Division of Urology

The Schulich School of Medicine & Dentistry
Western University

Resident Handbook

Revised: June 2025

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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 to 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. After Dr. McAninch retired in 1974, his first two residents, Dr. Jack Wyatt and Dr. Jack Sales, took on leadership roles as Chiefs of Urology Services at Victoria Hospital and St. Joseph's Hospital, respectively. Dr. Wyatt also became Professor and Chair of the Division of Urology at Western University. As Program Director, Dr. Wyatt significantly expanded and formalized the residency training program.

In 1990, Dr. Joseph Chin was appointed as both Chair and Program Director of Urology. He played a crucial role in consolidating the training program to two primary 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 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.

From 1998 to 2005, Dr. Hassan Razvi served as Program Director. He then succeeded Dr. Chin as Chair and city-wide Chief of Urology from 2005 to 2019, overseeing all three sites: St. Joseph's Hospital, and the Victoria and University Hospitals of the London Health Sciences Centre.

Dr. Jonathan Izawa served as Program Director from 2005 to 2009, followed by Dr. Gerald Brock from 2010 to 2014. Dr. Alp Sener then took on the role from 2014 to 2019, before transitioning to Chair of Urology at the Schulich School of Medicine & Dentistry, Western University, and Chief of Urology at London Health Sciences Centre and St. Joseph's Health Care London in 2019.

Dr. Sumit Dave served as Program Director from 2019 to 2022. Dr. Peter Wang held the position of Residency Program Director, with Dr. Jeffrey Campbell serving as Assistant Program Director from 2022 to 2025. Dr. Jenifer Bjazevic began as program director in 2025.

At the present time the urology residency program is five years duration, the first two years being devoted to core surgical training and the final three years to clinical and surgical Urology.

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 Chair/Chief	University Hospital Room C4-208	Angela Gough	33352	alp.sener@lhsc.on.ca angela.gough@lhsc.on.ca
Dr. Jennifer Bjazevic Program Director (PD)	St. Joseph's Hospital Room B4-655	Stephanie Teves	66233	jennifer.bjazevic@sjhc.london.on.ca stephanie.teves@sjhc.london.on.ca
Dr. Jeffrey Campbell	St. Joseph's Hospital Room B4-663	Amelia Gallagher	66087	jeffrey.campbell@sjhc.london.on.ca amelia.gallagher@sjhc.london.on.ca
Dr. Sumit Dave	Victoria Hospital Room B1-190A	Angela Godden	58439	sumit.dave@lhsc.on.ca angela.godden@lhsc.on.ca
Dr. John Denstedt	St. Joseph's Hospital Room B4-657	Robyn Colford	66036	john.denstedt@sjhc.london.on.ca robyn.colford@sjhc.london.on.ca
Dr. Melissa Huynh	Victoria Hospital Room E2-650	Carol Gerster	58451	Melissa.huynh@lhsc.on.ca Carol.gerster@lhsc.on.ca
Dr. Brant Inman	Victoria Hospital Room E2-650	Amy Gerster	55643	Brant.inman@lhsc.on.ca Amy.gerster@lhsc.on.ca
Dr. Jonathan Izawa	Victoria Hospital Room E2-650	Traci Devlugt	58550	jonathan.izawa@lhsc.on.ca traci.devlugt@lhsc.on.ca
Dr. Patrick Luke	University Hospital Room C4-211E	Amanda Travers	33180	patrick.luke@lhsc.on.ca amanda.travers@lhsc.on.ca
Dr. Stephen Pautler	St. Joseph's Hospital Room B4-673	Michelle Demaiter	66384	stephen.pautler@sjhc.london.on.ca michelle.demaiter@sjhc.london.on.ca
Dr. Nicholas Power	Victoria Hospital Room E2-650	Tawnya Murray	76787	nicholas.power@lhsc.on.ca tawnya.murray@lhsc.on.ca
Dr. Hassan Razvi	St. Joseph's Hospital Room B4-656	Samina Noman	66259	hrazvi@uwo.ca samina.noman@sjhc.london.on.ca
Dr. Peter Wang	Victoria Hospital Room B1-127	Victoria Gast	76584	peter.wang@lhsc.on.ca Victoria.gast@lhsc.on.ca
Dr. Blayne Welk	St. Joseph's Hospital Room B4-671	Brenda Hodgins	66367	blayne.welk@sjhc.london.on.ca brenda.hodgins@sjhc.london.on.ca
Shelley Paolini Program Administrator	St. Joseph's Hospital Room B4-654		64407	shelley.paolini@sjhc.london.on.ca
Kim Nitz Division Administrator	St. Joseph's Hospital Room B4-654		64405	Kim.nitz@sjhc.london.on.ca

