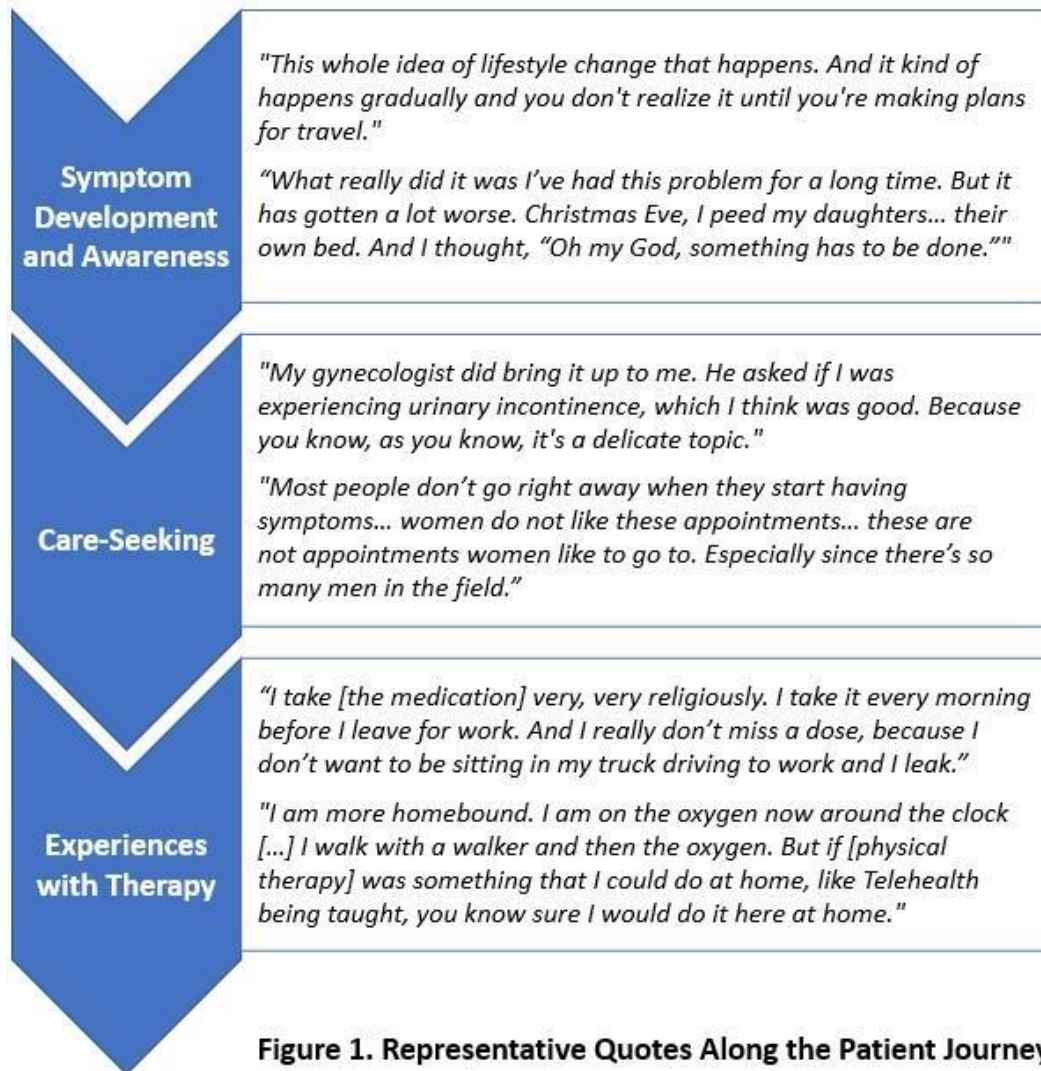
Results: We performed 19 interviews and identified several key themes that were central to the patient experience, including symptom impact and severity, knowledge, stigma, self-efficacy, and regret. We considered these themes along the following stages of the patient journey through OAB care:

Symptom Development and Awareness: When OAB symptoms are not impeding quality of life or are managed behaviorally, patients are less likely to seek care. The routine of self-care is insidious and normalized by patients, making realization of a lifestyle that is centered around voiding less obvious to patients. Participants noted restrictions on all aspects of life including travel, visiting with family, fluid intake, sleep, occupation and overall enjoyment of life. Adjectives used to describe symptom impact included “annoyance, depression, humiliation and desperation.”

