Division of Urology

The Schulich School of Medicine & Dentistry
Western University

# Resident Handbook

Revised: August 2024

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# UROLOGY AT WESTERN UNIVERSITY

The Division of Urology at Western University was established in 1954 when Dr. Lloyd McAninch was appointed Chief of the newly created subdivision of General Surgery. Dr. McAninch received his training in General Surgery at Western University and Victoria Hospital, and in Urology under Dr. Eldon Busby, a pioneer in Southwestern Ontario. He furthered his urology training in Toronto and as a traveling Fellow in the United States of America.

The late 1960s brought the excitement of renal transplantation to Western University, with Dr. McAninch leading animal research and developing a dialysis unit at Victoria Hospital. In 1966, three human kidney transplants were performed as a collaborative effort involving Urologists, Vascular Surgeons, and Nephrologists. From 1970-1972, the face of the Division of Urology changed significantly with the construction of the University Hospital campus, joining the relocated Medical School of Western University. The Division of Urology at University Hospital was designed as a Nephro-Urological unit from the beginning. Renal transplantation became a major component of the multi-organ transplant program and was consistently performed by Urologists.

Dr. McAninch retired in 1974. His first two residents, Dr. Jack Wyatt and Dr. Jack Sales, became Chiefs of Urology Services at Victoria Hospital and St. Joseph's Hospital, respectively. Upon Dr. McAninch's retirement, Dr. Wyatt became Professor and Chair of the Division of Urology at Western University. During his tenure as Program Director, the residency program expanded and formalized its training.

In 1990, Dr. Joseph Chin became Chair and Program Director of Urology, consolidating the training program to two sites: St. Joseph's Health Centre and London Health Sciences Centre. Dr. Chin served as Program Director until 1993, when Dr. John Denstedt took over the role.
Dr. Denstedt, who had completed his medical degree at The University of Western Ontario (now Western University) in 1982 and his residency in Urology at Western from 1983 to 1987, returned to London in 1990 after completing a fellowship in Endourology at Washington University in St. Louis. He served as Program Director from 1993 to 1998 and later became Chair and Chief of the Department of Surgery at Western University in 2002, a position he held for 14 years.

Dr. Hassan Razvi succeeded Dr. Joseph Chin as Chair and city-wide Chief of Urology from 2005-2019, overseeing all three sites: St. Joseph's Hospital, and the Victoria and University Hospitals of the London Health Sciences Centre. In 2019, Dr. Alp Sener transitioned from Program Director to Chair of Urology at the Schulich School of Medicine & Dentistry, Western University, and Chief of Urology at London Health Sciences Center and St. Joseph's Health Care London.

## PROGRAM DIRECTOR ROLE

- **1974**: Dr. Jack Wyatt served as Program Director
- **1990-1993**: Dr. Joseph Chin served as Program Director
- **1993-1998**: Dr. John Denstedt served as Program Director
- **1998-2005**: Dr. Hassan Razvi served as Program Director
- **2005-2009**: Dr. Jonathan Izawa served as Program Director
- **2010-2014**: Dr. Gerald Brock served as Program Director
- **2014-2019**: Dr. Alp Sener served as Program Director
- **2019-2022**: Dr. Sumit Dave served as Program Director
- **2022-Present**: Dr. Peter Wang is the current Residency Program Director

The Urology website can be found at: https://www.schulich.uwo.ca/urology
Please visit this site for all up to date information regarding schedules, calendars, meeting notices and general information.

# CURRENT UROLOGY FACULTY

| MEMBERS | OFFICE | SECRETARY | PHONE | EMAIL |
|---|---|---|---|---|
| Dr. Alp Sener<br>Chair/Chief | University Hospital<br>Room C4-208 | Angela Gough | 33352 | alp.sener@lhsc.on.ca<br>angela.gough@lhsc.on.ca |
| Dr. Peter Wang<br>Program Director (PD) | Victoria Hospital<br>Room B1-132 | Victoria Gast | 76584 | peter.wang@lhsc.on.ca<br>Victoria.gast@lhsc.on.ca |
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| Dr. Sumit Dave | Victoria Hospital<br>Room B1-190A | Angela Gannon | 58439 | sumit.dave@lhsc.on.ca<br>angela.gannon@lhsc.on.ca |
| Dr. John Denstedt | St. Joseph's Hospital<br>Room B4-657 | Robyn Colford | 66036 | john.denstedt@sjhc.london.on.ca<br>Janine.yule@sjhc.london.on.ca |
| Dr. Melissa Huynh | Victoria Hospital<br>Room E2-650 | Carol Gerster | 58451 | Melissa.huynh@lhsc.on.ca<br>Carol.gerster@lhsc.on.ca |
| Dr. Brant Inman | Victoria Hospital<br>Room E2-650 | Nikol Burlie | 55643 | Brant.inman@lhsc.on.ca<br>Nikol.burlie@lhsc.on.ca |
| Dr. Jonathan Izawa | Victoria Hospital<br>Room E2-650 | Traci DevLugt | 58550 | jonathan.izawa@lhsc.on.ca<br>traci.devlugt@lhsc.on.ca |
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| Dr. Stephen Pautler | St. Joseph's Hospital<br>Room B4-673 | Michelle Demaiter | 66384 | stephen.pautler@sjhc.london.on.ca<br>michelle.demaiter@sjhc.london.on.ca |
| Dr. Nicholas Power | Victoria Hospital<br>Room E2-650 | Tawnya Murray | 76787 | nicholas.power@lhsc.on.ca<br>tawnya.murray@lhsc.on.ca |
| Dr. Hassan Razvi | St. Joseph's Hospital<br>Room B4-656 | Melanie Van Damme | 66259 | hrazvi@uwo.ca<br>melanie.vandamme@sjhc.london.on.ca |
| Dr. Blayne Welk | St. Joseph's Hospital<br>Room B4-671 | Brenda Hodgins | 66367 | blayne.welk@sjhc.london.on.ca<br>brenda.hodgins@sjhc.london.on.ca |
| Kimberly Nitz<br>Program Administrator | St. Joseph's Hospital<br>Room B4-654 | | 64405 | kim.nitz@sjhc.london.on.ca |

| HOSPITAL MAILING ADDRESSES: | | |
|---|---|---|
| London Health Sciences Centre<br>Victoria Hospital<br>800 Commissioners Road<br>London, ON N6A 4G5 | London Health Sciences Centre<br>University Hospital<br>339 Windermere Road,<br>London, ON N6A 5A5 | St. Joseph's Hospital<br>268 Grosvenor Street<br>London, ON N6A 4V2 |

| **Research:** | | | |
|---|---|---|---|
| Dr. Jeremy Burton | Lawson Research Institute,<br>St. Joseph's Hospital | x 61365 | Jeremy.burton@lawsonresearch.com |
| Dr. Jessica Prodger | Epidemiol & Biostats<br>Microbiology & Immunology | x 84743 | jprodge@uwo.ca |

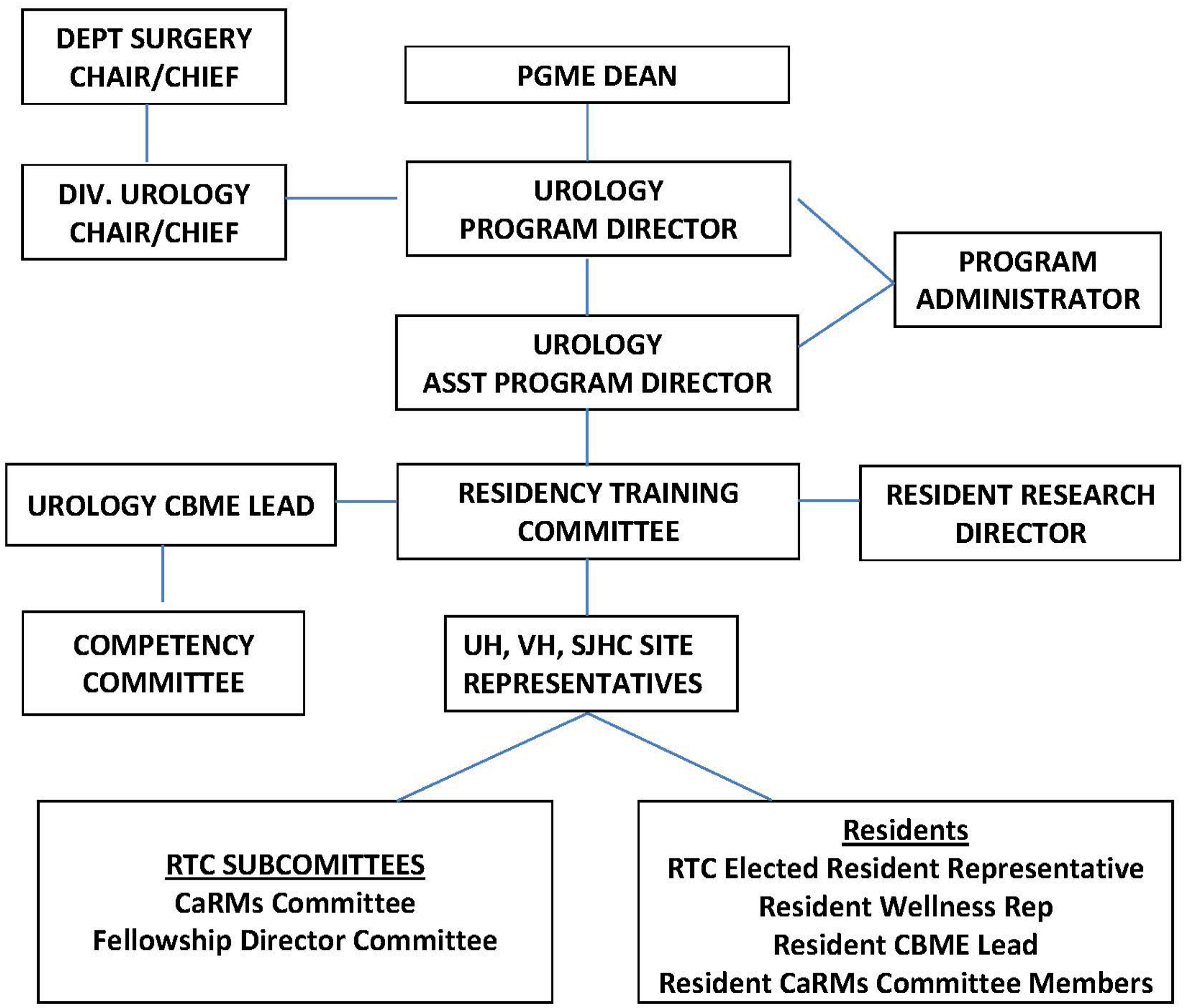
## RESIDENCY TRAINING COMMITTEE MEMBERSHIP 2024-2025

| | |
|---|---|
| Dr. Peter Wang | Urology Program Director<br>Director, Surgical Education/Simulation |
| Dr. Jeffrey Campbell | Assistant Program Director<br>Chair – Competence Committee |
| Dr. Alp Sener | Chair/Chief Urology<br>LHSC-University Hospital faculty representative |
| Dr. Nicholas Power | Wellness Faculty Representative<br>LHSC-Victoria Hospital faculty representative |
| Dr. John Denstedt | SJHC faculty representative |
| Dr. Stephen Pautler | Resident Research Director |
| Kimberly Nitz | Urology Program Administrator |
| Haider Abed | Senior Resident Representative |
| Victoria Turnbull | Resident Wellness Representative |

## COMPETENCY COMMITTEE MEMBERSHIP 2024-2025

| Position | Name | Site |
|---|---|---|
| Chair | Dr. Jeffrey Campbell | Assistant Program Director |
| Member | Dr. Melissa Huynh | LHSC – Victoria Hospital |
| Member | Dr. Blayne Welk | St. Joseph's Hospital |
| Member | Dr. Jennifer Bjazevic | St. Joseph's Hospital |
| | Kimberly Nitz | Program Administrator |

## UROLOGY EDUCATION PROGRAM ORGANIZATION CHART



## Program Director / Assistant Program Director / Program Administrator Roles

**2024-2025** Dr. Peter Wang, Program Director
Dr. Jeffrey Campbell, Assistant Program Director
Kimberly Nitz, Program Administrator

| FIRST POINTS OF CONTACT FOR RESIDENTS: | |
|---|---|
| **Program Administrator**:<br><br>• **On-Call schedules (questions, changes)**<br>• **All education schedules**<br>• **Rotation schedules**<br>• **Vacation requests/concerns**<br>• **Elective proposals/questions/paperwork**<br>• **All administrative forms incl. reference forms**<br>• **Site Switches (approved by APD)** | **Program Director/Assistant Program Director**:<br><br>• **Safety concerns**<br>• **Personal/wellness concerns**<br>• **Education advice/career help**<br>• **Professionalism concerns**<br>• **Interpersonal conflicts**<br>• **Peer to peer positive feedback**<br><br>***Please adhere to this so the PD's do not receive unnecessary emails *** |

| Program Director Roles | Assistant Program Director Roles |
|---|---|
| 1. Resource for residents and faculty<br>2. Plan/organize resident research day with Research director<br>3. Organize/schedule biannual lap/surgical simulation courses and biannual OSCES<br>4. Develop and revise policies and procedures<br>5. Prepare documentation for accreditation<br>6. Develop/revise curriculum and program evaluation schedule<br>7. Prepare objectives and curriculum mapping (including EPA and CanMEDs)<br>8. Participate in Urology Finance Committee<br>9. Attend all Royal College/Department of Surgery/Division of Urology meetings<br>10. Chair, Residency Program Committee<br>11. Chair, Fellowship Director Committee<br>12. Chair, CaRMs Subcommittee<br>13. Complete FITERS annually<br>14. Attend bi-annual resident review meetings<br>15. Ad hoc meetings with residents<br>16. Attend annual ICRE conference | 1. Assist with Resident Research Day planning<br>2. Assist PD in organizing and scheduling biannual lap/surgical simulation courses and OSCEs<br>3. Plan and coordinate summer Olympics<br>4. Attend biannual Resident Review Meetings<br>5. Chair, Competence Committee<br>6. Chair Residency Program Committee in absence of PD<br>7. Coverage for PD if PD away<br>8. Member, CaRMs Subcommittee<br>9. Assist PA with resident rotation schedule and approve resident electives<br>10. Organize reading schedule<br>11. Assist with aspects of accreditation process<br>12. APD to attend annual ICRE conference if PD unable to attend |

**Program Administrator Roles:**

| | |
|---|---|
| 1. Resource for residents and faculty<br>2. All administrative forms incl. reference forms/letters<br>3. Coordinate and prepare all education schedules and activities<br>4. Rotation schedules<br>5. Prepare all documentation for accreditation | 6. Resident support (communication, schedules, call conversions, vacation requests, annual travel, reimbursement, electives, references)<br>7. Prepare and support all documentation for RTC, CC, orientation<br>8. Assist with all aspects of CaRMS process |

# SURGICAL FOUNDATIONS

Surgical Foundations is a Royal College of Physicians and Surgeons of Canada Accredited Residency Program that runs in parallel with the Urology program. Urology residents are automatically enrolled into this program in their first 2 years of residency:

- Surgical Foundations is an initial period of post-graduate training where a resident learns the fundamental skills of surgery. Nine surgical specialties participate in Surgical Foundations
- A resident completes the Surgical Foundations training over the first two stages of residency, while simultaneously training in their surgical specialty
- Two competence committees oversee resident progress, one for the Surgical Foundations' EPAs and one for the surgical specialty's EPAs - progress in one does not impact the other
- All Surgical Foundations EPAs must be completed before a resident can be promoted to the Core of Discipline stage of the surgical specialty
- The Surgical Foundations exam takes place approximately 15 months after the beginning of residency
- Success at the Surgical Foundations exam is not required for promotion to the Core of Discipline stage of the surgical specialty, but is required by the end of training

The course is designed for first year surgical residents in Cardiac Surgery, General Surgery, Orthopaedic Surgery, Plastic & Reconstructive Surgery, Urology, Otolaryngology – Head & Neck Surgery, Obstetrics/Gynaecology, Oral and Maxillofacial Surgery, Vascular Surgery, and Neurosurgery at Western.

The course outline includes:

- technical skills training
- ATLS certification
- an introduction to basic science
- an anatomy review
- an introduction of the CanMEDS roles as they relate to surgical specialties
- the principles of surgery seminars

Course Goals:
The intent of this program is to ensure all surgical residents achieve the course goals in an enjoyable and friendly learning environment. Upon completion of the course, the resident should be able to:

1. Demonstrate skill in performing basic technical surgical procedures
2. Demonstrate a knowledge of basic science and anatomy
3. Demonstrate a knowledge of the RCPSC CanMEDS roles (Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional)
4. Demonstrate their ATLS knowledge and skills in the clinical management of severe trauma cases Readings: Surgical residents must complete the required readings for all classroom and lab sessions

Note:
The following five resources listed below are the index resources from which the RCPSC Surgical Foundations exam is cross-referenced. Recommended Textbooks for RCPSC Surgical Foundations Examination:

1. Sabiston's Textbook of Surgery (19th Edition)
2. Schwartz's Principles of Surgery (9th Edition). Available through the LHSC Library as an electronic resource 3. Blood Easy 3. Available through the Ontario Regional Blood Coordinating Network via the following weblink: http://www.transfusionontario.org/index.php/en/bloody-easy-e-tools-acourses/bloody-easy-for-healthcare-professionals
3. ATLS Manual (Provided to residents prior to the ATLS Course)
4. Royal College Ethics Modules (http://www.royalcollege.ca/rcsite/bioethics/bioethics-cases-e) Assessment: Resident assessment is based on the following:
    a. OSCE Examination (25%)
    b. Skills Examination (25%)
    c. Written Examination (20%)

d. Assignments (20%)
e. Attendance at classroom and lab sessions (10%)
f. Successful completion of the Advanced Trauma Life Support course (ATLS)

Residents must receive a mark of at least 70 percent in the first year Surgical Foundations Program and obtain their ATLS certification to receive a passing grade.