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

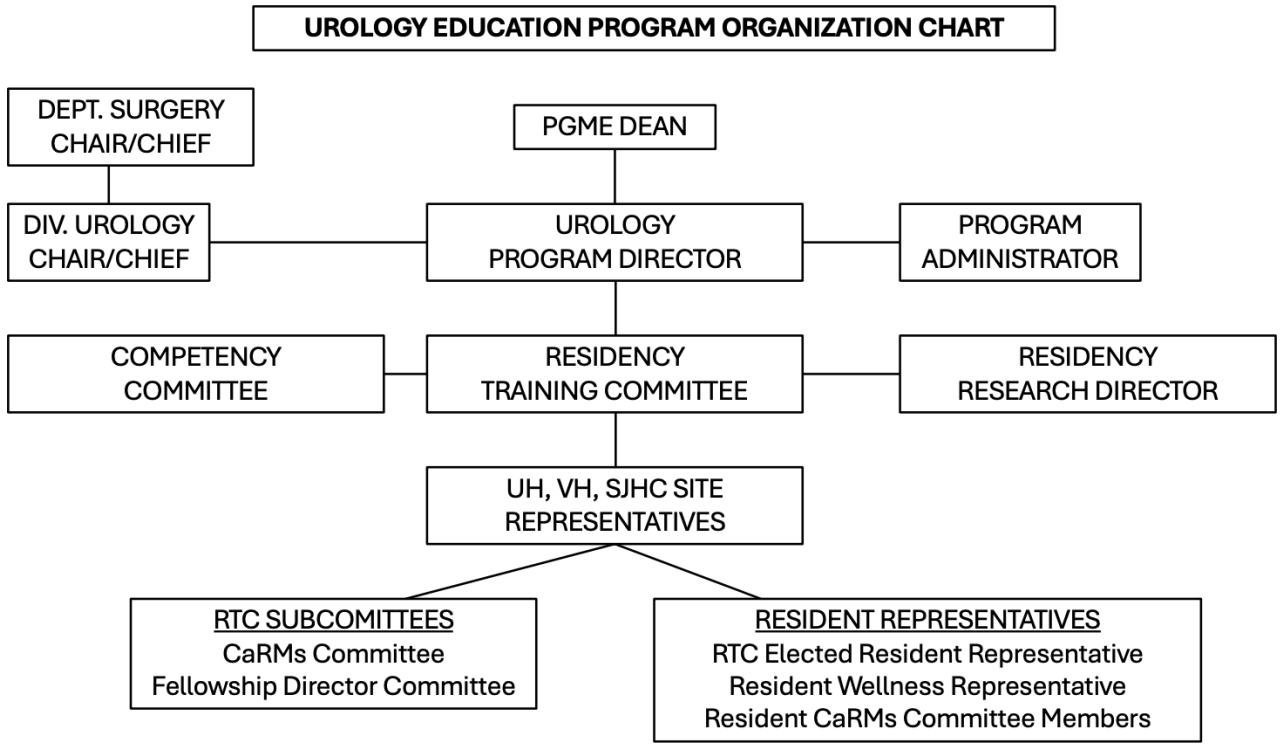
HOSPITAL MAILING ADDRESSES:		
London Health Sciences Centre Victoria Hospital 800 Commissioners Road London, ON N6A 4G5	London Health Sciences Centre University Hospital 339 Windermere Road, London, ON N6A 5A5	St. Joseph's Hospital 268 Grosvenor Street London, ON N6A 4V2