Care-Seeking: Participants expressed coping behaviors during onset and gradual worsening of symptoms, however many recounted a “sentinel event,” such as an embarrassing incontinence event that heightened their perception of severity and served as a cue to action. Other reasons for care-seeking included being advised by friends or screening at routine primary care visits. Reasons for care-seeking delay included lack of OAB knowledge/awareness, stigma, and embarrassment. Many participants expressed desire for their primary care provider to initiate conversations about overactive bladder and incontinence.

Experiences with Therapy: Participants expressed recognition that treatment outcomes depended on their engagement with care and self-efficacy, this was evidenced by participants expressing regret for their lack of self-advocacy and self-efficacy. Participants highlighted internal barriers (forgetfulness, doubting treatment effectiveness) and external barriers (comorbidities, children, COVID-19, insurance and clinic location) to therapy adherence. Among participants with high self-efficacy, internal cues of fear of treatment failure, and external cues through calendar tools and social support networks, facilitated treatment compliance (Figure 1).

Conclusions: Living with OAB affects patients physically, mentally, and socially. Gaining a better understanding of OAB experiences can help physicians tailor their practice to meet patients’ needs.



Funding: NIDDK K-12 (Lane)

Reference #7640

SEXUAL HARASSMENT IN UROLOGY: SWIU CENSUS FINDINGS

Megan McMurray, DO¹, Lourdes Guerrios-Rivera, MD^{2,3}, Arshia Sandozi, DO⁴, Smita De, MD, PhD⁵, Jessica Dai, MD⁶, Kelly Harris, MD⁷, Akanksha Mehta, MD⁸, Francesca Monn, MD¹

¹*Division of Urology, Southern Illinois University, Springfield, Illinois*, ²*Urology Section, Surgery Department, Veterans Administration Caribbean Healthcare System, San Juan, Puerto Rico*, ³*Surgery Department, Medical Sciences Campus, University of Puerto Rico*, ⁴*Division of Urology, Maimonides Medical Center, Brooklyn, New York*, ⁵*Department of Urology, Cleveland Clinic, Cleveland, Ohio*, ⁶*EvergreenHealth Urology Care, Kirkland, Washington*, ⁷*The James Buchanan Brady Urological Institute and Department of Urology, Johns Hopkins University School of Medicine, Baltimore, Maryland*, ⁸*Department of Urology, Emory University School of Medicine, Atlanta, Georgia*

Introduction & Objectives

Sexual harassment and gender discrimination toward female surgeons is a longstanding, well-recognized issue. Urologists often discuss topics of an intimate nature with their patients and routinely perform genital exams, putting them in a uniquely vulnerable position. As more women pursue training in urology, we must acknowledge the distinct challenges women urologists face within our specialty. The objective of this study was to evaluate the prevalence of sexual harassment of women urologists and trainees and to understand the factors associated with this behavior.

