

FREE PREVIEW

The Efficient Urologist

How to Use AI to Cut Down Admin Time

Inside this free preview: the Introduction + a complete chapter

A practical guide for UK urology registrars and consultants

George Shaker

Before you begin

Thank you for reading. What follows is a genuine, unedited excerpt from *The Efficient Urologist* — not a teaser. You get the book's Introduction, which names the problem honestly, and one complete chapter from the engine room: the Stent Tracker, the workflow with the clearest moral case in the whole book.

Read it in ten minutes. If it speaks to your Tuesday nights, the full book is waiting at the end — eighteen chapters, clinic by clinic, plus the personal system that ties them together.

“By the final page, you should never again be the surgeon typing letters at midnight.”

INTRODUCTION

The Letter You Wrote at Midnight

It is 11:47 on a Tuesday night. The house is quiet. Your family went to bed hours ago. And you — a highly trained urological surgeon, someone who can navigate a ureteroscope through a tortuous ureter or counsel a frightened man through a new diagnosis of prostate cancer — are sitting at a laptop, typing clinic letters.

You saw twenty-two patients today. You dictated what you could between them, in the ninety-second gaps the template allowed. Now you are correcting the dictation errors, chasing the bloods you meant to request, checking whether the stent you placed three weeks ago was ever booked for removal, and trying to remember whether you actually told the GP to repeat the PSA in three months or whether that thought evaporated somewhere between patients fourteen and fifteen.

This is not a failure of discipline. It is not a failure of organisation. You did not miss the lecture at medical school on efficient administration, because there was no lecture. This is the predictable result of a system that has quietly doubled your job description without telling you, without paying you for it, and without giving you a single tool designed to carry the load.

Here is the uncomfortable truth at the heart of this book: the modern UK urologist has two jobs. The first is the one you trained for — diagnosing, operating, counselling, leading. The second is an unpaid, unacknowledged role as a data clerk, typist, tracker, chaser and form-filler. The second job is eating the first. It is eating your evenings, your weekends, your training time, your research ambitions, and — for a worrying number of colleagues — your health and your love of the specialty itself.

The good news, and the reason this book exists, is that for the first time in the history of the NHS, the second job can be largely delegated. Not to a person — there is no army of secretaries coming — but to well-designed artificial intelligence working under your supervision. AI will not consent your patients, will not make your operative decisions, and will not replace your judgement. What it can do, today, is draft your letters, structure your clinics, track your stents and biopsies so nothing is ever forgotten, and review your correspondence before it leaves the building. In other words: it can take back the second job, so you can return to the first.

This book is written for UK urology registrars and consultants. It is deliberately practical. Part I names the problem honestly — the administrative deficit in the NHS, what it is doing to waiting lists, to patients, and to you. Part II teaches the principles: what AI genuinely can and cannot do in clinical administration, how to use it safely and lawfully within NHS information governance, and the single mindset shift that separates clinicians who save hours every week from those who

dabble and give up. Part III is the engine room: chapter by chapter, clinic by clinic — LUTS, stones, female urology, paediatrics, oncology, andrology, haematuria — plus the three safety-critical workflows that haunt every department: stent tracking, biopsy tracking and letter quality. Throughout Part III, I will show you these workflows using a suite of purpose-built tools I developed for exactly this job, because abstract advice without a worked example is how good intentions die. Part IV puts it all together into a personal system, and asks the most important question of all: what will you do with the hours you get back?

Read this book in an evening. Apply it within a week. The aim is simple and unapologetic: by the final page, you should never again be the surgeon typing letters at midnight.

Let us begin with the problem — because you cannot fix what you have not honestly named.

The Stent Tracker — Ending the Forgotten Stent, Permanently

Every urologist carries a version of the same story. A patient re-presents — months, sometimes years, after a ureteric stent was placed — with loin pain, infection, haematuria. Imaging reveals the stent, still in place, now encrusted, sometimes calcified into a stone burden requiring multiple procedures to clear. The notes are reviewed. The stent was placed appropriately, documented appropriately, and then — nothing. A removal was intended; no system existed to guarantee it. The patient moved house, the letter went astray, the clinic was rescheduled, the spreadsheet had a gap, the person who kept the list left.

The forgotten stent is the purest example in all of urology of harm caused not by medicine but by administration. It is never a failure of clinical knowledge — every urologist knows stents must come out. It is a failure of memory infrastructure: the absence of a system that holds the commitment when every human involved has, reasonably and inevitably, moved on to other things. Departments have fought it with registers, spreadsheets, stickers on theatre lists and the vigilance of specialist nurses, and these measures help — but anything maintained by hand fails exactly the way the original process failed: at the gaps.

The principle is absolute: a stent insertion without a tracked removal commitment should be as unthinkable as an operation without consent. Insertion and the removal plan must be captured as a single inseparable event, held by a system that does not forget, does not take leave, and escalates with increasing insistence as the deadline approaches and — especially — after it passes.

The Stent Tracker does exactly this, and deliberately nothing else. Every stent is logged at insertion — patient, side, date, intended dwell time, planned removal route — taking seconds in theatre recovery or at the point of documentation. From that moment the commitment exists outside any individual's memory. The tracker maintains the live picture every department has always wanted and almost none has had: every stent currently in situ, every one approaching its window, and — in red, unmissable, impossible to quietly ignore — every one overdue. Approaching deadlines surface in time to book the removal; overdue stents escalate until a human acts and records the action. Removal closes the loop with an auditable record. The questions that once required an afternoon of cross-referencing — how many stents do we have in patients right now? Is anyone overdue? — are answered in one glance, every day, by design.

The arithmetic of adoption is almost embarrassing. The cost is seconds per stent. The benefit is the permanent elimination of one of the specialty's most notorious, most litigated, most patient-harming failure modes — plus the audit trail that proves it, which clinical governance committees receive with something close to joy. If your department adopts a single tool from this

book, the Stent Tracker is the one with the clearest moral case: it is not about saving your time. It is about the patient who, in the untracked version of the future, comes back encrusted. In the tracked version, that patient simply never exists.

Keep reading.

You've read the problem and one of the three tools that solves it. The full book gives you the whole system — clinic by clinic, workflow by workflow.

Part I — The Problem

The second job nobody trained you for · the admin deficit · the human cost and the burnout spiral.

Part II — The Shift

What AI actually is (and isn't) · safe, legal and defensible inside NHS governance · from doing admin to supervising it.

Part III — The Practice

LUTS · stones · female urology · paediatrics · uro-oncology · andrology · haematuria — plus the Stent Tracker, the Biopsy Tracker and the Clinic Letters Reviewer.

Part IV — The Efficient Urologist

Building your personal system · and the most important question of all: what will you do with the hours you get back?

Get the full book

The Efficient Urologist — read it in an evening, apply it within a week.

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About the author

George Shaker is a urology specialist who built the tools and workflows in this book because he was the surgeon typing letters at midnight — and refused to accept that this was simply the job now. The tools assist with administration; they never replace clinical judgement.

This preview provides general information on the use of AI in clinical administration. It does not constitute clinical, legal or regulatory advice. Responsibility for all clinical decisions and correspondence remains with the treating clinician at all times. Readers must comply with their organisation's information governance policies, UK data protection law and GMC professional standards.