If a resident fails the first-year program, the Surgical Foundations Program Director will discuss a remediation plan with the resident's Program Director.

Attendance: Attendance is required at all classroom and lab sessions
https://www.royalcollege.ca/en/eligibility-and-exams/exam-formats/surgical-foundations-exam-format.html

You will be given the Surgical Foundations exam objectives from the Department of Surgery Education Office.

For up-to-date Objectives of Surgical Foundations Training, please visit the Royal College of Physicians and Surgeons of Canada website at:
http://www.royalcollege.ca
Select the tab: *Credentials, Examinations & Accreditation*
Select: *Information by Specialty* from the dropdown menu
Under the Section *Information by Special Programs* select *Surgical Foundations* from the dropdown menu

## Surgical Foundations Seminars

The Royal College of Physicians and Surgeons holds the surgical Foundations exam each May. This is a one day long multiple choice exam written by PGY 2 general surgical and most subspecialty surgical residents, including Urology. In order to be eligible to write the Royal College specialty examination at the completion of training, the exam must be passed.

# YEAR SPECIFIC OBJECTIVES - UROLOGY

The general training objectives for Urology Residents in training across Canada have been outlined in a document formulated by the Specialty and Training Committee of the Canadian Urological Association. These objectives elaborate in detail the expected knowledge and technical acumen required to achieve a level of proficiency commensurate with successful completion of the Royal College Examinations and to be capable of competence in clinical practice.

The following objectives have been developed to assist trainees in reviewing their progress as they proceed though each rotation and year of clinical urology training at UWO. In addition, specific study objectives have been put together to help residents formulate a study schedule. The curriculum map (see appendix) details the number of EPA assessments required per year.

These specific objectives should be reviewed in conjunction with the more broad CUA training objectives.

## YEAR SPECIFIC OBJECTIVES - UROLOGY PGY 1-2 (JUNIOR RESIDENT)

### CLINICAL

The junior resident serves as an integral part of the hospital-based team. Residents at this level work in collaboration with the Senior/Chief residents and Consultants. Junior residents should be involved in all aspects of patient management through attendance in the outpatient clinics, Emergency Department, inpatient clinical teaching units (CTU) and operating rooms. The junior resident may be the first one called to see inpatient consultations. The resident should demonstrate the ability to manage urologic emergencies such as:

1. Urinary retention
2. Acute renal colic
3. The difficult catheterization
4. Acute scrotal pain
5. Priapism
6. Renal Failure

PGY1 and 2 residents should be able to demonstrate competent handling of uncomplicated pre-and post-operative care.

### TECHNICAL SKILLS

At the completion of the PGY2 year, technical expertise in endoscopic techniques and minor open surgical procedures should be acquired. By the end of the year, a PGY2 resident will be expected to perform simple endoscopic and minor open surgical procedures with consultant supervision. The resident should also be present to observe and assist with the more complex procedures. If the resident is scheduled to be in clinic on a particular day, he/she has the permission to leave for a portion of the clinic so as to obtain exposure to various PGY-level specific cases in the OR.

The following is a list of procedures that should be mastered in the PGY2 year:

1) Endoscopic Procedures
   a) Cystoscopy and urethroscopy
   b) Urethral dilatation
   c) Vesical and urethral biopsy and fulguration
   d) Visual Internal urethrotomy
   e) Litholapaxy

2) Open Surgical Procedures
   a) Ability to open and close abdominal and flank incisions
   b) Urethral meatotomy
   c) Insertion of percutaneous suprapubic tube
   d) Suprapubic cystostomy
   e) Circumcision
   f) Excision and fulguration of veneral warts
   g) Penile biopsy
   h) Testicular biopsy
   i) Vasectomy
   j) Cystolithotomy
   k) Drainage of periurethral/perivesical abscess
   l) Scrotal or inguinal surgery
   m) Insertion of testicular prosthesis

### READING

The required reading for the Royal College examination certification in Urology is based upon knowledge obtained from a variety of sources including Campbell's Urology, American Urological Association Updates and review articles form the Journal of Urology. A reading plan has been created by the Program as guide to help residents get through Campbell's Urology (please see attached Appendix). AUA updates and Journal of Urology Review articles over the past five years should be collected by the resident and reviewed. It is recommended that the resident create a steady study schedule to ensure adequate time for assimilation of the book knowledge. The goal of the reading plan is to ensure that each resident completes all reading, in preparation for the Royal College certification exam, by the beginning of their PGY5 year.

### TEACHING

By the end of PGY2 year, are expected to assist in the teaching of clinical clerks that rotate through the service and will be assigned clerks to mentor and teach. PGY1 and 2 residents are responsible for preparing and presenting several basic science or clinical topics to the other residents supervised by one of the consultant staff. Residents are expected to confer with the consultant staff assigned to supervise the topic at least one week in advance of the seminar date to review the material to be presented.

A two-week Surgical Foundations bootcamp is scheduled annually for incoming PGY1s – this is mandatory to attend and schedules will be sent out in advance. As well, weekly Surgical Foundations sessions are scheduled (Wednesdays) throughout the year. A two-day Urology bootcamp is also mandatory for incoming PGY1s. This is coordinated in conjunction with Toronto and Hamilton and will rotate through the three cities. The Program Administrator will advise of the date/location.

### RESEARCH

All residents in the clinical urology years are expected to undertake a research project each year that will be presented at the annual Residents' Research Day. It is hoped that these projects will also be submitted for presentation at national or international meetings. If a resident's paper is accepted, the resident is entitled to attend the meeting to present the work with expenses covered by the Division of Urology ($1000 to a maximum of $2000 per annum – see travel policy).

# YEAR SPECIFIC OBJECTIVES - UROLOGY PGY 3-4 (SENIOR RESIDENT)

### CLINICAL

PGY 3 and 4 residents are given greater independence in the clinic and in-patient settings. Clinical competence in all areas of urology should be demonstrated by the completion of this year of training. The resident should be able to describe and carry out appropriate management of more complex urological conditions. Senior residents are expected to attend outpatient clinics when not scheduled to be in the OR. The senior resident will often see the inpatient consultations initially or assist the junior resident in this assessment. The PGY4 resident may, from time to time, be in charge of the CTU in the absence of the Chief Resident.

### TECHNICAL SKILLS

Further consolidation of endoscopic and minor surgical skills learned in the PGY 2 year should occur this year. As well the PGY 4 resident will be expected to gain experience in more major endoscopic and open surgical techniques. The following surgical procedures should be performed by the end of this year of training with increasing competence:

1) Endoscopic Procedures
    a) Transurethral resection of bladder tumor
    b) Transurethral resection/incision of Ureterocele
    c) Transurethral resection of urethral valves
    d) Transurethral prostatectomy
    e) Ureteroscopy (flexible and rigid) (diagnostic and therapeutic)
    f) Laser lithotripsy
    g) Percutaneous nephrolithotomy
    h) Transurethral drainage of prostatic abscess
    i) ESWL

2) Open Surgical Procedures:
    a) Vasotomy and vasography
    b) Orchiopexy for testicular maldescent
    c) Drainage of cortical and perinephric abscess
    d) Pyeloplasy
    e) Ureterotomy
    f) Ureterectomy
    g) Ureterolysis
    h) Uretero-ureterostomy
    i) Uretero-neocystostomy
    j) Diverticulectomy of bladder
    k) Partial cystectomy
    l) Closure of vesico-vaginal fistula
    m) Urethrectomy
    n) Excision urethral diverticulum
    o) Surgery for stress urinary incontinence
    p) Penectomy (partial and total)
    q) Shunt for priapism
    r) Penile prosthesis insertion
    s) Correction of penile curvature
    t) Inguinal, pelvic and retroperitoneal lymphadenectomy
    u) Augmentation cystoplasty
    v) Insertion of artificial sphincter

### TEACHING

The senior residents play an important role in the teaching of the more junior house staff. The senior resident should discuss all in patient and emergency room consults with more junior house staff prior to contacting faculty. Senior residents are responsible for preparation and presentation of several clinical topics for the Seminar Series.

### RESEARCH

The senior residents will be expected to continue research initiated in the year before or begin a new project. Results will be presented at the annual Residents' Research Day. It is expected, as well, that these projects will be presented at national and international meetings and culminate in publication of the work.

### SPONSORED MEETINGS

PGY3 residents should plan to attend the AUA-sponsored Basic Science Review Course which is held in June each year. The trainee should plan to attend either the Canadian Urological Association or the American Urological Association annual meetings. Should the resident have an abstract accepted at another meeting, the resident is entitled to attend that meeting as well to present the paper (and, if annual travel allowable has reached the maximum, they are to seek financial request from their research supervisor, or apply for the Division of Urology Travel Award, well in advance of the meeting).

### READING

The required reading for the Royal College examination certification in Urology is based upon knowledge obtained from a variety of sources including Campbell's Urology, American Urological Association Updates and review articles form the Journal of Urology. A reading plan has been created by the Program as guide to help residents get through Campbell's Urology (please see attached Appendix). AUA updates and Journal of Urology Review articles over the past five years should be collected by the resident and reviewed. It is recommended that the resident create a steady study schedule to ensure adequate time for assimilation of the book knowledge. The goal of the reading plan is to ensure that each resident completes all reading, in preparation for the Royal College certification exam, by the beginning of their PGY5 year.

### CAREER PLANNING

By the mid-point of their PGY3 year, the resident should have initiated plans in preparation for completion of his/her residency training so that by the end of the PGY4 year, the fellowship has been secured. Fellowship training in particular may require considerable time to organize, especially if positions in the United States are being considered.

## YEAR SPECIFIC OBJECTIVES - UROLOGY PGY5 (CHIEF RESIDENT)

### CLINICAL

The chief resident is in charge of the inpatient CTU. The PGY5 resident is responsible for rounding on the inpatients each morning with the more junior house staff members. The chief resident should be aware of all inpatient and emergency room consultations and should review the management plan with the senior and junior resident. The chief resident should spend most of his/her time in the operating room. Ambulatory care exposure, however, should also be a part of the chief resident year experience, especially in the spring of their final year as they prepare for the Royal College exam.

### TECHNICAL SKILLS

The performance of all major urological procedures is mandatory. The chief resident should be competent to complete all open and endoscopic urologic procedures from start to finish listed above as well as those listed below. The chief resident is not expected to be in the OR for every case. The chief resident is not responsible for procedures in which competence has been achieved and the more minor procedures should be delegated to more junior residents.

1) Open Surgical Procedures:
   a) Partial nephrectomy
   b) Uretero-pyelo or calycostomy
   c) Radical nephrectomy (open and laparoscopic) including thoracoabdominal
   d) Nephroureterectomy
   e) Uretero-sigmoidostomy
   f) Ileal and sigmoid conduit
   g) Open prostatectomy (Retropubic and suprapubic)
   h) Anterior and posterior urethroplasty
   i) Vaso-vasostomy
   j) Epididymovasostomy
   k) Plastic correction of hypospadias and epispadias
   l) Adrenalectomy
   m) Donor nephrectomy
   n) Renal transplantation
   o) Ileal ureter
   p) Cystectomy
   q) Pelvic exenteration
   r) Radical prostatectomy
   s) Laparoscopic and /or Robot assisted surgery (a, d, l,m, r)

## TEACHING

The final year trainee will assist in the preparation and case selection for Grand Rounds, M&M Rounds, Radiology and Pathology Rounds. The chief resident should function as a role model for the more junior residents. The chief resident may be involved in the teaching of minor surgical skills to the more junior residents and Clinical Clerks.

## RESEARCH

For those residents involved in ongoing projects over the course of their training it is hoped this research will culminate in acceptance of the work at a major urological meeting and subsequent publication. Chief residents are expected to prepare a research presentation for the annual Urology Residents' Research Day.

# COMPETENCY-BASED MEDICAL EDUCATION (COMPETENCY BY DESIGN)

**Overview**

The Urology Program at Western adopted Competency by Design (CBD) in July 2018. Residents are assessed using Royal College-designed Entrustable Professional Activities (EPAs) in combination with other assessment methods. EPAs are divided into four stages:

- **Transition to Discipline**: 4 EPAs
- **Foundations**: 8 EPAs
- **Core**: 21 EPAs
- **Transition to Practice**: 6 EPAs

**Entrustable Professional Activities (EPAs)**

EPAs represent authentic tasks in the discipline. Supervisors delegate tasks to residents and observe their performance to assess competence over time. Each stage of training has specific EPAs that develop from simple to complex tasks, integrating various CanMEDS roles and milestones. EPAs guide supervisors in setting stage-appropriate expectations, identifying achievements, and areas for improvement. The Royal College Specialty Committee determines the number of EPAs required.

**Milestones**

Milestones offer detailed information about the necessary skills for each discipline. They are linked to EPAs and help guide feedback and coaching. Observers can use milestones to pinpoint areas needing improvement to ensure residents can successfully complete EPAs.

**Progression**

EPA assessments use milestones and an overall score (O-score/O-CAT) on a Likert scale of 1-5:

- Scores 4-5: Achieved
- Scores 1-3: In Progress

To meet the required 198 achieved assessments, the program expects 1022 assessments over five years. The breakdown by postgraduate year (PGY) is:

- **PGY 1**: 49 assessments
- **PGY 2**: 176 assessments
- **PGY 3**: 214 assessments
- **PGY 4**: 225 assessments
- **PGY 5**: 358 assessments

Residents must trigger a minimum of one EPA assessment in the operating room and clinic, chosen in consultation with faculty.

**Expectant Timeline and Requirements**

| ***Stage*** | ***EPAs*** | ***Completion Date*** | ***Achievements Needed*** |
|---|---|---|---|
| *Transition to Discipline* | 4 | December 31 of PGY1 | 7 |
| *Foundations* | 8 | 6 months after residency start | 54 |
| *Core of Discipline* | 21 | December 31 of PGY2 | 151 |
| *Transition to Practice* | 6 | May 31 of PGY5 | 13 |

Note: Residents should choose EPAs relevant to their current stage of training.

# PROCESS OF RESIDENT PROGRESS ASSESSMENT

The Competency Committee (CC) is an independent decision-making subcommittee of the Residency Program Committee (RPC) and is responsible for reviewing resident progress and make decisions about promotion and the need for enhanced learning plans, remediation and probation for those residents whose progress has been flagged. The CC, together with the RPC, is responsible for all resident trainee decisions for progress/promotion and are accountable to the RPC. The recommendations of the CC will be communicated to the RPC. The final decision on resident progression or re-assessment will be by the RPC.

The CC will be chaired by the current Assistant Program Director (APD) and include a minimum of three divisional faculty from the 3 clinical sites of the Urology Program who will act as faculty reviewers. The Program Director (PD) will be a non-voting observer. Membership shall also include the Program Administrator as recording secretary. The CC will meet 3-4 times per year (a week or to prior to each RPC meeting) to review the resident files (EPA assessments, ITERS, procedure logs, etc). The flow chart on the next page details the process of review and the metrics used.

Performance indicators to be reviewed during the decision-making process will include all documented Entrustable Professional Activities (EPAs) set up by the Royal College (RC) Urology Special Committee, peer-to-peer and co-worker evaluations, surgical log books and completed end of rotation and mid-rotation ITERs.

Each resident will be evaluated by a primary reviewer with additional input from a secondary reviewer and then discussed during the CC meeting with all members. Primary and secondary reviewers are assigned randomly for the education year, and then reassigned randomly for each academic year.

File review includes synthesizing the assessments and observations of each resident to make decisions related to:

- identifying areas in need of improvement and goals for next CC meeting
- promotion of residents to next stage of training
- determining when a resident is failing to progress and identifying the need for individual learning plans,
- reviewing and approving individual learning plans developed to address areas for improvement
- monitoring the outcome of any individual learning plan.

CC members will interpret available qualitative and quantitative data to achieve unbiased consensus, where possible, in making judgments on outcomes of the following:

- monitoring the progress of each resident as they progress through their state of training via the quality and number of EPAs
- determining readiness to challenge the Royal College examinations
- determining readiness to enter independent practice on completion of the transition to practice stage

**Evaluation:**

Rotation Evaluations (ITERs) are completed by CC member (or delegate) member at each hospital site: Dr. Patarick Luke for rotations at University Hospital, Dr. Melissa Huynh for rotations at Victoria Hospital, and Dr. Jennifer Bjazevic for rotations at St. Joseph’s Hospital.

1) You will be evaluated at the end of each rotation (plus mid-rotation if 2 months or greater in length). **Your final evaluation on any service must be completed before you leave the service and you are responsible for setting up a time with your supervisor to have this completed**. Daily feedback will be provided regarding your performance as well. Evaluations are done on-line and it is imperative that these be completed in a timely fashion. Evaluations are strictly confidential and are a very useful tool in improving the quality of our service. All evaluations are done electronically and available for review after completion.