RESIDENCY TRAINING COMMITTEE MEMBERSHIP 2025-2026

Dr. Jennifer Bjazevic	Urology Program Director
Dr. Alp Sener	Chair/Chief Urology LHSC-University Hospital faculty representative
Dr. Peter Wang	Wellness Faculty Representative LHSC-Victoria Hospital faculty representative
Dr. John Denstedt	SJHC faculty representative
Dr. Stephen Pautler	Resident Research Director
Shelley Paolini	Urology Program Administrator
Heather Rotz	Senior Resident Representative
Aurinjoy Gupta	Resident Wellness Representative

COMPETENCY COMMITTEE MEMBERSHIP 2025-2026

Position	Name	Site
Chair	Dr. Jeffrey Campbell	St. Joseph's Hospital
Member	Dr. Melissa Huynh	LHSC – Victoria Hospital
Member	Dr. Blayne Welk	St. Joseph's Hospital
Member	Dr. Sumit Dave	LHSC – Victoria Hospital
Admin	Shelley Paolini	Program Administrator


UROLOGY EDUCATION PROGRAM ORGANIZATION CHART
DEPT. SURGERY CHAIR/CHIEF
PGME DEAN
DIV. UROLOGY CHAIR/CHIEF
UROLOGY PROGRAM DIRECTOR
PROGRAM ADMINISTRATOR
COMPETENCY COMMITTEE
RESIDENCY TRAINING COMMITTEE
RESIDENCY RESEARCH DIRECTOR
UH, VH, SJHC SITE REPRESENTATIVES
RTC SUBCOMITTEES
CaRMs Committee
Fellowship Director Committee
RESIDENT REPRESENTATIVES
RTC Elected Resident Representative
Resident Wellness Representative
Resident CaRMs Committee Members

Program Director / Assistant Program Director / Program Administrator Roles

2025-2026 Dr. Jennifer Bjazevic, Program Director
Shelley Paolini, Program Administrator

FIRST POINTS OF CONTACT FOR RESIDENTS:	
Program Administrator: • **On-Call schedules (questions, changes)** • **All education schedules** • **Rotation schedules** • **Vacation requests/concerns** • **Elective proposals/questions/paperwork** • **Administrative forms incl. reference forms** • **Site Switches (approved by APD(if avail.))**	**Program Director:** • **Safety concerns** • **Personal/wellness concerns** • **Education advice/career help** • **Professionalism concerns** • **Interpersonal conflicts** • **Peer to peer positive feedback**

Program Director Roles	**Assistant Program Director (if available) Roles**
1. Leadership and Governance • Chair, Residency Program Committee (RPC) • Chair, CaRMs Subcommittee • Chair, Fellowship Director Committee • Attend all Royal College/Department of Surgery/Division of Urology meetings • Assist with planning resident research day • Participate in Urology Finance Committee • Lead all aspects of accreditation • Attend annual ICRE conference 2. Education and Curriculum • Curriculum mapping • Develop/revise curriculum • Develop, maintain, and revise program evaluation schedule • Oversee resident rotation schedule • Oversee resident evaluation • Develop and revise policies and procedures • Organize/schedule lap/surgical simulation courses and OSCES • Complete Confirmation of Completion of Training • Attend bi-annual resident review meetings • Ad hoc meetings with residents • Resource for residents and faculty	1. Leadership and Governance a. Chair, Competence Committee b. Chair Residency Program Committee in absence of PD c. Organize resident social events 2. Support and Oversight a. Assist with curriculum mapping b. Assist in development/revision curriculum c. Assist with resident rotation schedule d. Assist with development and revision policies and procedures e. Assist with organizing/scheduling lap/surgical simulation courses and OSCES f. Attend bi-annual resident review meetings g. Ad hoc meetings with residents h. Resource for residents and faculty

Program Administrator Roles:

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

SURGICAL FOUNDATIONS

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

For up-to-date Competencies of Surgical Foundations Training, please visit the Royal College of Physicians and Surgeons of Canada website at:
https://www.royalcollege.ca/content/dam/documents/ibd/surgical-foundations/surgical-foundations-competencies-e.pdf

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.