Methods

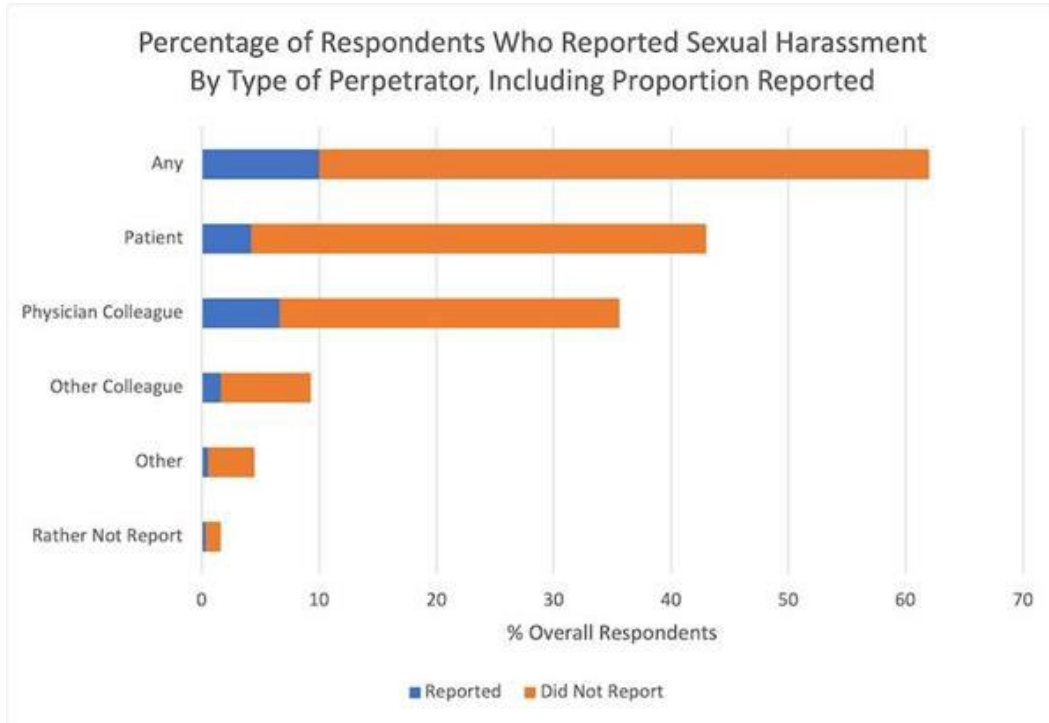
An electronic survey census was sent to all members of the Society of Women in Urology including residents, fellows, and women urologists practicing in the United States and territories. Surveys were also distributed to urology residency programs and via social media platforms. Responses were collected from February 2022 through May 2022. In addition to demographic data, we solicited information about whether respondents experienced sexual harassment and allowed for free-text descriptions of these events. Results were compiled and analyzed using descriptive statistics.

Results

There were 379 total female respondents with an average age of 43 (SD=18.6) years old. Of these, 75.0% were urologists in practice, 15.1% residents, and 9.8% fellows. 62.5% of respondents reported experiencing sexual harassment in training or in practice. Of those who reported experiencing sexual harassment, 70.9% described patient-perpetrated harassment, 59.5% had been harassed by a physician colleague, and 33.3% had experienced harassment from both sources. The incidence of harassment by each group overall, including rates of reporting, are summarized in Figure 1. Common themes included: comments about physician appearance or clothing, inappropriate sexual comments or questions, inappropriate physical touch, and sexual advances. Only 16.0% of respondents who had experienced sexual harassment chose to report it. Common reasons for not reporting included: presumption of institutional indifference, fear of retaliation, feeling it was not worth the time or effort, and a feeling of intimidation due to a power dynamic.

Conclusions

Sexual harassment of women urologists by patients and colleagues is common and grossly underreported. Creating environments in which women feel safe to report without repercussion and clinical settings in which sexual harassment is not tolerated by patients or physicians is critical as the number of women practicing urology increases.



Funding: N/A

Reference #7652

REPRODUCTIVE EXPERIENCES OF WOMEN IN UROLOGY: ANALYSIS FROM THE 2022 SOCIETY OF WOMEN IN UROLOGY CENSUS TASK FORCE

Tiffany Damm, MD¹, Arshia Sandozi, DO, MPH², Smita De, MD, PhD³, Akanksha Mehta, MD, MS⁴, Jessica Dai, MD⁵, Kelly Harris, MD⁶, Lourdes Guerrios-Rivera, MD^{7,8}, M. Francesca Monn, MD, MPH⁹

¹*Southern Illinois University School of Medicine, Department of Surgery, Division of Urology. Springfield, IL. USA,* ²*Maimonides Medical Center. Department of Surgery, Division of Urology. Brooklyn, NY.,*