2) You are expected to complete an on-line evaluation of each consultant prior to leaving the service. This is setup via the Department of Surgery Education Office. Staff evaluations are strictly confidential and, until such time that you complete the evaluation, you will not have access to your own rotation evaluation.
3) Procedure logging is a **MANDATORY** part of your training. At each CC meeting, procedure logs will be reviewed. Failure to keep an up-to-date procedure log can result in failure of a rotation.
4) Two OSCE's will be held per year and attendance is **compulsory.**
5) You are expected to present a research project four (4) out of your five (5) years (mandatory in years 2-5) at the annual Resident Research Day and, whether presenting or not, attendance at such research is **MANDATORY.**
6) To progress in the program and ultimately be successful in completing the program, a resident must demonstrate his or her ability to assume increased responsibility for patient care. Advancement to higher levels of responsibility will be on the basis of evaluation of his/her readiness for advancement. This determination is the responsibility of the Resident Training Committee with input from members of the teaching staff.
7) Progression takes place upon completeion of each CBD level (Transition to Discipline, Foundations, Core and Transition to Practice) not via PGY level.

**COMPETENCY COMMITTEE**

- MEMBERS: Chair (Assistant PD), 3 site specific faculty reviewers, PD as observer
- ROLE: Review assigned resident files, 1 primary and 1 secondary reviewer, resident assigned randomly and changed yearly
- DOCUMENTS REVIEWED: EPA assessments, Rotation ITERS, Peer to peer and Coworker evaluations, Self assessments, Procedure logs, External and community rotation ITERS, any other positive and negative issues raised by written documentation and acheivements
- REPORT: Provides current status of resident, areas needing improvement, acheivements , EPAS's completed and in progress
- RECOMMENDATION: Progressing as expected/Not progressing as expected; Advancement to next stage of training

**RESIDENCY PROGRAM COMMITTEE**

- MEMBERS: Chair (PD), 3 site specific faculty , Assistant PD to report CC recommendations, resident representative
- ROLE: Review CC report, decide on future course of action- create learning plans and objectives if needed (other RTC roles not described here)
- DOCUMENTS REVIEWED: CC report
- RECOMMENDATION: Progressing as expected/Not progressing as expected; Advancement to next stage of training

**BI-ANNUAL RESIDENT REVIEW**

- MEMBERS: Chair (PD), Assistant PD
- ROLE: Review CC and RPC report, review Self assessment and --- form, discuss future course and goals, discuss career goals and plans, decide on future course of action if needed to create learning plans and objectives
- DOCUMENTS REVIEWED: RPC and CC report

# ROTATION SPECIFIC OBJECTIVES

These objectives relate to all sites as consultations and general urology clinics are found at all 3 teaching hospitals. It is expected that all PGY levels strive to achieve these objectives in a graded manner with increasing responsibilities, depth of knowledge and technical skills as years progress from PGY1 to PGY5. We encourage all residents to strive towards higher performance in these categories, despite their PGY level, so as to encourage and promote competency and excellence early on.

## *General Objectives for PGY 1-5 ALL SITES:*

***Medical Expert***

1) Demonstrate a commitment to high-quality, timely and compassionate care of the urological patient
2) Apply knowledge of the clinical and biomedical sciences relevant to Urology
3) Perform a focused urological history and physical exam relevant to the urological care of the patient in an organized and time manner
4) Demonstrate an appropriate selection, administration and interpret laboratory test and/or relevant questionnaires (including pathology)
5) Demonstrate an appropriate selection and interpretation of imaging studies relevant to the urology care of the patient
6) Demonstrate ability to formulate a different diagnosis and provisional diagnosis
7) Demonstrate appropriate clinical judgement and decision-making skills to establish a comprehensive and patient-centered management plan, including potential complications, for general urological disease processes
8) Demonstrate an understanding of the impact of urological conditions and their management on patients and their families
9) Demonstrate an understanding of the principles of the therapeutic techniques used in urological practice
10) Apply knowledge of pregnancy to the care of the urological patient
11) Determine the appropriate timing and procedures for investigation or treatment for the urological patient
12) Demonstrate ability to obtain and document informed consent
13) Perform selected urological diagnostic procedures in a skillful and safe manner, adapting to unanticipated findings or changing clinical circumstance
14) Determine and establish plans for ongoing care, follow-up and/or surveillance
15) Identify and provide timely referral for consultations to other health care professionals
16) Contribute to quality improvement and patient safety including participation in M&M and surgical safety checklist

***Communicator***

1) Demonstrate ability to obtain and synthesize accurate and relevant information from patients and their family
2) Establish therapeutic relationships with patients and their family including engaging them in developing informed decisions regarding their health
3) Demonstrate ability to explain procedures and/or treatments, options for treatment, potential complications and unanticipated morbidity to patients and their family in clear and understandable language
4) Demonstrate and develop accurate, complete and timely documentation habits regarding informed consent, procedure details, consultation, discharge summary, progress notes and clinic notes

***Collaborator***

1) Demonstrate ability to work effectively and promote a positive, respectful and understanding (including resolving conflicts) relationship with physicians and other colleagues in the healthcare professions
2) Demonstrate effective handover of patient to physicians and other colleagues in the healthcare profession to facility patient safety

***Leader***

1) Demonstrate stewardship of healthcare resources (senior)
2) Demonstrate an understanding of the administrative (including equipment cost and maintain) operation of urological practice (senior)
3) Demonstrate an understanding and time management of a urologic practice (senior)
4) Demonstrate effective time management skills to integrate training, education and personal life

5) Demonstrate ability to manage team and effective delegation of graded tasks (senior)

***Health Advocate***

1) Demonstrate advocacy for a patient's needs based on individualized determinants of health (including socioeconomic factors
2) Incorporate disease prevention, health promotion and health surveillance into patient encounters

***Scholar***

1) Demonstrate commitment to lifelong learning by recognizing one's own limitations and defining personal educational needs (gaps)
2) Develop an approach to monitoring personal performance (internal and external) including the use of reflection and implementing personal learning plan to enhancement and improvement
3) Develop an approach to teaching students and residents by promoting a safe learning environment, role modelling and supervision of junior learners while ensuring patient safety
4) Develop an approach to assessing and providing feedback to learners, teachers and programs in a constructive manner
5) Demonstrate ability to integrate evidence into decision-making in practice

***Professional***

1) Demonstrate professional behaviors when interacting with patients, physicians and other colleagues in the healthcare profession (honesty, integrity, humility, commitment, compassion, respect, altruism and respect for diversity)
2) Demonstrate an understanding and respect for patient autonomy and confidentiality
3) Demonstrate timely provision of consultation from other physicians and appropriate referral to other physicians when deemed required
4) Demonstrate professional behaviors when interacting with industry and on technology-enabled communication
5) Demonstrate an understanding and adherence to medicolegal concepts as they pertain to liability and informed consent
6) Recognize and response to unprofessional and unethical behaviors amongst physicians and other colleagues in the healthcare profession
7) Develop an approach to manage and maintenance personal physical and mental well-being (occupational hazard, work-life balance) from the challenges of stressful clinical settings
8) Develop an approach to recognize, report and mitigate personal impacts (medical errors) on patient safety incidents and adverse outcomes
9) Participate in assessment of peers, faculty, program and institution for quality improvement
10) Promote a supportive culture for a colleague in need

*(see table at the end of this section for EPA's that can be achieved on this rotation)*

## *General Objectives for PGY 5 (Chief Resident):*

The chief resident will continue to consolidate their knowledge and surgical skills as outlined in the educational objectives. By the end of the final year, the resident should have acquired all of the necessary cognitive and non-cognitive skills and surgical skills that will allow him/her to be a competent independent consultant in urology.

1) Participation in ambulatory clinics including cystoscopies when not operating.
2) Assisting with cases as first or second assistant to the staff to include review of the surgical pathology and imaging of these cases.
3) See urology consultations with the other residents and staff.
4) Ensure that at least one research project, one review, or a case report for publication has been completed in the senior years.
5) Co-ordinate and participate in formal rounds and teaching activities that occur in the various clinical teaching units.
6) Co-ordinate, administrate and be responsible for all activities of the house staff including all administrative in patient responsibilities, teaching of undergraduate students, on-call coverage, OR assisting and cross coverage for house staff vacation.

7) Participate in coordinating, organizing and executing a day's list of core surgical and/or endoscopic procedures
8) Independent management of patients with common urological conditions in an out patient setting
9) Develop a personal learning plan that can define learning needs and career plans, including identifying ways to gain experiences, advance knowledge and commitment to enhancing competency
10) Supervise the urology service, including scheduling and teaching the junior learners (Core EPA 19)

*(see table at the end of this section for EPA's that can be achieved on this rotation)*

## ST. JOSEPH'S HOSPITAL:

The Urology service at St. Joseph's Hospital (St. Joe's) provides comprehensive training for residents of all levels of urology training. Residents are exposed to the most general urologic conditions in the outpatient clinic, Emergency Department and in the operating rooms, with the exception of major trauma, complex pediatric surgery and transplantation. During the St. Joe's rotation sub-specialty expertise should be gained in the following disciplines:

### ANDROLOGY

Residents will acquire and be able to demonstrate knowledge of the pathophysiology, investigation and medical/surgical management of sexual dysfunction, hypogonadism, and male infertility. This knowledge is expected to be obtained through individual study, attendance at outpatient clinics and the operating room.

The St Joseph's Hospital site has developed an academic program in the area of men's reproductive medicine with clinical areas of male infertility, sexual health, andropause, Peyronie's Disease and prosthetics.

At the end of the rotation the residents are expected to:
1) Demonstrate an understanding of the urological investigations for men with infertility, sexual dysfunction, hypogonadism and Peyronie's Disease
2) Demonstrate an understanding of the different types of therapies available for men with infertility, sexual dysfunction, hypogonadism and Peyronie's Disease as well as the role, risks and alternatives to each of the therapies
3) Demonstrate an understanding of the anatomy and physiology of erection
4) Demonstrate an understanding of the etiology, pathophysiology, classification, diagnosis and treatment of erectile dysfunction
5) Demonstrate an understanding of the etiology, diagnosis and management of ED unresponsive to medical management
6) Demonstrate an understanding of the etiology, diagnosis and management of benign, premalignant and malignant cutaneous lesions of the male genitalia
7) Demonstrate an understanding of the surgical anatomy of and the surgical approaches to the scrotum, testis, cord structures, penis and inguinal canal
8) Demonstrate an understanding of the pre-operative, and post-operative management of these conditions and their potential complications
9) Perform the following open procedures related to male fertility, sexual and gonadal function, in a skillful and safe manner, adapting to unanticipated findings or changing clinical circumstances
10) Perform the following open scrotal procedures, in a skillful and safe manner, adapting to unanticipated findings and management of complications

*(see table at the end of this section for EPA's that can be achieved on this rotation)*

## FUNCTIONAL UROLOGY

In-depth knowledge of the pathophysiology of urinary incontinence in men and women and the appropriate investigations and treatment should be acquired. An understanding of the practical aspects of performing urodynamics should be achieved through attendance of urodynamic procedures with the urodynamic nursing staff. Awareness of common female urologic problems should be achieved through regular attendance in the outpatient clinic and operating room.

***General Objectives:***

1) To understand the anatomy, neuro-anatomy and physiology of normal voiding.
2) To develop an understanding of the etiology, pathophysiology, classification, diagnosis and treatment of voiding dysfunction, urinary incontinence, and female pelvic floor disorders.
3) To understand the etiology, pathophysiology, classification and treatment of the neurogenic bladder.
4) To be able to manage the urologic conditions associated with acute and chronic spinal cord injured patients.
5) To further develop an understanding of the technical skills and options required to treat lower urinary tract dysfunction including female and male urinary incontinence.

**Specific Learning Objectives:**

1) Demonstrate an understand the anatomy, neuro-anatomy and physiology of normal voiding
2) Develop an understanding of the etiology, pathophysiology, classification and diagnosis of voiding dysfunction, urinary incontinence, and female pelvic floor disorders
3) Develop an understanding of the etiology, pathophysiology, classification and treatment of the neurogenic bladder
4) Demonstrate ability to manage the urologic conditions associated with acute and chronic spinal cord injured patients
5) Develop an understanding of the management and technical skills and options required to treat lower urinary tract dysfunction including female and male urinary incontinence (including fistula) and management of potential complications
6) Develop an understanding of the indications for, and perform (including interpretation) of urodynamic studies
7) Perform and interpret a retrograde and voiding cysto-urethrogram
8) Develop an approach in managing urethral stricture disease
9) Demonstrate an ability to counsel a patient regarding the treatment options for urinary incontinence including pharmacological therapy and surgical treatment
10) Demonstrate knowledge of the mechanism of action and physiological effects of botulinum toxin and neurostimulation for treatment of bladder pathologies

*(see table at the end of this section for EPA's that can be achieved on this rotation)*

## ENDOUROLOGY /UROLITHIASIS

Residents should achieve in-depth knowledge in the pathophysiology, investigation including metabolic assessment and surgical management of urinary stone disease. Residents should develop the skills of ureteroscopy, percutaneous nephrostomy insertion and percutaneous stone removal. Residents should be knowledgeable of the various techniques of both intracorporeal and extracorporeal shock wave lithotripsy including the mechanisms of action of each and potential complications associated with their use. The general goals of the rotation are as follows:

1) Demonstrate an understanding of the pathophysiology and diagnosis of urinary stone disease
2) Perform a focused history and physical examination for patients with urinary stone disease
3) Develop an approach to the medical management of urinary stone disease
4) Demonstrate an understanding of the indications (including emergent) and surgical management for urinary stone disease

5) Demonstrate and understanding and develop the technical skills required for surgical management of urinary stone disease and management of potential complications
6) Demonstrate knowledge of the mechanism of action and physiological effects of therapeutic technologies (medical and surgical) relevant to benign prostatic hyperplasia
7) Develop an understanding of the indications and technical skills required for transrectal ultrasound with or without prostate biopsy and management of potential complications

*(see table at the end of this section for EPA's that can be achieved on this rotation)*

### UROLOGIC ONCOLOGY

Residents should acquire comprehensive knowledge of the pathophysiology, investigation and medical/surgical treatment of BPH. An understanding of the role of PSA in prostate cancer screening, the investigation of men with an abnormal PSA and/or DRE and the technique of TRUS biopsy of the prostate should be acquired. An insight into the management of prostate cancer stage for stage should be attained. This knowledge is expected to be obtained through individual study, attendance at outpatient clinics and the operating room.

***General Objectives:***

1) To develop and understanding of the etiology, natural history, histopathology (including grading), investigation, diagnosis (including staging), techniques for treatment in common use and the multidisciplinary management of patients with urologic malignancy including treatment when cure is not the primary goal.
2) To further develop an understanding of and the technical skills for uro-oncologic surgery.
3) To understand the principles of cancer management and the role of radiotherapy, chemotherapy and immunotherapy.
4) To develop a familiarity with the current controversies in the management of urologic malignancy and proposals to resolve them by clinical trials and other research.
5) To develop an appreciation for the increasing role of molecular genetics in the understanding and management of urologic malignancy.
6) Demonstrate knowledge of the mechanism of action and physiological effects of therapeutic technologies relevant to benign prostatic hyperplasia

**Specific Learning Objectives:**

1) Develop an understanding of the etiology, natural history, histopathology (including grading), investigation, classification, diagnosis, staging of urological malignancies
2) Demonstrate an understanding of the treatment options, including the role for multidisciplinary care for patients with urological malignancy
3) Demonstrate an appreciation of non-curative palliative therapies is also required
4) Demonstrate an understanding the principles of cancer management as well as surgical oncology with emphasis on the role of chemotherapy, targeted therapies, radiotherapy and palliative care
5) Demonstrate an understanding of the role of percutaneous, angiographic and new techniques and their indications for urological malignancies; as well as potential complications
6) Develop an understanding of the controversies in the treatment of urological malignancy and to appreciate the role and need for clinical trials to help solve the aforementioned controversies
7) Develop an understanding of the natural history, diagnosis, staging, treatment outcomes and complications for early stage prostate cancer
8) Demonstrate an understanding of the indications and complications of systemic therapies for prostate cancer including androgen deprivation
9) Develop an approach to counselling patients with early stage prostate cancer about treatment options their outcomes and complications (including active surveillance)
10) Develop an understanding of the natural history, diagnosis, staging, treatment outcomes and complications for germ cell tumor.
11) Develop an understanding of the natural history, diagnosis, staging, treatment outcomes and complications for kidney cancers and small renal masses

12) Develop the minimally invasive technical skills required to diagnosis and treat urological malignancies

*(see table at the end of this section for EPA's that can be achieved on this rotation)*

## LONDON HEALTH SCIENCES CENTRE (LHSC):

The Urology service at LHSC provides comprehensive training for residents of all levels of urology training. The bulk of the residents' learning experience takes place at the Victoria Hospital Campus which houses the in-patient adult service, the pediatric surgical inpatient unit and the urology operating rooms. Transplantation activities take place at the University Hospital Campus. During the LHSC rotation subspecialty expertise should be gained in the following disciplines:

### UROLOGIC ONCOLOGY

It is expected that residents will acquire in-depth experience in all aspects of urologic oncology. The theories of urologic tumorigenesis, cancer biology, pertinent investigations and medical/surgical management of all urologic malignancies should be learned. An understanding of the mechanisms of action and indications for radiotherapy and chemotherapy in the treatment of urologic tumors should be obtained. These objectives will be achieved through regular attendance in the outpatient clinics and operating room.