A comprehensive series of lectures is organized each year by the Core Surgery Coordinator to prepare trainees for the POS. **All PGY 1 & 2 residents are expected to attend these lectures**. In conjunction with these didactic sessions, hands-on instruction of suturing and stapling techniques is given. An Advanced Trauma Life Support (ATLS) course is also offered each year for the core surgical residents.

UROLOGY PROGRAM

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 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 **261** achieved assessments, the program proposes the residents trigger a minimum of one EPA assessment in the operating room and clinic, chosen in consultation with faculty. Residents should choose EPAs relevant to their current stage of training. For instance, if you start CBD in the Core stage, do not trigger EPAs for the Transition to Practice stage.

Expected Timeline and Requirements

Stage	*EPAs*	*Completion Date*	*Achievements Needed*
Transition to Discipline	4	December 31 of PGY1	8
Foundations	8	6 months after residency start	57
Core of Discipline	21	December 31 of PGY2	180
Transition to Practice	6	May 31 of PGY5	16

ROTATION SPECIFIC OBJECTIVES

These objectives complement the general training objectives set by the Canadian Urological Association (CUA), which outline the knowledge and technical skills necessary for successful completion of the Royal College Examinations and for competence in clinical practice. Residents should review these expectations in conjunction with the rotation objectives and CBD curriculum map, which details the number of EPA assessments required per year.

See RCPSC Urology Competencies here:
https://www.royalcollege.ca/content/dam/documents/ibd/urology/urology-competencies-e.pdf

See RCPSC Urology Training Experiences here:
https://www.schulich.uwo.ca/urology/docs/Final-ENG---Urology-CBD-Training-Experiences-November-2017.pdf

General Urological (Float/On-Call) Objectives

Medical Knowledge

1. Develop an approach to urological emergencies, including GU trauma, testicular torsion, priapism, and septic renal colic, ensuring timely and appropriate care.
2. Develop appropriate clinical judgement and decision-making skills to establish a comprehensive and patient-centered management plan, including potential complications for general urological disease processes.
3. Develop the ability to perform a focused urological history and physical exam relevant to the urological care of the patient in an organized and timely manner.

Communication

1. Develop the ability to obtain, synthesize and provide accurate and relevant information from patients and their family
2. Demonstrates and develops accurate, complete and timely documentation habits regarding informed consent, procedure details, consultation, discharge summary, progress notes and clinic notes

Collaboration

1. Demonstrates an 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

Leadership

1. Demonstrates effective stewardship of healthcare resources. **(Senior)**
2. Demonstrates ability to manage team and effective delegation of graded tasks **(Senior)**
3. Demonstrates effective time management skills to integrate training, education and personal life.

Health Advocacy

1. Demonstrates advocacy for patients' needs by addressing individualized determinants of health and incorporate strategies for disease prevention and health promotion.

Professionalism

1. Demonstrates professional behaviors and upholds patient autonomy, confidentiality, and ethical standards in all interactions.
2. Demonstrates accountability by recognizing, reporting, and mitigating the impact of medical errors and adverse outcomes on patient safety
3. Implement strategies to maintain physical and mental well-being and promotes a supportive culture for colleagues.

Surgical Skill and Knowledge

1. Demonstrates the ability to competently perform selected urological procedures, as defined by rotation objectives and achievable EPA document, in a skillful and safe manner, adapting to unanticipated findings or changing clinical circumstances.