³*Cleveland Clinic, Glickman Urological and Kidney Institute, Cleveland, OH.,* ⁴*Emory University School of Medicine. Department of Urology. Atlanta, GA,* ⁵*UT Southwestern Medical Center. Department of Urology. Dallas, TX. USA,*

⁶*Johns Hopkins University School of Medicine, The James Buchanan Brady Urological Institute and Department of Urology. Baltimore, MD. USA,* ⁷*Veterans Administration Caribbean Healthcare System. Surgery Department, Urology Section. San Juan, Puerto Rico,*

⁸*University of Puerto Rico, Medical Sciences Campus. Surgery Department. San Juan, Puerto Rico.,* ⁹*Southern Illinois University School of Medicine Department of Surgery, Division of Urology, Springfield, IL. USA.*

Introduction:

The percentage of female urologists in practice in the U.S. surpassed 10% in 2020 according to the American Urological Association (AUA) census; this number is expected to rise. Women are motivated to succeed in their careers, but face disproportionate challenges surrounding reproduction, childrearing, and other family responsibilities. It is unknown the number of women in urology who had children, at what point in their career, and how their employer or training program accommodated them.

Objectives: To determine childbearing practices of women in urology, and to identify specific challenges that women who choose to have children experience.

Methods: An electronic survey was sent to members of the Society of Women in Urology including residents, fellows, and female urologists practicing in the United States and U.S. territories via email and social media. The survey was distributed from February through May 2022 and included demographics, practice type, workplace, personal, and reproductive barriers to practice. Descriptive statistics were applied.

Results:

There were 379 responses received. The average age was 42.9 years (SD 18.6 years), and 71.0% self-reported white, 16.4% Asian or Asian American, and 6.3% African American. Most women urologists practiced in an urban location (63.5%) at an academic setting (55.7%) followed by private practice and hospital-employed settings. 67.2% felt that being female put them at a disadvantage for career advancement. Of the respondents, 68.7% have had children, with most having given birth either during training (54.3%) or after training (66.7%). Most respondents (78.0%) took 6 weeks or less for maternity leave. During pregnancy, women were offered redistribution of call, partner coverage of cases, coverage of overhead, decrease in productivity requirements or other accommodations (Figure 1). A significant number of women faced complications associated with pregnancy (29.4%), and 19.6% utilized reproductive assistance.

Conclusion:

Knowing how to best support women in urology who choose to build a family is imperative as more women enter the field. Urologists who experience pregnancy require time off, access to healthcare for complications associated with pregnancy, and reproductive assistance. The results of this survey show the current accommodations, none of which are specifically codified in AUA or Accreditation Council of Graduate Medical Education. It is also unknown what strategies to improve work-life balance are preferred or if these accommodations had an impact on career progression.



Funding: N/A

Reference #7656

Increasing Diversity in the Urology Workforce: the Michigan Urology Academy Experience

Laura Zebib¹, Sarosh Irani¹, Ganesh Palapattu², Salami Simpa², Meidee Goh²

¹University of Michigan School of Medicine, ²Department of Urology, Michigan Medicine, Ann Arbor, MI

Objective: The Michigan Urology Academy (MUA) was launched with the goal to increase exposure and provide mentorship to underrepresented in medicine (URiM) students interested in urology.

Methods: The two-day virtual mentorship program was piloted in June 2020, 2021, and 2022. The program targeted URiM students and med students without a home urology training program. Sessions included the “hidden curriculum” of the urology match, residency, and application logistics, handling micro- and macro-aggressions, and opportunities for engagement with Michigan faculty as well as other national mentorship programs (UReTER, R Frank Jones and Urology Unbound). Demographic information was collected and two post-event surveys were distributed 1 week and 3 months. Surveys assessed participants’ perception of the utility and effectiveness of the sessions using Likert scales and narrative feedback. Thematic analysis was performed on qualitative data. Fourth year med students were followed longitudinally to determine if they participated in the urology match and the outcome of the match.