***General Objectives:***
1) To develop an understanding of the etiology, natural history, histopathology (including grading), investigation, classification, diagnosis, staging of urological malignancies.
2) To understand the treatment options, including the role for multidisciplinary care for patients with urological malignancy. An appreciation of non-curative palliative therapies is also required.
3) To further develop the technical skills for uro-oncology surgery.
4) To understand the principles of cancer management and surgical oncology with emphasis on the role of chemotherapy, targeted therapies, radiotherapy and palliative care.
5) To be familiar with the role of percutaneous, angiographic and new techniques and their indications
6) To develop familiarity with the controversies in the treatment of urological malignancy and to appreciate the role and need for clinical trials to help solve them.
7) To understand the controversies and limitations of screening for urological malignancy.

**More specifically the objectives include:**
1) Develop an understanding of the etiology, natural history, histopathology (including grading), investigation, classification, diagnosis, staging of urological malignancies
2) Demonstrate an understanding of the treatment options, including the role for multidisciplinary care for patients with urological malignancy
3) Demonstrate an appreciation of non-curative palliative therapies is also required
4) Demonstrate an understanding the principles of cancer management as well as surgical oncology with emphasis on the role of chemotherapy, targeted therapies, radiotherapy and palliative care
5) Demonstrate an understanding of the role of percutaneous, angiographic and new techniques and their indications for urological malignancies; as well as potential complications
6) Develop an understanding of the controversies in the treatment of urological malignancy and to appreciate the role and need for clinical trials to help solve the aforementioned controversies
7) Develop an understanding of the natural history, diagnosis, staging, treatment outcomes and complications for early stage prostate cancer
8) Demonstrate an understanding of the indications and complications of systemic therapies for prostate cancer including androgen deprivation
9) Develop an approach to counselling patients with early stage prostate cancer about treatment options their outcomes and complications (including active surveillance)

10) Develop an understanding of the natural history, diagnosis, staging, treatment outcomes and complications for urothelial cancers
11) Develop an understanding of the natural history, diagnosis, staging, treatment outcomes and complications for germ cell tumor.
12) Develop an understanding of the natural history, diagnosis, staging, treatment outcomes and complications for kidney cancers and small renal masses
13) Develop the open technical skills required to diagnosis and treat abdominal/retroperitoneal urological malignancies
14) Develop the open technical skills required to diagnosis and treat pelvic urological malignancies
15) Develop the open technical skills required to diagnosis and treat scrotal and inguinal urological malignancies
16) Develop the open technical skills required to diagnosis and treat penile and urethral urological malignancies
17) Develop the minimally invasive technical skills required to diagnosis and treat urological malignancies

*(see table at the end of this section for EPA's that can be achieved on this rotation)*

### TRANSPLANTATION (UNIVERSITY HOSPITAL)

The objective of this rotation is to expose residents to the medical and surgical aspects of renal transplantation. Residents should develop an appreciation of the work-up of the patient being considered for a renal transplant. The procedures involved in cadaveric and living related donor selection should be understood. The principles and techniques of organ retrieval and preservation should be learned. Residents should be involved in both cadaveric and living related transplant surgical procedures. The post-operative management of renal transplant patient and an appreciation of the principles of immunosuppression and the mechanisms of action of the major immunosuppressive agents must be understood. These objectives will be fulfilled through individual study, attendance in the outpatient clinic, operating room and in the post-operative follow up of patients.

***General Objectives:***

1) Develop an understanding of the etiology, natural history, histopathology (including grading), investigation, classification, diagnosis, staging of renal failure and end stage renal disease (ESRD)
2) Demonstrate an understanding of the treatment options, including the role for multidisciplinary care for patients with ESRD
3) Demonstrate an understanding of the principles of renal transplantation surgery and develop the technical skills for renal transplantation surgery (including donor nephrectomy)
4) Demonstrate an understanding of the principles of immunosuppression
5) Develop an approach to infections, malignancies, and complications in renal transplant patients

*(see table at the end of this section for EPA's that can be achieved on this rotation)*

### TRAUMA / OBSTRUCTIVE UROPATHY / INFLAMMATION AND INFECTION

LHSC serves as the regional trauma referral centre. Residents will receive the bulk of their trauma exposure at the Victoria Hospital site. Residents should acquire in-depth knowledge of the approach to the management of the patient with multisystem trauma as well as the patient with injury isolated to the GU system. Techniques involved in stabilizing patients, appropriate investigations and the surgical management of urologic injuries will be learned. Residents will achieve these objectives through personal study, through evaluation of patients in the emergency department and attendance in the operating room.

**Objectives:**

1) Develop an approach to the intraoperative consultation for a urological concern
2) Demonstrate an understanding and develop an approach of the assessment, diagnosis, classification and management of genitourinary trauma in a multidisciplinary manner
3) Demonstrate an understanding and develop an approach of the assessment, diagnosis, and management of common urological emergencies such as testicular torsion, priapism and septic renal colic

4) Demonstrate an understanding of the pathophysiology of upper and lower genitourinary tract
5) Develop an approach to the assessment, diagnosis, and management of patients with upper and/or lower urinary tract obstruction
6) Demonstrate an understanding and develop the skills required to alleviate obstruction of the upper/lower urinary tract
7) Demonstrate an approach to the management and follow-up of the urological patient post alleviation of upper/lower urinary tract obstruction
8) Demonstrate an understanding of the pathophysiology and diagnosis of inflammatory and infectious conditions as they pertain to the urological patient
9) Develop an approach to the management, follow-up and monitoring (for potential complications) of the urological patient with inflammatory or infectious conditions

### PEDIATRIC UROLOGY (VICTORIA HOSPITAL)

Most of the Pediatric Urology is carried out at Victoria Hospital. Residents will be exposed to a large volume of Pediatric Urology through attendance at Dr. Dave's outpatient clinics and OR days. Additional ambulatory Pediatric Urology can also be obtained by participating in satellite clinics attended by Dr. Dave. Residents should acquire comprehensive knowledge of all common urologic conditions afflicting children including: enuresis, urinary tract infection, vesico-ureteral reflux, ureteropelvic junction obstruction, cryptorchidism and hypospadias. The surgical and clinical objectives of this rotation are tailored to developing precise technical and intellectual skills, which will have a general applicability to the surgical cases residents will see as they enter subsequent years in the program. Similarly, an introduction and basic grounding in clinical evaluation through history and radiologic evaluation will be stressed. Aspects of evaluation of the pediatric patient will be emphasized.

**Specific learning objectives**:

1) Demonstrate an understanding of normal genitourinary embryology and the consequences of resultant congenital abnormalities
2) Perform a history and physical examination in neonates, infants, and children with emphasis on normal/abnormal growth & development
3) Perform interview with parents with respect to childhood urologic health and disease, antenatal maternal and fetal health
4) Demonstrate an approach to fluid and electrolyte management in the pediatric urology patient and dosing of commonly used medications
5) Demonstrate an approach (pathophysiology, diagnosis and management) to common pediatric urological conditions including oliguria & anuria, undescended testicle, testicular torsion and phimosis
6) Demonstrate an understanding of the rational use, indication & interpretation of biochemical and imaging studies (ultrasound, voiding cystourethrogram and nuclear renal studies) in the pediatric urologic patient
7) Demonstrate an approach to urodynamic studies, including interpretation, in the pediatric urologic patient
8) Demonstrate an understanding of the pathophysiology, diagnosis, and management of urinary tract infections in the pediatric urologic patient (simple and complex)
9) Demonstrate and understanding and approach to the pathophysiology, diagnosis and management of common pediatric urologic conditions including vesicoureteral reflux, hydronephrosis, enuresis, dysfunctional voiding, and incontinence
10) Demonstrate an understanding of the urological manifestations and management of complex congenital conditions such as spina bifida, posterior urethral valve, disorder of sexual differentiation and exstrophy
11) Demonstrate the ability to perform common urologic pediatric procedures such as circumcisions, orchidopexy and hydrocelectomy and manage potential complications
12) Demonstrate an understanding and approach to complex urologic pediatric procedures such as hypospadias repair, epispadias and exstrophy repair and management of potential complications

*(see table at the end of this section for EPA's that can be achieved on this rotation)*

| | General EPAs All Sites PGY1-4 | General EPAs All Sites PGY5 | SJHC Androl. | SJHC Functi. Urology | SJHC EndoU | SJHC Prostate Disorders (BPH, prostate cancer) | LHSC - Urologic Oncology | LHSC - Transplant (UH) | LHSC Peds (Vic) |
|---|---|---|---|---|---|---|---|---|---|
| TD1: Assessing patients with a urological presentation | X | | | | | | | | |
| TD2: Admitting patients to the urology service | X | | | | | | | | |
| TD3: Discharging patients from the urology service | X | | | | | | | | |
| TD4: Collaborating with other services | X | | | | | | | | |
| F1: Assessing and managing patients with a difficult catheterization in an urgent setting | X | | | | | | | | |
| F2: Recognizing and managing urosepsis in patients with urinary obstruction | X | | | | | | | | |
| F3: Assessing and managing patients with acute scrotal/perineal pain | X | | | | | | | | |
| F4: Assessing and establishing a management plan for patients with common non-emergent urological presentations | X | | | | | | | | |
| F5: Performing rigid cystoscopy with examination in an elective setting | X | | | | | | | | |
| F6: Performing flexible cystoscopy with examination in an elective setting | X | | | | | | | | |
| F7: Opening and closing an abdominal incision in low-complexity patients | X | | | | | | | | |
| F8: Managing urology specific tubes and drains on the ward | X | | | | | | | | |
| C1: Performing an initial consultation, and developing a plan for investigation or management, for patients presenting to the emergency department | X | | | | | | | | |
| C2: Performing an initial consultation, and developing a plan for investigation or management, for patients presenting in the clinic or inpatient non-urgent settings | X | | | | | | | | |
| C3: Performing an intraoperative consultation for a simple scenario | X | | | | | | | | |
| C4: Assessing and managing urinary tract and/or genital anomalies in children | | | | | | | | | X |
| C5: Performing transurethral resection of bladder tumors | | | | | | | X | | |
| C6: Performing transurethral resection of prostate | | | | X | | X | | | |
| C7: Performing a stricture incision of the lower urinary tract | | | | X | | | | | |
| C8: Performing rigid ureteroscopy and lithotripsy of the upper urinary tract | | | | | X | | | | |
| C9: Performing retrograde flexible ureteroscopy/nephroscopy and lithotripsy of the upper urinary tract | | | | | X | | | | |
| C10: Performing percutaneous nephroscopy and lithotripsy of the upper urinary tract | | | | | X | | | | |
| C11: Performing laparoscopic renal surgeries | | | | | | | X | X | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| C12: Performing the surgical skills of open abdominal/retroperitoneal procedures | | | | | | | X | X | |
| C13: Performing the surgical skills of open pelvic procedures | | | | | | | X | | |
| C14: Performing genital procedures | | | | | | | | | |
| C15: roviding care for patients with complications following urologic interventions | X | | | | | | | | |
| C16: Providing post-operative care for children following a urologic intervention | | | | | | | | | X |
| C17: Providing management for patients with benign urologic conditions in the office setting, including monitoring progress and ongoing treatment | X | | | | | | | | |
| C18: Providing management for patients with malignant urologic conditions in the office setting, including monitoring progress and ongoing treatment | | | | | | X | X | | |
| C19: Supervising the urology service, including scheduling and teaching the junior learners | X | X | | | | | | | |
| C20: Delivering effective teaching presentations | X | | | | | | | | |
| C21: Advancing the discipline through scholarly work | X | | | | | | | | |
| TP1: Managing patients with urological conditions in the outpatient setting | | X | | | | | | | |
| TP2: Coordinating and executing the day's list of endoscopy (cystoscopy) procedures | | X | | | | | | | |
| TP3: Coordinating, organizing and executing the day's list of core surgical procedures | | X | | | | | | | |
| TP4: Performing an intraoperative consultation in a complex scentario | | X | | | | | | | |
| TP5: Contributing to administrative responsibilities | | X | | | | | | | |
| TP6 Developing and implementing a personal learning plan geared to setting of future practice | | X | | | | | | | |

# *WHERE TO ACHIEVE EPA'S*

*Click here to view on the website:*

| | | | | | | | Urology Rotations | | | | | Off Service Rotations | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| STAGE | | EPA | Formal Teaching | Simlation / AnatLab | Research Day | After Hours Call | Comm. | UH | SJHC | Vic | T2P Block | GU Rad. | Adult ER | Adult Gen Surg | ICU-CCTC | Int. Med | Nephro | RadOnc MedOnc | ICU-CCTC |
| Transition To Discipline | TD1 | Assessing patients with a urological presentation | | | | X | X | X | X | X | | | X | X | X | X | X | X | X |
| | TD2 | Admitting patients to the urology service | | | | X | X | X | X | X | | | | | | | | | |
| | TD3 | Discharging patients from the urology service | | | | X | X | X | X | X | | | | | | | | | |
| | TD4 | Collaborating with other services | | | | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Foundations | F1 | Assessing & managing patients with a difficult catherization in an urgent setting | | | | X | X | X | X | X | | | X | | X | | | | |
| | F2 | Recogizing & managing urosepsis in patients with urinary obstruction | | | | X | X | X | X | X | | | X | | X | | | | |
| | F3 | Assessing & managing patients with acute scrotal/perineal pain | | | | X | X | X | X | X | | | X | | | | | | |
| | F4 | Assessing & establishing a management plan for patients with common non-emergent urological presentations | | | | | X | X | X | X | | X | | X | X | X | X | X | X |
| | F5 | Performing right cystoscopy with examination in an elective setting | | X | | | X | X | X | X | | | | | | | | | |
| | F6 | Performing flexible cystoscopy with examination in an elective setting | | X | | | X | X | X | X | | | | | | | | | |
| | F7 | Opening & closing an abdominal incision in low-complexity patients | | X | | | X | X | X | X | | | | X | | | | | |
| | F8 | Managing urology specific tubes and drains on the ward | | | | X | X | X | X | X | | | | | | | | | |
| Core | C1 | Performing an initial consultation, and developing a plan for investigation or management, for patients presenting to the ER | | | | X | | | | | | | X | | | | | | |
| | C2 | Performing an initial consultation, and developing a plan for investigation or management, for patients presenting in the clinic or inpatient non-urgent settings | | | | X | X | X | X | X | | | | | | | | | |
| | C3 | Performing an intraoperative consultation for a simple scenario | | | | X | X | X | X | X | | | | X | | | | | |
| | C4 | Assessing & managing urinary tract and/or genital anomalies in children | | | | X | X | | | X | | | | | | | | | |
| | C5 | Performing transurethral resection of bladder tumors | | | | | X | X | X | X | | | | | | | | | |
| | | Logbook | | | | | X | X | X | X | | | | | | | | | |
| | C6 | Performing transurethral resection of prostate | | | | | X | X | X | X | | | | | | | | | |
| | | Logbook | | | | | X | X | X | X | | | | | | | | | |
| | C7 | Performing a stricture incision of the lower urinary tract | | | | | X | X | X | X | | | | | | | | | |
| | | Logbook | | | | | X | X | X | X | | | | | | | | | |

| STAGE | | EPA | Formal Teaching | Simlation / AnatLab | Research Day | After Hours Call | Comm. | UH | SJHC | Vic | T2P Block | GU Rad. | Adult ER | Adult Gen Surg | ICU-CCTC | Int. Med | Nephro | RadOnc MedOnc | ICU-CCTC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Urology Rotations | | | | | Off Service Rotations | | | | | | | |
| Core | C8 | Performing rigid ureteroscopy and lithotripsy of the upper urinary tract | | | | | X | X | X | X | | | | | | | | | |
| | | Logbook | | | | | X | X | X | X | | | | | | | | | |
| | C9 | Performing retrograde flexible ureteroscopy/nephroscopy and lithotripsy of the upper urinary tract | | X | | | X | X | X | X | | | | | | | | | |
| | | Logbook | | | | | X | X | X | X | | | | | | | | | |
| | C10 | Performing percutaneous nephroscopy and lithotripsy of the upper urinary trac | | X | | | X | X | X | | | | | | | | | | |
| | | Logbook | | | | | X | X | X | | | | | | | | | | |
| | C11 | Performing laparoscopic renal surgeries | | | | | X | X | X | X | | | | | | | | | |
| | | Logbook | | | | | X | X | X | X | | | | | | | | | |
| | C12 | Performing the surgical skills of open abdominal/retroperitoneal procedures | | | | | X | X | X | X | | | | | | | | | |
| | | Logbook | | | | | X | X | X | X | | | | | | | | | |
| | C13 | Performing the surgical skills of open pelvic procedures | | | | | X | X | X | X | | | | | | | | | |
| | | Logbook | | | | | X | X | X | X | | | | | | | | | |
| | C14 | Performing genital procedures | | | | | X | X | X | X | | | | | | | | | |
| | | Logbook | | | | | X | X | X | X | | | | | | | | | |
| | C15a | Providing care for patients with complications following urologic interventions - patient management | | | | X | X | X | X | X | | | | | | | | | |
| | C15b | Providing care for patients with complications following urologic interventions - disclosure to patient/family and reporting | | | | X | X | X | X | X | | | | | | | | | |
| | C16 | Providing post-operative care for children following a urologic intervention | | | | | | | | X | | | | | | | | | |
| | C17 | Providing management for patients with benign urologic conditions in the office setting, including monitoring progress and ongoing treatment | | | | | X | X | X | X | | | | | | | | | |
| | C18a | Providing management for patients with malignant urologic conditions in the office setting, including monitoring progress and ongoing treatment - Initial Discussion | | | | | X | X | X | X | | | | | | | | | |
| | C18b | Providing management for patients with malignant urologic conditions in the office setting, including monitoring progress and ongoing treatment - longoing management/surveillance | | | | | X | X | X | X | | | | | | | | | |

| STAGE | | EPA | Formal Teaching | Simlation / AnatLab | Research Day | After Hours Call | Comm. | UH | SJHC | Vic | T2P Block | GU Rad. | Adult ER | Adult Gen Surg | ICU-CCTC | Int. Med | Nephro | RadOnc MedOnc | ICU-CCTC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Urology Rotations | | | | | Off Service Rotations | | | | | | | |
| Core | C19a | Supervising the urology service, including scheduling and teaching the junior learners - patient care | | | | X | X | X | X | X | X | | | | | | | | |
| | C19b | Supervising the urology service, including scheduling and teaching the junior learners - interprofessional care/supervision | | | | X | X | X | X | X | X | | | | | | | | |
| | C20 | Delivering effective teaching presentations | X | | X | | | | | | X | | | | | | | | |
| | C21 | Advancing the discipline through scholarly work | X | | X | | | | | | X | | | | | | | | |
| Transition to Practice | P1 | Managing patients with urological conditions in the oupatient setting | | | | X | X | X | X | X | X | | | | | | | | |
| | P2 | Coordinating and executing the day's list of endoscopy (cystoscopy) procedures | | | | | | X | X | X | X | | | | | | | | |
| | P3a | Coordinating, organizing and executing the day's list of core surgical procedures - surgical competence | | | | | | X | X | X | X | | | | | | | | |
| | P3b | Coordinating, organizing and executing the day's list of core surgical procedures - interprofessional team work | | | | | | X | X | X | X | | | | | | | | |
| | P4 | Performing an intraoperative consultation in a complex scenario | | | | | X | X | X | X | X | | | | | | | | |
| | P5 | Contributing to administrative responsibilities | X | | | | X | X | X | X | X | | | | | | | | |
| | P6 | Developing and implementing a personal learning practice plan geared to setting of future practice | X | | | | X | X | X | X | X | | | | | | | | |