Achievable EPAs during Rotation

Transition to Discipline	Foundations	Core
TD1, TD2, TD3, TD4	F1. F2, F3, F8 Float - F4, F5, F6, F7	C1, C2, C3, C4, C14, C16 Float - C5, C6, C7, C8, C9, C11-Senior, C15, C17, C18, C19 – Senior

Potential Diagnostic and Surgical Procedures Exposure

Common	Less Common	Diagnostic
Site/Rotation Specific		

Uro-Oncology Rotation Objectives

Medical Knowledge

1. Develop an understanding of the pathophysiology and diagnosis of inflammatory and infectious conditions as they pertain to the urological patient.
2. Develop an approach to the management, follow-up and monitoring (for potential complications) of the urological patient with inflammatory or infectious conditions.
3. Develop an approach to intraoperative consultation for a urological concern
4. Develop an understanding and develop an approach of assessment, diagnosis, classification and management of genitourinary trauma in a multidisciplinary manner
5. Develop 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.
6. Develop an understanding of the pathophysiology, management and follow-up of upper and lower urinary tract obstruction
7. Develop an understanding of the natural history, diagnosis, staging, treatment outcomes, and complications for prostate, urothelial, adrenal, and kidney cancers, including small renal masses and systemic therapies for advanced disease.
8. Develop an understanding of the natural history, diagnosis, staging, treatment outcomes, and complications for penile, testicular (germ cell tumors) cancer and systemic therapies for advanced disease.
9. Develop an understanding of the role, indications and potential complications of management (medical and surgical) for the treatment of urological malignancies; as well as an understanding of the role and indications for percutaneous, angiographic, and emerging techniques, including their potential complications.
10. Develop an understanding of multidisciplinary treatment options for urological malignancies, including the roles of chemotherapy, targeted therapies, radiotherapy.

Surgical Skill and Knowledge

1. Develop the ability to competently perform the procedures (open/MIS) to alleviate obstruction of the upper and lower urinary tract
2. Develop the ability to competently apply the technical skills required for open procedures for the diagnosis and treatment of urological malignancies including the management of postoperative complications
3. Develop the ability to competently apply the technical skills required for minimally invasive procedures in the diagnosis and treatment of urological malignancies including the management of postoperative complications
4. Develop an understanding of the indications and technical skills required for transrectal ultrasound with or without prostate biopsy and management of potential complications

Achievable EPAs during Rotation

Transition to Discipline	Foundations	Core	Transition to Practice
TD1, TD2, TD3, TD4	F1. F2, F3, F4, F5, F6, F7, F8	C1, C2, C3, C5, C6, C7, C8, C9, C11, C12, C13, C14, C15, C17, C18, C19 - Senior	P1, P2, P3, P4, P5, P6

Potential Diagnostic and Surgical Procedures Exposure

Common	Less Common	Diagnostic
Orchidectomy: simple, radical, partial	Exploration for testicular torsion with or without orchidopexy	Complex urinary catheter insertion
Transurethral fulguration of bladder lesions	Cavernosal shunt: distal or proximal	Ureteric catheterization, including insertion and removal of ureteral catheter/stent
Laparoscopic / Robot Assisted Nephrectomy: simple, radical	Repair of penile fracture	Rigid and flexible cystoscopy, and urethroscopy
Laparoscopic / Robot Assisted Partial nephrectomy	Ureterolysis	Rigid and flexible ureteroscopy
Laparoscopic / Robot Assisted Nephroureterectomy	Uretero-ureterostomy	Retrograde urethrography, cystography and pyelography
Laparoscopic / Robot Assisted Prostatectomy	Ureteric reconstruction	Cystoscopic/ureteroscopic stricture incision of the urinary tract
Laparoscopic / Robot Assisted Cysectomy	Bladder Repair	Loopography
Open Nephrectomy	Urinary diversion: continent, incontinent	Antegrade nephrostography
Open Partial Nephrectomy	Trauma Nephrectomy (Rare)	Collection of cytological specimens from the genitourinary tract
Open Nephroureterectomy	Partial Cysectomy	Biopsy of lesions of urothelium; prostate; testis; and penis
Open Pelvic Lymph Node Dissection	Drainage/debridement of genital abscess	Transurethral biopsy of bladder and urethra
Open Cysectomy, simple and radical	Perineal urethrostomy	
Open Prostatectomy, simple and radical	Suprapubic catheter insertion	
Open Urinary diversion; continent, incontinent	Urethral dilatation and visual internal urethrotomy	
Penectomy; partial, radical, totoal	Transurethral resection of prostate, using standard or alternative electrocautery or laser	
Open Radical Urethrectomy	Laparoscopic / Robot Assisted Adrenalectomy	
	Open Adrenalectomy	
	Open Retroperitoneal Lymph Node Dissection	
	Open Inguinal Lymph Node Dissection	