Results: Over the last 3 years, MUA hosted 208 students from 104 medical schools. Participants identified as 46% (n=96) male, 53% (n=110) female, and <1% (n=1) gender non-conforming. Of these, 42.3% (n=88) identified as African-American/Black, 15% (n=31) Hispanic/LatinX, 12.5% (n=26) white, 19.2% (n=40) as Asian/Indian and 7.7% (n=16) as Middle Eastern/ North African. The majority of participants (54%) were in their fourth year of medical school, with 21.6% in third, 20.7% in second, <1% in first year, and 2.9% post-graduate. One third of participating students indicated that they did not have a home urology training program. Post-program survey was completed two time periods following the meeting: at 1 week and at 3 months. Initial survey results suggest that 100% of participants reported a high degree of satisfaction with the program and would recommend the program to a peer. At three months follow-up, respondents noted that MUA was most useful for finding a mentor (27%), networking with other applicants (44%), and serving as an introduction to the field of urology (23%). Overall, fourth year MUA participants (2020 and 2021 combined) matched at a higher rate than the national average (76.1% versus 70%).

Conclusion: Participants in MUA reported benefits including gaining greater exposure to the field of urology and networking opportunities. Further investigation into what impact this mentorship program has on applicant match rate is still needed. In addition, this program has affirmed a greater need to support URiM medical students from schools without a home urology residency.

Funding: N/A

Reference #7676

DISTRIBUTION OF DIAGNOSES AND THEIR RELATIONSHIP TO SURGICAL PROCEDURES IN FPMRS: DATA FROM THE AMERICAN BOARD OF UROLOGY

Patricia Maymi-Castrodad¹, Samuel Plaska², Giulia Lane¹, Alyssa Gracely³, Stephanie Daignault-Newton¹, J. Quentin Clemens¹

¹University of Michigan, ²Research Assistant, Department of Molecular and Integrative Physiology, University of Michigan, ³Chesapeake Urology

Introduction and Objective

We hypothesize that many Female Pelvic Medicine and Reconstructive Surgery (FPMRS) trained urologists clinical practices are not optimized to translate clinical volume into surgical procedures reflective of their surgical training. We aim to evaluate the distribution of diagnoses seen in office visits and the surgical procedures performed by FPMRS trained urologists.

Methods

We obtained the de-identified clinical practice logs of urologists who have applied ABU subspecialty certification in FPMRS from 2013 to 2021. These logs were inclusive of a subset of relevant FPMRS urologic ICD-9 codes and procedure CPT codes. We calculated a ratio of patient visits to procedure for common FPMRS procedures.

Results

From 2013 to 2021, 370 FPMRS practice logs were identified of which 295 (80%) were new applicants. The average age was 45 (SD 7.6) with 213 (58%) male surgeons.

The most common clinical diagnoses seen were overactive bladder (26.2%), urinary incontinence (30%), and benign prostatic hyperplasia (10.4%). Urologic infection (14.4%), pelvic organ prolapse (10.1%), neurogenic bladder (7.7%), and interstitial cystitis (1.0%) were less frequent.

The most common FPMRS procedures were cystoscopy (38%), prolapse repairs (4.9%), slings (3.8%) and sacral neuromodulation (3.6%).

Among the 364 urologists for which relevant procedure and clinical CPT codes were available, overall there were 1.33 (SD 0.80) clinic visits for each surgery performed. A total of 2.8 (SD 2.58) patients with incontinence were seen for every incontinence surgery performed, with 2.1 (SD 1.76) encounters for stress urinary incontinence for each SUI surgery performed. Urologists saw 1.7 (SD 1.40) women with prolapse per prolapse repair performed. Only 53% of FPMRS urologists performed complex abdominal reconstruction with a ratio of 31 visits (SD 47) for neurogenic bladder per abdominal reconstruction.

Conclusion: FPMRS trained urologists have robust practices reflective of their training. Overactive bladder and urinary incontinence are among the most common diagnoses managed by FPMRS-trained urologists, while pelvic organ prolapse and neurogenic bladder are less common. Diagnoses of stress urinary incontinence and pelvic organ prolapse are likely to result in surgical intervention whereas neurogenic bladder is often managed medically.

Funding: Medtronic Fellowship Educational Grant - AWD016079