# LEARNING OBJECTIVES
# UROLOGY COMMUNITY ELECTIVES

During the PGY 2-5 years, residents have the opportunity to participate in community electives. Community Urology rotations are not a requirement of the Royal College but are offered to Urology residents by the program. The program may opt to cancel/change these rotations if a resident is not in good standing, or if revisions to the rotation schedule need to occur.

Elective time will be reviewed 2-3 months in advance of the scheduled elective and may be cancelled if the resident is not in good standing. The resident would then be placed back onto the rotation schedule at one of the Urology hospital sites.

Please contact the Urology Program Administrator for an updated list of locations previously attended by residents; however, adding new locations for electives is encouraged if objectives can be clearly met, and assurances that the preceptors will complete the end of rotation evaluation. This elective experience gives residents an introduction to community urologic practice with its attendant challenges and gratifications.

Sarnia (Dr. Paul Martin), Windsor (Dr. Ryan McLarty), Stratford (Dr. Jeffrey Law) and Owen Sound (Dr. Geoffrey Wignall) fall within the Schulich School of Medicine Distributed Education Network so costs to attend those locations is covered and housing is provided.

The objectives that should be met during this rotation include:

1. To develop an understanding of the logistics of establishing and running a community practice.
2. To be able to assess patients in the office setting with common urologic problems and present the relevant findings.
3. To be capable of formulating a management plan on patients seen in the office, understanding potential constraints unique to community practice.
4. To be aware of the types of investigational and interventional procedures which can appropriately be carried out in an ambulatory care setting.
5. To gain surgical experience in both endoscopic and open surgical procedures through supervised attendance in the operating room.
6. To understand the strengths and limitations of office-based vs. hospital-based clinical practice.
7. To gain a sense of the support services available in the community to assist in patient care.
8. To participate in the multi-disciplinary pathology rounds. Residents will be expected to present an interesting case for discussion and provide an update on a relevant topic of interest to the group.

*Urology EPA's are to triggered while on all community urology electives.

# AMBULATORY CLINIC GUIDELINES

1. **Punctuality**
    - Morning clinics: 8:00 am sharp (9:00 am on Wednesdays for certain clinics)
    - Afternoon clinics: 1:00 pm
    - Notify the consultant if you cannot be on time

2. **Patient Assessments**
    - **New Patients**: Complete history and physical examination within 15 minutes.
    - **Follow-up Patients**: Directed history and physical within 10 minutes.
    - **Patients Requiring OR**: Enter pre-admit and peri-operative orders

3. **Sensitive Encounters**
    - Female pelvic exams and sensitive male genital exams should include a chaperone which can include a same gender nurse or faculty member
        - This includes all vaginal exams, patient exams with a history of sexual trauma, or patients in which the resident feels uncomfortable examining the patient alone for any reason

4. **Missing Information**
    - Request missing investigations from the consultant's secretary
    - Inform the consultant if not available

5. **Consultant Interaction**
    - Consultants will repeat part of the interview and physical exam to build rapport and verify findings

6. **Management Plan (Senior Trainees PGY4-5)**
    - Discuss the management plan with the patient before consulting with the consultant.
    - Inform the patient that the consultant will review the plan before implementation.

7. **Case Presentation**
    **If Patient IS Present**
    - Use simple language, maintain eye contact and seek clarification as needed

8. **Dictation of Consultation Notes**
    - Please copy family physician and relevant allied healthcare professions on the dictation note
    - Keep notes comprehensive yet concise.
        - For consultations, please include all elements (CC, HPI, Past Hx, Allergies, etc.)
    - Provide an assessment and treatment plan or follow-up
    - Indicate on the chart if dictation is completed with your initials (include dictation #)
    - ***Ensure all clinic charts remain in the hospital and are returned to the consultant's office the next day. Charts must not be removed from the hospital premises.***

9. **Documentation**
    - Document the assessment and plan on the written record
    - Use "stat dictation" sparingly unless a timely report is required for an OR or intervention

10. **Leaving the Clinic**
    - Notify a clinic nurse or the consultant if you need to leave to see a patient in ER or assist in the OR

# OPERATING ROOM GUIDELINES AND ETIQUETTE

## 1. Punctuality

- OR starts at 8:00 AM, except Wednesday at 9:00 AM
- Please attend the OR 10 – 15 minutes prior to OR start time (notify the consultant if you are unable to be on time)

## 2. Pre-operative

- Prepare for the cases of the day - familiarize yourself with the patients
- Review all imaging and other relevant investigations
  - Ensure that you read up on the pathology and indications of each case
  - Ensure that you are familiar with the steps of the procedure - specifically on the steps for the surgeon's variation of the procedure
- Ensure all relevant orders are entered - this includes preoperative antibiotics, DVT prophylaxis, special pre-operative medication and/or investigations; admission reconciliations
- Arrive early to introduce yourself to the patient and answer any questions - mark side of operation and ensure documentation is in order
- Introduce yourself to nursing staff, make sure that your name and glove size are on the board, and request any special equipment that may be needed

## 3. Intraoperative

- Discuss any questions about the procedure with the consultant prior to each case
  - Clarify your role and what specific tasks / steps you hope to accomplish that day (parts of a case, primary surgeon etc)
- Review which case(s) you are hoping to receive feedback on with an EPA <u>before the start of the day</u> so that the consultant can appropriately evaluate you and provide timely assessment
  - Ensure the consultant is aware of your level of comfort or familiarity with the procedure or the surgeon's technique prior to the start of each case – example, ensure consultants are aware if this is the first time you've performed the procedure or have performed the procedure with the consultant.
- **Senior Supervisions**
  - The primary responsibility when supervising junior residents on a procedure is to ensure patient safety
  - Ensure a safe and supportive learning environment for the junior residents
  - Ensure that the case does not go into overtime, as this puts the patients later in the day at risk of being cancelled
- Ensure that you are performing the procedure in the variation of the most responsible consultant. It may be viewed as disrespectful to perform the procedure in a way that is not comfortable for the consultant.
- For junior residents, politely ask nurses to return pages as they come in to prevent any missed urgent calls – use common courtesy: do not ask while they are busy or while you are finishing closing, for example, and can therefore answer it yourself in a timely fashion. Before starting the case, you can ask nursing staff if they can return pages during the case when they have time.
- If you need to leave the case for an emergency, please discuss with the consultant before doing so and an estimated time of return

## 4. Post-operative

- Ensure all relevant postoperative orders are entered including admission reconciliation
- Accompany the patient to PACU and provide handover

## 5. Documentation

- Dictate operative at the direction of the consultant promptly, adhering to hospital policy
- Use "stat dictation" sparingly unless a timely report is required for an additional intervention.

## 6. Leaving the OR

- Notify a nursing team and the consultant if you need to leave to see a patient in ER

# STUDY OBJECTIVES FOR UROLOGY RESIDENTS

Studying for the Royal College Exams will be unlike any other exam preparation you have done before. The sheer volume of material to cover and the demands on your time during your surgical training should not be underestimated. Getting started on the "right foot" in the beginning is very important. It is realized that everyone studies differently and what works for one individual may not work for another. The information presented here may provide some suggestions on preparing for the Surgical Foundations and Urology Fellowship exams.

The following study objectives have been put together to serve as a periodic reminder of what material needs to be covered and whether you are on schedule with your reading. The objectives should be kept handy and referred to from time to time.

**SURGICAL FOUNDATIONS EXAM**

See section on Surgical Foundations

**UROLOGY ROYAL COLLEGE EXAM**

**Purpose**
The purpose of the examination is to assess the candidate's clinical competence and readiness to enter clinical practice. The exam is developed and reviewed by the Urology examination board, which is made up of practicing Canadian physicians who are recognized content experts. In addition, the exam is reviewed by a quality reviewer, a linguistic reviewer for translation accuracy, and a Royal College editor. The content of the examination is based on a blueprint that reflects the Competencies in Urology and the depth of knowledge required for the examination to ensure that the examination reflects relevant clinical practice in Urology. All candidates are strongly encouraged to read the blueprint and the Competencies thoroughly.

**Passing the Exam**
The Royal College examination in Urology consists of a written and an applied component.

- The written component of the examination is taken before the applied, and only those candidates passing the written examination will be invited to the applied examination
- The pass score is 70% for each component
- The examination is decoupled, and due to the standalone nature of each exam component, a candidate that is successful at the written component but not successful at the applied will not be required to retake the written component on their subsequent attempts
- Questions that were overly difficult, fail to distinguish between low and high scoring candidates, or for which new evidence emerged between the time of question writing and exam administration are reviewed

**Overall Format of the Examination**

| Component | Format | Number of Items | Total Test time |
|---|---|---|---|
| Written | Paper 1: MCQ | ~100-120 | 3 hours |
| Written | Paper 2: MC! | ~100-120 | 3 hours |
| Applied | OSCE | 6 stations x 20 minutes each | 2 hours |

For more information on the breakdown of the station time (for example, if there is reading time) please consult the Candidate Information Session document for your specialty at Information on applied exams at hotel sites closer to the exam date.

**Written Examination**

**Objective of the Written Examination:** The written examination measures knowledge and application of knowledge necessary to function as a competent specialist in Urology. Most questions will concentrate on the

Medical Expert role, but some can also assess the other intrinsic CanMEDS roles (Communicator, Professional, Health Advocate, Leader, Collaborator and Scholar).

**Content of the Written Examination:** The content of the examination is based on a blueprint that reflects the Competencies in Urology. The content is balanced to ensure an appropriate representation of the relevant domains. Typical areas of knowledge assessment and a range of percent marks on the examination are included in the table below.

| **Classification** | **% Marks*** |
|---|---|
| Neoplasm | 15-25 |
| Urolithiasis | 10-20 |
| Urinary tract obstruction | 5-15 |
| Trauma and fistula | 5-15 |
| Neurourology and voiding dysfunction | 5-15 |
| Pediatric urology and embryology | 5-15 |
| Andrology and endocrinopathy | 10-20 |
| Transplantation, nephrology, renovascular disease | 5-10 |
| Infection and inflammation | 5-15 |
| Basic sciences | 5-10 |
| Diagnostic techniques and imaging | 5-10 |
| Intrinsic CanMEDs roles (communicator, collaborator, leader, health advocate, scholar, professional | 0-10 |

*The ranges are approximate and may vary slightly

**Scoring of the Written Examination:** Each multiple-choice question is created with a single best answer. Scoring is an automated computer process through the online exam platform. All written examinations are combined to create one overall written score. In other words, you need a combined written score of 70% to pass the written component, but you do not need 70% on each paper.

See link for further details regarding the Royal College Exam: Home (royalcollege.ca)

Develop a filing system as early as possible to keep track of important references and handouts of specific topics. The following resources are considered **Core Urology** references:

1. Campbell's Urology 12th Edition*
2. AUA Updates*
3. CUA Guidelines
4. AUA Guidelines
5. CUAJ Review Articles
6. Journal of Urology Review Articles
7. AUA Core Curriculum

The following Urological periodicals are the most often referred to for the most current information:

1. Journal of Urology ("The Journal")
2. Urology ("Gold Journal")
3. Contemporary Urology
4. Journal of Endourology
5. Canadian Urological Association Journal

**In addition, up to date clinical practice guidelines published by the CUA and AUA should be part of your study material.*

# Reading Campbell's Urology

**Comprehensive Resource**
Campbell's Urology is essential for preparing for the Urology Royal College Exams, offering the most cited and consolidated core urology knowledge.

**Early Start**: Begin reading and summarizing the chapters as soon as possible to allow time for reviewing current information and focusing on difficult areas.

**Study Tips**

1. **Summarize Chapters**
   - Create study notes to review material quickly in the future, avoiding the need to re-read the entire text.
   - Use study notes and updated sources for consolidation in the final year.
2. **Focus on Basics First**
   - Start with basic chapters like anatomy and physiology to build a strong foundation.
   - As your knowledge grows, you'll better distinguish critical information from less important details.
3. **Reading Schedule**
   - Follow a structured reading schedule (provided) to stay organized and ensure you cover all necessary material in chronological order as you progress through residency.

## Additional Reading Tips for Royal College Exam Preparation

- **Regular Review**: Revisit your study notes regularly to reinforce your memory.
- **Practice Questions**: Use previous AUA-IS questions to familiarize yourself with the exam format and identify weak areas.
- **Group Study**: Join a study group to discuss and review material, which can enhance understanding and retention.
- **Stay Updated**: Keep up with the latest research and guidelines in urology to complement your knowledge from Campbell's. This can be accomplished by active participation during journal clubs and grand rounds.
- **Healthy Study Habits**: Maintain a balanced study routine, including breaks and a healthy lifestyle to ensure optimal focus and retention.

By organizing your study approach and utilizing these tips, you can efficiently prepare for the Urology Royal College Exams using Campbell's Urology.