Community Urology Rotation Objectives

Medical Knowledge

1. Develop an approach to urological emergencies, including GU trauma, testicular torsion, priapism, and septic renal colic, ensuring timely and appropriate care.
2. Develop an understanding of the mechanisms, indications, and physiological effects of medical and surgical therapies for benign prostatic hyperplasia.
3. Demonstrates an understanding of the pathophysiology, management and follow-up of upper and lower urinary tract obstruction
4. Develop an understanding of the etiology, pathophysiology, classification, and diagnosis of voiding dysfunction, urinary incontinence, female pelvic floor disorders, neurogenic bladder, and urethral stricture disease
5. Develop an understanding of the pathophysiology and diagnosis of urinary stone disease and an evidence-based approach to medical management, including prevention and treatment strategies.
6. Develop competency in interpreting urological imaging and apply this information to guide patient care.
7. Develop an understanding of the natural history, diagnosis, staging, treatment outcomes, and complications for prostate, urothelial, adrenal, and kidney cancers, including small renal masses and systemic therapies for advanced disease.
8. Develop an understanding of the natural history, diagnosis, staging, treatment outcomes, and complications for penile, testicular (germ cell tumors) cancer and systemic therapies for advanced disease.
9. Develop an understanding of the role, indications and potential complications of management (medical and surgical) for the treatment of urological malignancies; as well as an understanding of the role and indications for percutaneous, angiographic, and emerging techniques, including their potential complications.

Surgical Skill and Knowledge

1. Develop the ability to competently perform surgical procedures for the treatment of benign prostatic hyperplasia
2. Develop the ability to competently perform the procedures (open/MIS) to alleviate obstruction of the upper and lower urinary tract
3. Develop the ability and competency in the medical and surgical management of lower urinary tract dysfunction, including male and female urinary incontinence, neurogenic bladder, and associated complications.
4. Develop knowledge of the indications and ability to competently perform surgical procedures for the management for urinary stone disease, including the management of intraoperative and postoperative complications.
5. Develop the ability to competently apply the technical skills required for open procedures for the diagnosis and treatment of urological malignancies including the management of postoperative complications
6. Develop the ability to competently apply the technical skills required for minimally invasive procedures in the diagnosis and treatment of urological malignancies including the management of postoperative complications
7. Develop an understanding of the indications and technical skills required for transrectal ultrasound with or without prostate biopsy and management of potential complications (If Available)

Achievable EPAs during Rotation

Transition to Discipline	Foundations	Core
TD1, TD2, TD3, TD4	F1. F2, F3, F4, F5, F6, F7, F8	C1, C2, C3, C4, C5, C6, C7, C8, C9, C10 – If Available, C11, C12, C13, C14, C15, C17, C18