## Campbell's Urology 12th Ed – Proposed Reading Schedule by PGY Year

| | | | PG YEAR | | | |
|---|---|---|---|---|---|---|
| **Ch** | **Section** | **Title** | **1** | **2** | **3** | **4** |
| 1 | Clinical Decision Making | Evaluation of the Urologic Patient: History and Physical Exam | 1 | | | |
| 2 | | Evaluation of the Urologic Patient: Testing and Imaging | 1 | | | |
| 3 | | Urinary Tract Imaging: Basic Principles of CT, MRI, and Plain Film Imaging | 1 | | | |
| 4 | | Urinary Tract Imaging: Basic Principles of Urologic U/S | 1 | | | |
| 5 | | Urinary Tract Imaging: Basic Principles of Nuclear Medicine | 1 | | | |
| 6 | | Assessment of Urologic and Surgical Outcomes | 1 | | | |
| 7 | | Ethics and Informed Consent | 1 | | | |
| 8 | Basics of Urologic Surgery | Principles of Urologic Surgery: Perioperative Care | 1 | | | |
| 9 | | Principles of Urologic Surgery: Incisions and Access | 1 | | | |
| 10 | | Principles of Urologic Surgery: IntraopTechnical Decisions | | 1 | | |
| 11 | | Lower Urinary Tract Catheterization | 1 | | | |
| 12 | | Fundamentals of Upper Urinary Tract Drainage | 1 | | | |
| 13 | | Principles of Urologic Endoscopy | 1 | | | |
| 14 | | Fundamentals of Laparoscopic and Rototic Urologic Surgery | | 1 | | |
| 15 | | Basic Energy Modalities in Urologic Surgery | 1 | | | |
| 16 | | Evaluation and Management of Hematuria | 1 | | | |
| 17 | | Complications of Urologic Surgery | | 1 | | |
| 18 | | Urologic Considerations in Pregnancy | | 1 | | |
| 19 | | Intraoperative Consultation | | | 1 | |
| 20 | Pediatric Urology | Embryology of the GU Tract | | 1 | | |
| 21 | | Urologic Aspects of Pediatric Nephrology | | 1 | | |
| 22 | | Perinatal Urology | | 1 | | |
| 23 | | Urologic Evaluation of the Child | | 1 | | |
| 24 | | Pediatric Urogenital Imaging | | 1 | | |
| 25 | | Infection & Inflammation of Pediatric GU Tract | | 1 | | |
| 26 | | Core Principles of Perioperative Management in Children | | 1 | | |
| 27 | | Principles of Laparoscopic & Robotic Surgery in Children | | 1 | | |
| 28 | | Clinical and Urodynamic Evaluation of Lower Urinary Tract Dysfunction in Children | | 1 | | |
| 29 | | Management Strategies for Vesicoureteral Reflux | | 1 | | |
| 30 | | Bladder Anomalies in Children | | | 1 | |
| 31 | | Exstrophy-Epispadias Complex | | | 1 | |
| 32 | | Prune Belly Syndrome | | | 1 | |
| 33 | | Posterior Urethral Valves | | 1 | | |
| 34 | | Neuromuscular Dysfunction of LUT in Children | | | 1 | |
| 35 | | Functional Dysorders of LUD in Children | | 1 | | |
| 36 | | Management of Defecation Disorders | | 1 | | |
| 37 | | LUT Reconstruction in Children | | | 1 | |
| 38 | | Anomalies of the LUT | | | 1 | |
| 39 | | Renal Dysgenesis and Cystic Disease of the Kidney | | | 1 | |
| 40 | | Pathophysiology and Urinary Tract Obstruction | | | 1 | |
| 41 | | Ectopic Ureter, Ureterocele, and Ureteral Anomalies | | | 1 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 42 | | Surgery of the Ureter in Children: Ureteropelvic Junction, Megaureter, and Vesicoureteral Reflux | | | 1 | |
| 43 | | Management of Pediatric Kidney Stone Disease | | | 1 | |
| 44 | | Management of Abnormalities of External Genitalia in Boys | 1 | | | |
| 45 | | Hypospadias | 1 | | | |
| 46 | | Etiology, Diagnosis and Management of Undescended Testis | 1 | | | |
| 47 | | Management of Abnormalities of External Genitalia in Girls | | | 1 | |
| 48 | | Disorders of Sexual Development: Etiology, Evaluation, and Medical Management | | | 1 | |
| 49 | | Surgical Management of Differences of Sexual Differentiation and Cloacal and Anorectal Malformations | | | 1 | |
| 50 | | Adolescent and Transitional Urology | | | 1 | |
| 51 | | Urologic Considerations of Pediatric Renal Transplantation | | | 1 | |
| 52 | | Pediatric Genitourinary Trauma | | 1 | | |
| 53 | | Pediatric Urologic Oncology - Renal and Adrenal | | | 1 | |
| 54 | | Pediatric Urologic Oncology - Bladder and Testis | | | 1 | |
| 55 | Infections & Inflammation | Infections of the Urinary Tract | 1 | | | |
| 56 | | Inflammatory & Pain Conditions of Male Genitourinary Tract: Prostatitis Related Pain & Conditions, Orchitis, &Epididymitis | 1 | | | |
| 57 | | Interstitial Cystitis/Bladder Pain Syndrome & Related Disorders | | 1 | | |
| 58 | | Sexually Transmitted Diseases | | 1 | | |
| 59 | | Cutaneous Diseases of the External Genitalia | | | 1 | |
| 60 | | Tuberculosis & Parasitic Infections of the GU Tract | | | 1 | |
| 61 | Molecular & Cellular Biology | Basic Principles of Immunol & Immunotherapy in UroOncology | | 1 | | |
| 62 | | Molecular Genetics and Cancer Biology | | 1 | | |
| 63 | Reproduction & Sexual Function | Surgical, Radiographic, and Endoscopic Anatomy of the Male Reproductive System | | 1 | | |
| 64 | | Male Reproductive Physiology | 1 | | | |
| 65 | | Integrated Men's Health: Androgen Deficiency, Cardiovascular Risk, and Metabolic Syndrome | | 1 | | |
| 66 | | Male Infertility | | 1 | | |
| 67 | | Surgical Management of Male Infertility | | | 1 | |
| 68 | | Physiology of Penile Erection and Pathophysiology of Erectile Dysfunction | | 1 | | |
| 69 | | Evaluation and Management of Erectile Dysfunction | | 1 | | |
| 70 | | Priaprism | 1 | | | |
| 71 | | Disorders of Male Orgasm and Ejaculation | | 1 | | |
| 72 | | Surgery for Erectile Dysfunction | | | 1 | |
| 73 | | Diagnosis and Management of Peyronie's Diseease | | | 1 | |
| 74 | | Sexual Function and Dysfunction in the Female | | | 1 | |
| 75 | Male Genitalia | Surgical, Radiographic, & Endoscopic Anatomy of Retroperitoneum | | 1 | | |
| 76 | | Neoplasm of the Testis | | 1 | | |
| 77 | | Surgery of Testicular Tumors | | 1 | | |
| 78 | | Laparoscopic and Robotic-Assisted Retroperitoneal Lymphadenectomy for Testicular Tumors | | | 1 | |
| 79 | | Tumors of the Penis | | 1 | | |
| 80 | | Tumors of the Urethra | | 1 | | |
| 81 | | Inguinal Node Dissection | | | 1 | |
| 82 | | Surgery for Benign Disorders of the Penis and Urethra | | | 1 | |

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|---|---|---|---|---|---|---|
| 83 | | Surgery of Scrotum and Seminal Vesicles | | | 1 | |
| 84 | Renal Physiology & Pathophysiology | Surgical, Radiologic, & Endoscopic Anatomy of Kidney & Ureter | 1 | | | |
| 85 | | Physiology and Pharmacology of the Renal Pelvis and Ureter | | 1 | | |
| 86 | | Renal Physiology and Pathophysiology Including Renovascular Hypertension | | 1 | | |
| 87 | | Renal Insufficiency and Ischemci Neuropathy | | 1 | | |
| 88 | | Urologic Complications of Renal Transplantation | | | 1 | |
| 89 | UUT Obstruction & Trauma | Management of UUT Obstruction | | | 1 | |
| 90 | | UUT Trauma | | | 1 | |
| 91 | Lithiasis & EndoUrology | Urinary Lithiasis: Etiology, Epidemiology, and Pathogenesis | | 1 | | |
| 92 | | Evaluation and Medical Management of Urinary Lithiasis | | 1 | | |
| 93 | | Strategies for Nonmedical Management of UUT Calculi | | 1 | | |
| 94 | | Surgical Management for UUT Calculi | | 1 | | |
| 95 | | LUT Calculi | | 1 | | |
| 96 | Neoplasms of UUT | Benign Renal Tumors | | 1 | | |
| 97 | | Malignant Renal Tumors | | 1 | | |
| 98 | | Urethelial Tumors of the UUT and Ureter | | | 1 | |
| 99 | | Surgical Management of UUT Urethelial Tumors | | | 1 | |
| 100 | | Retroperitoneal Tumors | | | 1 | |
| 101 | | Open Surgery of the Kidney | | | 1 | |
| 102 | | Lap and Robot Surgery of the Kidney | | | 1 | |
| 103 | | Nonsurgical Focal Therapy of Renal Tumors | | | 1 | |
| 104 | | Treatment of Advanced Renal Cell Carcinoma | | | 1 | |
| 105 | The Adrenals | Surgical and Radiographic Anatomy of the Adrenals | | | 1 | |
| 106 | | Pathophysiology, Evaluation, & Med Mgmt of Adrenal Disorders | | | 1 | |
| 107 | | Surgery of the Adrenal Glands | | | 1 | |
| 108 | Transport, Storage & Emptying | Surgical, Radiographic, & Endoscopic Anatomy of Female Pelvis | 1 | | | |
| 109 | | Surgical, Radiographic, & Endoscopic Anatomy of Male Pelvis | 1 | | | |
| 110 | | Physiology and Pharmacology of the Bladder and Urethra | | 1 | | |
| 111 | | Pathophysiology & Classification of LUT Dysfunction: Overview | | 1 | | |
| 112 | | Evaluation and Management of Women With Urinary Incontinence and Pelvic Prolapse | | 1 | | |
| 113 | | Evaluation & Management of Men With Urinary Incontinence | | 1 | | |
| 114 | | Urodynamic and Video-Urodynamic Evaluation of the LUT | | 1 | | |
| 115 | | Urinary Incontinence & Pelvic Prolapse: Epidemiology & Pathophysiology | | 1 | | |
| 116 | | Neuromuscular Dysfunction of LUT | | 1 | | |
| 117 | | Overactive Bladder | | 1 | | |
| 118 | | The Underactive Detrusor | | 1 | | |
| 119 | | Nocturia | 1 | | | |
| 120 | | Pharmacologic Management of LUTStorage & Emptying Failure | | 1 | | |
| 121 | | Conservative Management of Urinary Incontinence: Behavioral & Pelvic Floor Therapy, Urethral & Pelvic Devices | | 1 | | |
| 122 | | Electrical Stimulation and Neuromodulation in Storage and Emptying Failure | | | 1 | |
| 123 | | Retropubic Suspension Surgery for Incontinence in Women | | | 1 | |

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|---|---|---|---|---|---|---|
| 124 | | Vaginal and Abdominal Reconstructive Surgery for Pelvic Organ Prolapse | | | 1 | |
| 125 | | Slings: Autologous, Biologic, Synthetic, and Mid-urethral | | | 1 | |
| 126 | | Complications Related to the Use of Mesh and Their Repair | | | 1 | |
| 127 | | Additional Therapies for Storage and Emptying Failure | | | 1 | |
| 128 | | Aging and Geriatric Urology | | 1 | | |
| 129 | | Urinary Tract Fistulae | | | 1 | |
| 130 | | Bladder and Female Urethral Diverticula | | | 1 | |
| 131 | | Surgical Procedures for Sphincteric Incontinence in the Male | | | 1 | |
| 132 | Benign & Malignant Bladder Disorders | Bladder Surgery for Benign Disease | | 1 | | |
| 133 | | Genital and LUT Trauma | | 1 | | |
| 134 | | Special Urologic Considerations of Transgender Individuals | | 1 | | |
| 135 | | Tumors of the Bladder | | 1 | | |
| 136 | | Management Strategies for Non–Muscle-Invasive Bladder Cancer (Ta, T1, and CIS) | | 1 | | |
| 137 | | Management of Muscle-Invasive and Metastatic Bladder Cancer | | | 1 | |
| 138 | | Surgical Management of Bladder Cancer: Transurethral, Open, and Robotic | | | 1 | |
| 139 | | Use of Intestinal Segments in Urinary Diversion | | | 1 | |
| 140 | | Cutaneous Continent Urinary Diversion | | | 1 | |
| 141 | | Orthotopic Urinary Diversion | | | 1 | |
| 142 | | Minimally Invasive Urinary Diversion | | | 1 | |
| 143 | Prostate | Development, Molecular Biology, & Physiology of Prostate | 1 | | | |
| 144 | | Benign Prostatic Hyperplasia: Etiology, Pathophysiology, Epidemiology, and Natural History | | 1 | | |
| 145 | | Evaluation * Nonsurgical Management of BPH | | 1 | | |
| 146 | | Minimally Invasive & Endoscopic Management of BPH | | 1 | | |
| 147 | | Simple Prostatectomy: Open and Robotic-Assisted Laparoscopic Approaches | | | 1 | |
| 148 | | Epidemiology, Etiology, and Prevention of Prostate Cancer | 1 | | | |
| 149 | | Prostate Cancer Biomarkers | | | 1 | |
| 150 | | Prostate Biopsy - Technique and Imaging | | | 1 | |
| 151 | | Pathology of Prostatic Neoplasia | | | 1 | |
| 152 | | Diagnosis and Stating of Prostate Cancer | 1 | | | |
| 153 | | Active Management Strategies for Localized Prostate Cancer | | 1 | | |
| 154 | | Active Surveillance of Prostate Cancer | | 1 | | |
| 155 | | Open Radical Prostatectomy | | | 1 | |
| 156 | | Laparoscopic and Robotic-Assisted Laparoscopic Radical Prostatectomy and Pelvic Lymphadenectomy | | | 1 | |
| 157 | | Radiation Therapy for Prostate Cancer | | | 1 | |
| 158 | | Focal Therapy for Prostate Cancer | | | 1 | |
| 159 | | Treatment of Locally Advanced Prostate Cancer | | | 1 | |
| 160 | | Management Strategies for Biochemical Recurrence of Prostate Cancer | | | 1 | |
| 161 | | Treatment of Castration Resistant Prostate Cancer | | | 1 | |
| | | **Total** | **28** | **65** | **68** | **0** |

## Study Recommendations for the Latter Half of PGY4

1. **Complete Reading Key Chapters**
    - By this time, ensure you have read the most important chapters from Campbell's Urology.
2. **Create Study/Review Notes**
    - Begin consolidating information from Campbell's with material from AUA Updates and Journal of Urology Review Articles.
3. **Seek Guidance**
    - If you need someone to review your study notes or discuss study techniques, feel free to ask.
    - Recent exam takers are available to provide guidance and share their experiences.

# GENERAL EXPECTATIONS OF UROLOGY RESIDENTS

## General Responsibilities:

***Role Model***

- As a resident, you are a role model for those working with you, especially medical students on the service - your behavior and attitudes will be closely observed by them
- Maintain responsibility to your patients, ensuring their proper management and continuity of care
- Remember your CanMEDS roles, as you will be evaluated on each of them

***Self-Confidence and Responsibility***

- Develop a sense of self-confidence and responsibility throughout your training
- Never hesitate to ask questions, especially when uncertain about what to do - this demonstrates self-awareness and insight into your own limitations

***Patient Advocacy and Ethical Decision-Making***

- Grow basic skills in advocating for patients who cannot speak for themselves
- Become involved in difficult ethical decision-making such as withdrawal of care and organ donation

***Professional Attitude and Behavior***

- Demonstrate the appropriate attitude and behavior expected of a competent physician
- Effectively interact and communicate with other members of the health care team and with patients and their families

***Code of Conduct***

- Abide by the Western & LHSC code of conduct, which includes:
    - Respecting and considering the opinions and contributions of others
    - Embracing compassion and showing genuine concern for patients and their families
    - Sharing suggestions and concerns with discretion and tact
    - Protecting privileged information
    - Engaging in honest, open, and truthful communication
    - Creating and fostering a collaborative and caring work environment
    - Treating everyone with dignity and respect

## Clinical Expectations

***Junior Resident***

- **Consultation Review**: All junior residents (PGY1-2 and PGY3 not approved for senior call) must review consultations with senior residents before consulting with the on-call or the most responsible urologist

***Senior Resident***

- **Morbidity and Mortality (M&M)**: Chief residents (PGY5) at each site must log all morbidity and mortality cases and present them at M&M Rounds, held quarterly
- **Clinic and OR Allocation**: Most senior resident at each site assign residents to various clinics and ORs, with the understanding that junior residents may need to move between clinic and OR as required

***Morning Rounds***

- **Timing and Tasks**: Begin morning rounds early enough to complete all tasks, including patient assessments and interventions (bladder irrigations, etc..) before attending the operating room or outpatient clinic
- **Patient Problem List**: Review and update each patient's problem list during rounds

- **Task Delegation**: Most senior resident at the site assign tasks and investigations to junior team members
- **Critical Patients**: Reassess more critical patients later in the day before leaving
- **Progress Notes**: Write progress notes for each assessment and any status changes

***Handover Procedure***

The most senior resident at each site must communicate the following to the on-call team before leaving the hospital:

- **Inpatient and Consultation Summary**: Overview of all inpatients and active patients on the consultation list
- **Postoperative Patients**: Summary of postoperative procedures, including the plan and disposition
- **Discharged Patients**: Brief summary and plan for recently discharged patients
- **Pending Tasks**: Details of required pending tasks and follow-up investigations, including the plan after task completion and the contact person
- **Critical Patients**: Summary of critical patients, including the plan, contact information, and necessary follow-up (e.g., reassessments)
- **Pending Consultations/Transfers**: Status of pending consultations or transfers

***Ward Management***

- **Collaboration**: Work with the healthcare team (nurses, psychologists, nutritionists, social workers, physiotherapists) to plan patient care and expedite discharge
- **Bed Management**: Contact the responsible urologist or on-call bed manager for bed management issues

***Outpatient Clinics***

- **Attendance**: Attend at least one outpatient clinic per week, as mandated by the program and the Royal College
- **Timeliness and Education**: Be on time for clinics - attending clinics and managing consultations are integral to education and training
- **Patient Assessment**: Assess patients in outpatient settings, determine operative risks, obtain informed consent, and educate patients and families
- **Review with Urologists**: Review all patients with attending urologists.

***Operative Room***

- **Pre-operative Assessments**: Study the pathology, procedure, and surgeon's technique the night before. Review patient charts before coming to the OR
- **Pre-op Preparation**: Arrive early, introduce yourself to the patient, and mark the surgical site
- **Intra-operative**: Assist in operations, introduce yourself to the anesthesiologist and nursing staff, and prepare relevant images and blood work - coordinate with the fellow or resident on first assist duties
- **Post-operative Reports**: Dictate operative reports unless stated otherwise by the staff surgeon and ensure continuity of postoperative care

***Inpatient or Emergency Room Consultations***

- **Timely Response**: Accommodate consultation requests promptly and inform the on-call or patient's urologist if unable to attend
- **Documentation**: Write and dictate notes for all inpatient consultations, dictate notes for ER patients who are discharged - ensure the quality of dictated notes, revising if necessary
- **Review**: Review consultations with attending urologists and manage the inpatient consultation list

***On-call Responsibilities***

- **Communication**: Communicate patient-care issues to the on-call urologist in a timely manner, no later than 9:00 am the following morning if the issue is non-urgent or requires admission

- **Consultations**: Do not block consultations from the ER, wards, or transferring hospitals - if a consultation seems inappropriate, notify the on-call urologist immediately

***Discharge Documentation***

- **Timeliness**: Complete discharge summaries for all patients within 24 hours of discharge - junior residents should dictate summaries following rounds
- **Disposition:** Ensure follow-up or confirm disposition with responsible urologist prior to removing off consultation list

## Educational Expectations

***General Requirements***

- **Attendance**: Prepare, attend, and arrive on time for weekly Grand Rounds and Royal College Exam Prep (RCEP) sessions - attendance is mandatory for residents on the Urology service and strongly recommended for those on off-service rotations
- **1st-Year Residents**: Required to attend all Surgical Foundations courses and are excused from the resident seminar series during this time

***Grand Rounds***

- **Preparation**: Responsibility of all on-service residents and fellows
- **Scheduling**: Follow the grand round schedule for resident and faculty assignments
- **Coordination**: Contact faculty at least 2 weeks in advance to ensure availability and discuss the case to be presented

***Morbidity and Mortality Rounds***

- **Responsibility**: Chief residents (PGY5) are responsible for:
    - Maintaining a list of cases at each site.
    - Preparing cases for M&M rounds.
    - Presenting cases and attending M&M rounds.

***Academic Half Days***

- **Attendance**: Mandatory attendance at Tuesday morning academic half-day sessions, arriving promptly at 6:45 am
- **Resident Seminar Series**: Each resident must prepare for their assigned seminar and contact the supervising faculty to review the presentation at least 2 weeks prior to presentation – mandatory attendance for all residents
- Send objectives and presentation in advance of the day to the PA

***Journal Clubs***

- **Participation**: Attend and participate in all scheduled Journal Clubs
- **Preparation**: Residents will be assigned to prepare a summary of articles in advance of the journal club

***Simulation Labs***

- **Usage**: Utilize the simulation training facilities at CSTAR and the Kelman Centre at University Hospital

***Anatomy Labs and OSCEs***

- **Attendance**: Attend scheduled simulation sessions, anatomy labs, and OSCEs. These are supervised by faculty, with schedules provided at the beginning of the year (July 1). Attendance is mandatory.

***Reading***

- **Case Preparation**: Familiarize yourself with operative procedures, indications, complications, relative anatomy, and embryology related to your cases
- **General Reading**: Maintain a set reading schedule for Campbell's Urology, reading outside of case-specific materials

# RESIDENT WELLNESS

**2024-2025** Victoria Turnbull, Urology Resident Wellness Representative/Champion
Dr. Nicholas Power, Urology Faculty Wellness Representative

Visit the Urology website: (http://www.schulich.uwo.ca/urology/education/postgraduate/residents_in_distress.html)

## Take Care of Yourself!

If at any time you are experiencing difficulty during your Residency training and do not feel comfortable speaking to the Residency Program Director, you may contact any of the following:

**London**

- Dr. Sandra Northcott, Associate Dean, Learner Experience, Schulich School of Medicine & Dentistry is available to discuss any issues or concerns related to equity/intimidation/professionalism and/or gender issues. Dr. Northcott can be reached at snorthc2@uwo.ca

- Dr. Robert Stein, Assistant Dean, Learner Experience, Undergraduate Wellness. Dr. Stein can be reached at robert.stein@lhsc.on.ca

- Dr. Laura Diachun, Assistant Dean, Postgraduate Learner Experience. Dr. Diachun can be reached at laura.diachun@sjhc.london.on.ca

- Ms. Pam Bere, Manager/Counsellor, Learner Experience: 519.661.2111 x 86250 or by email at pamela.bere@schulich.uwo.ca

**Windsor**

- Assistant Director, Learner Experience - TBD

- Ms. Stephanie Coccimiglio, Learner Experience Coordinator: 519.253.3000 x4302 or by email at learnerexperience@uwindsor.ca

Ontario Medical Association: Physician Health Program php.oma.org
1-800-851-6606 joy.albuquerque@oma.org

## Help is Only a Phone Call Away!

- Postgraduate Medical Education Office**: 519.661.2019,** postgraduate.medicine@schulich.uwo.ca
- LHSC Employee Assistance Program**: Homewood Human Solutions**
  www.homewoodhumansolutions.com **1.800.265.8310**
- The Western University Ombudsperson**:** 519.661.3573, ombuds@uwo.ca

## Protect Yourself and Take Time Off!

**The PARO 24 Hour Helpline** is available for any resident, partner or medical student needing help. It is separately administered by the Distress Centre of Toronto and is totally confidential.
Phone: 1.866.435.7362 (1-866-HELP-DOC)

# PGME POLICIES AND GUIDELINES

Visit the Academic Resources page of the PGME Website:

https://www.schulich.uwo.ca/medicine/postgraduate/academic_resources/policies.html

Resources available on this page:

- Resident & Trainee Selection
- Assessment, Appeals, Probation, Suspension & Termination
- Program Director Appointment and Support for Accredited Programs
- Learning Accommodations
- Leaves of Absence and Training Waivers
- Supervision
- Resident Safety, Health, Wellness, and Fatigue Risk Management
- Virtual Care
- Transfers
- Conduct, Ethics, Professionalism
- Rotations Related
- Faculty Evaluation
- Moonlighting
- Program Responsibilities in Clinical Fellowship and AFC Education
- Competency Based Medical Education (CBME)

Division of Urology

# Vacation Protocol

(Applies to On-Service Urology Residents)

1. The resident must submit to the Urology Program Administrator (PA) and Chief Resident, via email, the vacation/academic leave request - *at minimum* - 4 weeks prior to proposed start date of the leave.

2. The chief resident will review the request and determine whether this request can be accommodated, given the number of residents on rotation at that particular site at that time, and respond back to the requestion resident (copying the PA) within two weeks of the request being made. The request will then be logged into the vacation tracker.

3. If the request is denied by the chief resident, then alternate dates will be proposed to the requesting resident for review and the Program Director (PD) will be notified.

4. Once steps 1-3 have been completed and approval acquired, the PA will document the time away and notify the requesting resident that the time has been approved.

- Requests are approved resident on a first-come basis. Please allow two weeks for the process and approval notification
- A resident cannot be post-call on the first day of vacation
- Verbal vacation, education/conference requests will not be granted - all requests must be submitted as above.

Vacation:
Residents are entitled to 4 (four) weeks, 20 business days, paid vacation per year (a week consists of 7 days which includes 5 working days and 2 weekend days) of paid vacation per year. Book-ending weekends will not be approved. If a resident is scheduled to work on a recognized holiday, he/she shall be entitled to a paid day off in lieu of the holiday to be taken at a time mutually convenient within ninety (90) days of the holiday worked.

Professional Leave:
In addition to vacation entitlement, residents shall be granted additional paid leave for educational purposes - up to a maximum of seven (7) working days per year. Such leave may be taken by housestaff at any time, provided only that professional and patient responsibilities are met to the satisfaction of the hospital department head and pre-approved per the same process as vacation requests.

Exam Time:
Each resident shall be entitled to paid leave for the purpose of taking any Canadian or American professional certification examination; for example, Royal College examinations, LMCC, etc. This leave shall include the exam date(s) and reasonable travelling time to and from the site of the examination. This leave shall be in addition to other vacation or leave.

RC Exams for Chiefs: Each Chief resident will be granted two extra weeks of study time – one week prior to each exam. This is non-transferable (ie. cannot be used as vacation time or re-allocated).

2014.05.22 20191106 Reviewed by RTC, no changes

# GUIDELINES FOR DIVISION OF UROLOGY SUPPORT OF RESIDENTS TRAVEL/CONFERENCE EXPENSES

1. The Division of Urology will provide funding per annum (July 1-June 30) for travel as follows:

| PGY | Amount | Meeting | Details |
|---|---|---|---|
| 1 | $2,000 | AUA, CUA or other urology meeting (ie. ISSM, Northeastern Section | - abstracts to be provided to the program in advance of the meeting<br>- all residents must request permission from the program prior to attending as priority is given to those presenting and to PGY4s |
| 2 | $2,000 | | |
| 3 | $2,000 | | |
| 5 | $2,000 | | |
| 4 | $2,000 | Fellowship interviews, AUA | |

2. On occasion, a resident may wish to attend **additional meetings to present research work**. The resident must speak with the research supervisor prior to submitting an abstract, who **may be able** to provide financial aid. Confirmation should be secured, **<u>in writing and well in advance of the meeting</u>, from the supervisor of the ability to provide support.** If more than one resident is involved in a research project, ***the resident most responsible for the work to be presented will be the only resident provided with financial assistance***. By definition, a "presentation" refers to a podium talk or a moderated poster session where a verbal report is given. An un-moderated poster session would not be subject to financial support. Funding requests to research supervisors after the meeting will **<u>not</u>** be approved.

3. The maximum allowable claim for expenses will be $2,000 per annum as noted above. Claims for reimbursement of expenses will require completion of a travel expense form and receipts provided to Program Administrator, as well as the abstract if applicable.
   - If a room is shared, both/all names must be on the receipt, and only that share of the room expenses can be claimed
   - Each resident must submit their own receipts (residents submitting receipts/costs to be attributed to another residents annual allowable is not allowed)

4. Personal costs such as entertainment and alcohol expenses will not be reimbursed.

5. Travel, accommodation and meal expenses should be claimed for the resident only. If family members attend the conference, their expenses will not be covered by the Division.

6. Airfare re-imbursement will be for **Advanced Purchase Economy Class rates (lowest fares).** Flights should be booked as early as possible to take advantage of the lowest available fares.

7. Accommodation reimbursement will be for a standard, single room rate, preferable shared accommodation with other residents.

8. When meeting expenses were incurred in the US or foreign currency, currency conversion should be performed using rates obtained at: http://www.uwo.ca/finance/finexch/.

9. If a cash advance is needed to cover certain expenses prior to the meeting, please contact the Program Director to discuss.

10. There will be no carry forward of unused funding in a given year to a future year.

11. Time off for meetings is at the discretion of the Chief Resident to ensure adequate coverage of clinical activities. Preference will be given to PGY4s and residents **orally** presenting at meetings.

12. To claim reimbursement, email receipts to the Program Administrator, together with a summary of expenses

Revised: 2021.10.04 2023.09.12 2024.08.26

# THE DR. GERALD BROCK RESIDENT CAREER DEVELOPMENT AWARD

1. One award will be provided per academic year for urology residents primarily presenting at specialty international conferences (excluding the AUA, CUA or NSAUA), for short-term international electives, or educational courses (example POCUS, robotics, etc.) that align with individual career plans/goals.

2. Up to $5,000 Canadian per year will be awarded to one resident. Unused funds will be carried forward to the following year.

3. For residents presenting at an international conference, this award may be used in addition to the annual travel allowable by the Division of Urology.

4. Deadline for applications is December 31 (for the academic year July 1 to June 30) each year and adjudicated by members of the Residency Training Committee.

5. Eligibility criteria:
   a. All urology residents, regardless of PGY level, are eligible to receive this award.
   b. For specialty international conferences, research must have been carried out by the resident and accepted for presentation as a podium or a moderated poster. An un-moderated poster session would not be subject to support.
   c. For courses or international electives, the resident must confirm acceptance by receiving institution, as well as prior approval from their home institution in order to be eligible for this award. Retrospective support will not be supported by this award.
   d. Priority will be given to residents who have not previously received a travel award in the past two years. This award will not be considered for residents presenting the same research at multiple conferences.

6. Application requirements:
   a. An essay (1000 words maximum) describing why attending this course, specialty conference, elective will be beneficial for the academic career of the resident.
   b. For specialty international research conferences:
      i. Accepted abstract including the acceptance letter detailing the nature of the presentation format.
      ii. Details regarding the topic, name, date and location of the conference/course.
      iii. If involving research, a one-page outline of the proposed manuscript including the following sections: introduction, materials and methods, results, discussion and a brief list of references.
      iv. Letter of support from research supervisor.
   c. For international electives
      i. Acceptance letter detailing the institution, date, duration and supervisor of elective.
         1. Supervisor at receiving institute agrees to submit formal evaluation of elective rotation.
      ii. Letter of support from Program Director.
   d. Upon 30 days of returning from the conference or elective, resident must submit the following:
      i. a 250-word description of what they learned from the conference/elective/course.
      ii. Travel expense form with original receipts flights/mileage, accommodation and meals.
      iii. Personal costs such as entertainment expenses will not be reimbursed.

iv. When meeting expenses were incurred in the US or foreign currency, currency conversion should be performed using rates obtained at: http://www.uwo.ca/finance/finexch/.

7. The Program Director and/or Divisional Chair, in consultation with the Residency Training Committee, may approve the use of the award under unprecedented circumstances to support residents presenting at ALL research conferences (with the same requirements listed above).

8. If a cash advance is needed to cover certain expenses before the meeting, please contact the Program Director to discuss.

2021.07.08

# Division of Urology

## UROLOGY RESIDENT
## ELECTIVE POLICY – Clinical / Research

(Applies to On-Service Urology Residents)

- Community Urology rotations are not a requirement of the Royal College but are offered to Urology residents by the program. The program may opt to cancel/change these rotations if a resident is not in good standing, or if revisions to the rotation schedule need to occur.
- Elective time will be reviewed 2-3 months in advance of the scheduled elective and may be cancelled if the resident is not in good standing. The resident would then be placed back onto the rotation schedule at one of the Urology hospital sites.
- Community electives are not transferable between years. If a community elective is redistributed / cancelled for any reason the program cannot guarantee that a new elective will be scheduled in its place.
- Sarnia, Windsor, Stratford and Owen Sound fall within the Schulich School of Medicine Distributed Education Network so costs to attend those locations is covered and housing is provided.
- A four (4) week reading/study block is NOT an acceptable substitute for a true research rotation.

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1. Research and Clinical Electives will be granted only to residents in good standing within the program.

2. Proposed electives must be submitted, **in writing**, to the Assistant Program Director (APD) and the Program Administrator for approval a **minimum of eight (8) weeks prior** to the start of the elective.

   **Each proposal must be accompanied by the following**:
   a. A defined set of objectives for the elective
   b. The name and email address of the elective supervisor
   c. Proof of agreement from the elective supervisor
      - Proof of agreement by elective supervisor to accept your request of the elective must include a statement that "they agree to accept your elective request, and that they agree to complete and return an evaluation upon completion of the elective"
   d. Completed, signed form must be submitted 8 weeks in advance of elective (see form below)

3. Elective requests that are not one full block (example: concurrent clinical electives, split time – research/clinical) must be pre-approved a minimum of 8 weeks in advance of the elective by the Program Director and Assistant Program Director, as well as the elective supervisor.

4. For research electives, a **mid-elective progress report is required** to be provided to the elective supervisor and the PD for review, as well as an end-elective report of work accomplished.

5. Any vacations during this research or clinical elective must be approved and requested as per the vacation policy. Preceptor approval of this vacation time is also required.

6. For research electives, the resident must remain in the city and be available to attend all education events, participate in call and must check-in with their preceptor on a regular basis.

PGME policy on resident elective rotations: Resident-Electives-Rotation-Policy-2024.pdf (uwo.ca)
2014.05.22 Updated: 2019.09.03 Revised: 2020.11.13, 2023.04.26: approved by RPC 2024.08.29

Schulich MEDICINE & DENTISTRY

Western

# Division of Urology

## UROLOGY RESIDENT
## ELECTIVE (Clinical or Research) REQUEST FORM

| | |
|---|---|
| Resident Name | |
| PG Year | |
| Dates of Requested Elective | |
| Location of Requested Elective | |
| Submission Date of Elective Request to Program | |

List Objectives for this Elective:

| |
|---|
| |
| |
| |
| |

| | |
|---|---|
| Name of Preceptor for this Elective | |
| Email Address of Preceptor | |
| Date of Signature | |
| Signature of Preceptor | |
| As Preceptor of this elective, I agree to complete (and return) an evaluation form for this rotation | Yes or No |

| | Date | Signature |
|---|---|---|
| Resident | | |
| Program Director/ Assistant Program Director | | |

# DIVISION OF UROLOGY

## ON-CALL SCHEDULE POLICY

**1. Overview**

The resident on-call schedule is managed by the Chief Resident, who is responsible for the following:

- Approving all vacation and educational/professional leave requests in collaboration with the Program Administrator, adhering to PARO guidelines
- Ensuring equitable distribution of call duties, including weekend and holiday coverage

**2. Schedule Creation and Approval**

- *Quarterly Planning:* The Chief Resident is responsible for drafting weekend and holiday call schedules quarterly, ensuring equitable distribution across the year
- *Monthly Planning:* Monthly on-call schedules must be finalized well in advance of each month (e.g., the June schedule by May 1) and should aim for fairness and equity, with adjustments made annually to balance any disparities
- *Final Approval:* Once the schedule is finalized, no changes can be made without the approval of the Chief Resident. In case of disputes, the Chief Resident will review and resolve them. If a resolution is not reached, the Program Director or Assistant Program Director will make the final decision.