Potential Diagnostic and Surgical Procedures Exposure

Common	Less Common	Diagnostic
Laparoscopic / Open Nephroureterectomy	Drainage/debridement of genital abscess	Rigid and flexible cystoscopy, and urethroscopy
Laparoscopic / Open Nephrectomy: simple, radical	Cavernosal shunt: distal or proximal	Transurethral biopsy of bladder and urethra
Orchidectomy: simple, radical, partial	Repair of penile fracture	Rigid and flexible ureteroscopy
Transurethral resection of prostate, using standard or alternative electrocautery or laser	Urethral dilatation and visual internal urethrotomy	Retrograde urethrography, cystography and pyelography
Transurethral fulguration of bladder lesions	Ureterolysis	Urodynamic studies
Ureteric catheterization, including insertion and removal of ureteral catheter/stent	Uretero-ureterostomy	Collection of cytological specimens from the genitourinary tract
Cystoscopic/ureteroscopic stricture incision of the urinary tract	Ureteric reconstruction	Biopsy of lesions of urothelium; prostate; testis; and penis
Laparoscopic / Open Prostatectomy	Bladder Repair	Transurethral biopsy of bladder and urethra
Laparoscopic / Open Cysectomy	Urinary diversion: continent, incontinent	Transrectal ultrasound with or without prostate biopsy (If available)
Penectomy; partial, radical, totoal	Trauma Nephrectomy (Rare)	
Open Radical Urethrectomy	Partial Cysectomy	
Rigid ureteroscopy, lithotripsy, and basket extraction of calculi of the upper urinary tract	Perineal urethrostomy	
Retrograde flexible ureteroscopy/nephroscopy and lithotripsy of upper urinary tract stones	Laparoscopic / Open Pyeloplasty	
Percutaneous nephroscopy and lithotripsy of the upper urinary tract (If available)	Fistula repair	
Male sling	Repair of vesico-vaginal and/or urethro-vaginal fistula	
Mid-urethral sling	Laparoscopic / Open Adrenalectomy	
	Exploration for testicular torsion with or without orchidopexy	
	Laparoscopic / Open Partial nephrectomy	
	Complex urinary catheter insertion	
	Suprapubic catheter insertion	

University Hospital Urology Rotation Objectives

Medical Knowledge

1. Develop an approach to urological emergencies, including GU trauma, testicular torsion, priapism, and septic renal colic, ensuring timely and appropriate care.
2. Develop an understanding of the pathophysiology and diagnosis of inflammatory and infectious conditions as they pertain to the urological patient.
3. Develop an approach to the management, follow-up and monitoring (for potential complications) of the urological patient with inflammatory or infectious conditions.
4. Develop an understanding of the mechanisms, indications, and physiological effects of medical and surgical therapies for benign prostatic hyperplasia.
5. Develop an understanding of the pathophysiology, management and follow-up of upper and lower urinary tract obstruction
6. Develop an understanding of the etiology, pathophysiology, classification, and diagnosis of voiding dysfunction, urinary incontinence, female pelvic floor disorders, neurogenic bladder, and urethral stricture disease
7. Develop an understanding of the natural history, diagnosis, staging, treatment outcomes, and complications for prostate, urothelial, adrenal, and kidney cancers, including small renal masses and systemic therapies for advanced disease.
8. Develop an understanding of the role, indications and potential complications of management (medical and surgical) for the treatment of urological malignancies; as well as an understanding of the role and indications for percutaneous, angiographic, and emerging techniques, including their potential complications.
9. Develop an understanding of multidisciplinary treatment options for urological malignancies, including the roles of chemotherapy, targeted therapies, radiotherapy.

Surgical Skill and Knowledge

1. Develop the ability to competently perform surgical procedures for the treatment of benign prostatic hyperplasia
2. Develop the ability to competently perform the procedures (open/MIS) to alleviate obstruction of the upper and lower urinary tract
3. Develop the ability and competency in performing and interpreting urodynamic studies, retrograde, and voiding cystourethrograms, and applies this information to guide patient care.
4. Develop the ability and competency in the medical and surgical management of lower urinary tract dysfunction, including male and female urinary incontinence, neurogenic bladder, and associated complications.
5. Develop the ability to competently apply the technical skills required for open procedures for the diagnosis and treatment of urological malignancies including the management of postoperative complications
6. Develop the ability to competently apply the technical skills required for minimally invasive procedures in the diagnosis and treatment of urological malignancies including the management of postoperative complications
7. Develop an understanding of the indications and technical skills required for transrectal ultrasound with or without prostate biopsy and management of potential complications

Achievable EPAs during Rotation

Transition to Discipline	Foundations	Core	Transition to Practice
TD1, TD2, TD3, TD4	F1. F2, F3, F4, F5, F6, F7, F8	C1, C2, C3, C4, C5, C6, C7, C8, C9, C11, C12-Senior, C13-Senior, C14, C15, C17, C18, C19-Senior	P1, P2, P3, P4, P5, P6