**3. Ensuring Adequate Coverage (I.e. for Annual Urology Meetings, etc...)**

- *Responsibility*: The Chief Resident is to ensure adequate daytime and on-call coverage during the resident examinations, educational courses, the American Urological Association (AUA) and Canadian Urological Association (CUA) meetings, adhering to PARO guidelines – the program will have the final decision regarding time off for the AUA and CUA annual meetings
- *Approval Process*: The Chief Resident reviews requests for educational leave or vacation during these meetings, considering the presentations and roles of residents, and then approves or denies these requests.
- Approvals or denials must be communicated to the Program Administrator for documentation
- *Documentation:* The Program Administrator maintains up-to-date records of vacation days, education days, lieu, and float days, and on-call days, and provides this information regularly to the Chief Residents

**4. Criti-Call Protocol**

*Process*:

- The senior resident is contacted by Criti-Call to discuss patient admission and transfer appropriateness
- If appropriate, the senior resident checks bed availability and coordinates with the Criti-Call assigned faculty
- If no bed is available, the senior resident contacts the on-call faculty at other sites

**5. On-Call/Night Float**

*5.1 On-Call Limits*

- *PARO Compliance*: Call duties must not exceed the limits set by the PARO agreement
- *Home Call Limits*: The maximum home call is 1 in 3. Specific limits are as follows:

| Number of Days | Maximum Home Calls |
|---|---|
| 17-19 | 6 |
| 20-22 | 7 |
| 23-25 | 8 |
| 26-28 | 9 |
| 29-30 | 10 |

- *Restrictions:* Residents cannot be on home call for two consecutive weekends - home call duties cannot be averaged over multiple months
- *Blended Call*: For services requiring both in-house and home call, use the following formula to calculate the maximum number of calls over a 28-day period:

  ***(Number of Home Call Assignments) x 3 + (Number of In-House Assignments) x 4 = Maximum of 30***

*5.2 Night Float Call*

- *Scheduling*: Night float call is scheduled as home call, typically covered by PGY1-3 residents, with backup from more senior residents (PGY3-5).
- *Format:*
  - Days: Monday (work during the day) to Thursday
    - Residents cover night float from 17:00 – 08:00.
  - Post-Call: Residents must leave the hospital by 08:00 and may round with their teams but cannot be assigned tasks that delay departure.
- *Exemptions*: Residents on night float are not expected to cover flanking weekend call
- *Participation*: Residents on research blocks or other non-clinical rotations are still expected to provide backup home call coverage in a reduced capacity

**6. On-Call Conversions and Post-Call Days**

- *Conversion Criteria: Calls can be converted if:*
  - The resident is called into the hospital between midnight and 06:00
  - The resident is called in for at least four consecutive hours, with at least one hour extending past midnight
- *Post-Call Protocol:*
  - Junior Residents: Excused from all duties the following day if call is converted
  - Senior Residents: May opt out of clinical duties the following day if the call is converted - the Chief Resident must ensure clinical coverage and notify relevant staff of the absence
- *Handover:*
  - Residents must ensure proper handover and sign out of patients before leaving post-call
- *Communication:*
  - Residents are expected to respond to pages promptly and notify the Chief Resident, staff person, and Program Administrator if unable to report for duties

Revised: 2024.08.14

Approved: 2024.08.29

# *UROLOGY CHIEF RESIDENT EXPECTATIONS AND GUIDELINES*

1. Call schedule is to be sent out a month in advance.

2. Master rotation schedule should be done as early as possible (sent to us by the Department of Surgery by mid-May). Try to give PGY4s electives starting in September for interviews and site visits. PGY5s to be assigned to St. Joseph's (or UH if necessary) while Acting Chief.

2. Vacations should be approved ASAP (general rule of no more than two off at a time). PARO rules – residents are to submit vacation requests 4 weeks before the proposed commencement of the vacation.

3. Rules for conferences:
   - Need to maintain a minimum of 6 residents in the city
   - Priority to attend conferences:
     1. Interviews
     2. Podium presentation (if issues, program may ask for copy of acceptance letter)
     3. Then posters
     4. First come first serve (PGY5s lowest priority)

4. Controversies with Junior residents regarding scheduling changes can occur. Decisions by Chiefs to move junior residents from site to site for coverage may occur if absolutely necessary, but if the switch encompasses more than one day approval is required - the Assistant PD and Program Administrator are to be notified and approval requested.

5. Disagreement among Chiefs may occur which should be handled professionally and respectfully -- it is never appropriate to use aggressive or derogatory language against another resident. If disagreement occurs, the PD/APD should be contacted to mediate.

6. Grand rounds schedules and Resident Seminar schedules are done well in advance by the program. Chief residents are to ensure that residents have cases, are prepared and have contacted assigned faculty by the deadline. Presentations and objectives are to be sent in advance to the PA.

7. Keep track of radiology rounds and ensure years at the site to compile cases and send to radiologist one week in advance.

Updated: 2024.08.26

# Expectations for PGY4/5 Residents During Exam Preparation

**1. Clinical Duties**

- **Attendance:** PGY4/5 residents are expected to fulfill their clinical duties throughout the year; absences are only acceptable during approved vacation or designated time off for pre-exam preparation
- **Exam Preparation Time:** The program provides two weeks off for exam preparation—one week prior to each portion of the Royal College written and oral exams, in line with PARO guidelines and other Canadian programs
- **Reading Days:** Reading days should only be taken if there are no scheduled clinical activities for that day
- **Clinical Participation:** PGY4/5 residents must participate in all day-to-day clinical activities - they are encouraged to attend 1-2 clinics per week when there is no OR available where they can serve as primary assistants or surgeons
- **PGY5 Responsibilities:** PGY5 residents are responsible for all rounds and communications related to patients and consults unless they are on a research elective block or vacation. They must remain available to junior and senior residents on the team for patient care and administrative issues.

**2. PGY5 Electives**

**General Expectations:** Electives during PGY5, whether Clinical or Research, are not considered free study time. Specific objectives for each elective type must be submitted to the Program Director (PD) and Program Administrator (PA) at least one month in advance.

*2.1 Research Elective:*

- Objectives for the research elective must be approved by the supervisor and the program well in advance of the elective start date. Failure to obtain approval will result in the cancellation of the research elective, and the resident will be placed back on clinical service
- Supervisors will be contacted at the end of the rotation, and failure to meet objectives will result in a rotation failure on the In-Training Evaluation Report (ITER)

*2.2 Clinical Elective:*

- Clinical elective objectives must be approved by the PD or Assistant Program Director (APD) in advance and the elective should include a personal learning plan that addresses identified deficiencies in operative and clinical skills
- The elective must include a minimum of three clinical days per week. During the clinical elective, PGY5 residents are not responsible for rounding, consults, or other daily clinical activities.

**3. Call Schedule**

- **Pre-Exam Call Reduction:** PGY5 residents are allowed to stop taking call one month before the written exam date. Calls may be reduced up to two months before the written exam, provided adequate coverage is available.
- **Program Discretion:** The program reserves the right to assign call duties (first and second call) to PGY5 residents based on clinical, wellness, and educational needs, regardless of the call tally. Prior call in the year cannot be used as a reason to avoid call during this period.
- **Final Week:** PGY5 residents are relieved of all clinical duties during the week prior to the exam.

This policy ensures that PGY4/5 residents maintain their clinical responsibilities while allowing adequate preparation time for their exams, with clearly defined expectations for elective participation and call duties.

Revised: 2024/08/14 Approved: 2024.08.29

# PGY5 Urology Resident
## Expectations and Guidelines: Post-RC Exam

**1. Clinical and Educational Responsibilities**

- **Clinic Attendance:** PGY5 residents are expected to attend the clinic as much as possible following the RC exam.
- **Educational Activities:** Active participation in educational activities is required, especially in a supervisory role. This includes ensuring other residents also participate.
- **Operating Room:** Residents may attend the OR post-exam on academic half-days
- **Teaching:** Post-RC exam residents are expected to take an active role in teaching, particularly during academic half days, OSCEs, and labs.

**2. Team Supervision**

- **Supervisory Role:** The most senior resident at each site is responsible for supervising the team; this includes:
  - Reviewing consults
  - Communicating with staff via email and ensuring updates are provided
  - Maintaining closed-loop communication between residents and staff
- **Assignment of Duties:** PGY5 residents are responsible for assigning residents to clinics and ORs according to the weekly schedule

**3. On-Call Duties**

- **Participation:** Post-RC exam residents are expected to participate in on-call duties, including first-call responsibilities, particularly over the Christmas/New Year period and during AUA/CUA coverage if they are not attending or presenting at these meetings
- **On-Call Support:** PGY5 residents should take One-Number calls and assist in on-call cases with more junior residents as needed

**4. Teaching Responsibilities**

- **M&M Rounds:** PGY5 residents are responsible for planning M&M Rounds
- **Grand Rounds:** Participation in grand rounds is expected, including presenting cases
- **CSTAR/Simulation Labs:** PGY5 residents should supervise and teach in these labs
- **RCEP Teaching:** Residents will be assigned teaching sessions for the RCEP

**5. Research Day Responsibilities**

- **Research Presentation:** Post-RC exam residents are fully expected to continue their research and present at the annual JK Wyatt Urology Residents Research Day
- **Coordination:** Responsibilities include coordinating the roundtable discussion with the guest speaker and organizing resident and staff awards
- **Guest Speaker:** PGY5 residents are responsible for purchasing and presenting a gift to the guest speaker at the dinner

**6. Educational Milestones**

- **EPA Completion:** All EPAs, including Transition to Practice, must be completed

Revised 2024/08/14 Approved: 2024.08.29

# Division of Urology
## Tuesday Morning Coverage for Academic Half Days

**Implementation Date:** July 1, 2017 **Coverage Time:** 06:45 am – 12:00 noon, every Tuesday

**1. General Coverage Overview**

- **Site-Specific Coverage:** Coverage will be provided at each site by designated fellows or consultant
- **Fellow Responsibilities:** Fellows at each site will:
  - Cover all calls and consults during the designated hours
  - Optionally round with residents before 6:45 am
- **Consultant Backup:** A consultant will be assigned weekly to each site to support the fellow and provide coverage if no fellow is available
- **Schedule Integration:** Details of site-specific fellow/consultant coverage will be included in the monthly on-call schedule

**2. Tuesday Morning Coverage Duties**

- **Handover:**
  - Be available before 6:45 am to receive handover from residents (via phone or in person at Grand Rounds at SJH)
- **During Coverage:**
  - Answer pages and compile a list of consults and tasks for the residents, to be handed over at 12:00 noon
  - Perform urgent Emergency Room, ward, and intraoperative consultations that cannot wait until 12:00 noon
  - Non-urgent ward consults may be deferred and handed over to the on-call day resident at noon
- **Issue Management:**
  - For patients at UH or SJHC, review any arising issues with the on-call staff (for new patients without a London urologist) or with the patient's existing London urologist as necessary.

**3. Resident Responsibilities**

- **Morning Rounds:**
  - Ensure all orders are placed, and nursing questions are answered during morning rounds (before 6:45 am)
  - One member of the urology team at each site will provide handover to the fellow or consultant covering 1st call at the end of ward rounds - critical issues with inpatients or consult patients must be clearly communicated
- **End of Coverage:**
  - Notify switchboard at the end of the academic half-day to switch over pagers to the on-call resident at each site by 12:00 noon

**4. Special Circumstances**

- **No Scheduled Academic Activities:**
  - If no academic activities are scheduled due to meetings, vacations, or shutdowns, residents are to use the time for study or research. They are not expected to cover clinical activities during this time.
- **Holiday Coverage:**
  - Residents are expected to cover clinical activities during recognized holidays that fall on a Tuesday (e.g., Remembrance Day, Canada Day, Christmas, and New Year's).

Revised: 2024/08/14
Approved: 2024.08.29

# UROLOGY RESIDENT WELLNESS REPRESENTATIVE

*"Wellness: to enrich the experience of medical education as trainees, teachers, and clinicians to inspire a redefined work environment for resident physicians, promote a culture of respect, and to champion the good health of Canadian resident physicians in mind, body, and spirit."*

## Role Description

**Description of Wellness Representative:**
The Urology Resident Wellness Representative is the resident who will help guide fellow residents/colleagues in fostering a culture of respect and wellness, as well as collaborate with the Residency Training Committee to maintain focus on overall resident well-being.

**Qualifications:**
The Urology Resident Wellness Representative must be a resident currently enrolled at Western University and have an interest in resident wellness and education.

**Appointment and Review Process:**
The Urology Resident Wellness Representative is an annual voluntary position, with agreement from the resident body and approved by the Program Director/Assistant Program Director (PD/APD). If no volunteer, the PD/APD will assign a resident. If more than one volunteer, an anonymous resident vote will occur. The term of this appointment will be one year (July-June).

**Duties of the Role:**
1. Create and maintain the annual resident wellness budget, reporting to the Faculty Wellness Representative and Residency Training Committee.
2. Help to identify factors contributing to resident burnout and provide resources and support to residents (example: Learner Equity and Wellness office, PARO helpline).
3. Liaise with the Residency Training Committee to identify solutions in order to diminish resident burnout.
4. Act as a liaison between the resident body and program administration by attending Residency Training Committee meetings with the goal of maintaining focus on overall resident wellness.
5. Organize non-academic activities for the Urology residents (example: annual dinner) funded by the Division.
6. Coordinate non-academic non-funded social events/activities for the Urology residents (examples: game day, backyard potluck, ice cream day)
7. Plan and implement program-related social activities (examples: Urology Olympics, games for summer party) and liaise with residents regarding attendance/participation – including scheduling, games, create teams, run the games at the event, etc.
8. Mentor and support residents, while maintaining confidentiality, and guide them to resources

**Wellness Budget:**
The program will provide a maximum of $2,500 per year for resident wellness. The Wellness Representative will provide an annual projected budget, proposing how the monies will be spent for the year, to the RTC for approval each July.

2020.02.05

# DIVISION OF UROLOGY SOCIAL MEDIA COMMITTEE TERMS OF REFERENCE

Committee members: i) Staff supervisor ii) Junior Resident
Term: 2 years with opportunity for renewal

**Selection:**
Residents are selected based on interest in the role. If more than one resident, the Chief residents create a blind vote after interested parties do a present which includes their goals/plans for the role

**Role**:
- Maintenance of Division of Urology Instagram account (social)
- Contributor to Division of Urology twitter account (academic)

**Goals:**
- Enhance social media presence for our program to engage medical students, residents, and other health care professionals
- Highlight and enhance distribution of academic achievements
- Promote resident wellness
- Dissemination of social programs, events, etc.
- Attract future applicants to our program

**Responsibility:**
- Divisional social media passwords should be protected and maintained by the social media committee only and not to be shared outside of the committee
    - Passwords will change with the change of committee members
    - Passwords to be provided the Program Administrator
- Only members of the committee may post; however, photos/posts/text can be provided by other residents/staff as desired, but ultimately approved by a member of the social media committee
- At minimum a weekly Instagram post
    - Including, but not necessarily limited to: stories, reels, educational posts, features, giveaways, program updates, events, Instagram live, day in the life etc.

**Terms:**
- Any posted photos must be approved by those that appear in them
    - This can be by verbal, written text, or implied by providing the photo to the social media team for public use
- No posts of patients, discussion of cases, or any patient identifying information, this includes intraoperative photos that might include patients
- No photos of genitalia
- Photos and posts must be sensitive to EDID issues
- Cannot post sexual innuendos
- No derogatory posts about any person or group of persons. There will also be no post that suggestion discrimination against any group of people.
- Cannot post either direct or indirect slander or suggestion of malpractice against a colleague, co-resident, or any other professional
- These posts are not personal opinions and should not include feelings about public issues, which include but are not limited to politics, policies, public health issues, etc.

2022.10.18

# MASTERS OF SURGERY GRADUATE PROGRAM

**Introduction**
The MSc in Surgery at Western is tailored to the unique needs of surgical trainees, providing an intensive research experience and a solid foundation for success as an academic surgeon.

**Goals**
The MSc in Surgery is intended to fully prepare individuals specifically seeking future positions in Academic Health Science Centers for the demands of a research career in relation to the CanMeds roles of Medical Expert and Scholar. Demonstration of core competences will be required through coursework, basic/clinical/applied research, thesis preparation and defense.

**Program Information**

**Full-time Program**
Normal completion of the MSc in Surgery will be 12 months (3 terms) while enrolled full-time. However, each student's progress will be closely monitored by his/her supervisory committee and the final duration of the MSc program for each student will be at the discretion of the student's advisory committee and the Graduate Program Committee pending suitable progress in the program.

**Part-time Program**
The MSc in Surgery is available for part-time studies only with the permission of the student's supervisor and the Graduate Program Committee. The MSc must be completed within four years and no funding is available to part-time students. This is often the choice made by residents in a Royal College training program, where the research can often be accomplished through a minimum of 4 blocks of dedicated research time in addition to the eight months of weekly, three-hour mandatory teaching sessions. Most programs have been able to accommodate this for their residents. If you are interested in pursuing this, please let your Program Director know.

Website for further details, deadlines and tuition: MSc in Surgery - Surgery - Western University (uwo.ca)