Potential Diagnostic and Surgical Procedures Exposure

Common	Less Common	Diagnostic
Renal transplantation	Drainage/debridement of genital abscess	Rigid and flexible cystoscopy, and urethroscopy
Open Nephrectomy: simple, radical	Cavernosal shunt: distal or proximal	Transurethral biopsy of bladder and urethra
Orchidectomy: simple, radical, partial	Repair of penile fracture	Rigid and flexible ureteroscopy
Transurethral resection of prostate, using standard or alternative electrocautery or laser	Urethral dilatation and visual internal urethrotomy	Retrograde urethrography, cystography and pyelography
Transurethral fulguration of bladder lesions	Ureterolysis	Urodynamic studies
Ureteric catheterization, including insertion and removal of ureteral catheter/stent	Uretero-ureterostomy	Collection of cytological specimens from the genitourinary tract
Cystoscopic/ureteroscopic stricture incision of the urinary tract	Ureteric reconstruction	Biopsy of lesions of urothelium; prostate; testis; and penis
Laparoscopic / Robot Assisted Nephrectomy: simple, radical	Bladder Repair	Transurethral biopsy of bladder and urethra
Laparoscopic / Robot Assisted Partial nephrectomy	Urinary diversion: continent, incontinent	Transrectal ultrasound with or without prostate biopsy (Available)
Laparoscopic / Robot Assisted Nephroureterectomy	Trauma Nephrectomy (Rare)	
Laparoscopic / Robot Assisted Prostatectomy	Partial Cysectomy	
	Perineal urethrostomy	
	Laparoscopic / Robot Assisted Pyeloplasty	
	Fistula repair	
	Repair of vesico-vaginal and/or urethro-vaginal fistula	
	Laparoscopic / Robot Assisted Adrenalectomy	
	Exploration for testicular torsion with or without orchidopexy	
	Complex urinary catheter insertion	
	Suprapubic catheter insertion	

Transplant Urology Rotation Objectives

Medical Knowledge

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. Develop an understanding of the treatment options, including the role for multidisciplinary care and indications for transplantation for patients with ESRD
3. Develop an understanding of the principles of immunosuppression including the indication and adverse effects of immunosuppressive drugs.
4. Develop an approach to infections, malignancies, and complications in renal transplant patients
5. Develop an understanding of the ethical issues of human organ procurement for transplantation
6. Develop an approach to the postoperative care and management of complications following transplantation.

Surgical Skill and Knowledge

1. Develop an understanding of the principles of renal transplantation surgery and develop technical skills for renal transplantation surgery

Achievable EPAs during Rotation

Transition to Discipline	Foundations	Core
TD4	F2, F4, F5, F6, F7, F8	C12, C15

Potential Diagnostic and Surgical Procedures Exposure

Common	Less Common	Diagnostic
Renal transplantation		
Open Nephrectomy: simple, radical		

Endo-Urology Rotation Objectives

Medical Knowledge

1. Develop an approach to urological emergencies, including GU trauma, testicular torsion, priapism, and septic renal colic, ensuring timely and appropriate care.
2. Develop an understanding of the pathophysiology and diagnosis of urinary stone disease and an evidence-based approach to medical management, including prevention and treatment strategies.
3. Develop competency in interpreting urological imaging and apply this information to guide patient care.
4. Develop an understanding of the mechanisms, indications, and physiological effects of medical and surgical therapies for benign prostatic hyperplasia.
5. Develop an understanding of the pathophysiology, management and follow-up of upper and lower urinary tract obstruction
6. Develop an understanding of the natural history, diagnosis, staging, treatment outcomes, and complications for GU malignancies such as prostate, urothelial, adrenal and kidney cancers including small renal masses and systemic therapies for advanced disease.
7. Develop an understanding of the role, indications and potential complications of management (medical and surgical) for the treatment of urological malignancies; as well as an understanding of the role and indications for percutaneous, angiographic, and emerging techniques, including their potential complications.
8. Develop an understanding of multidisciplinary treatment options for urological malignancies, including the roles of chemotherapy, targeted therapies, radiotherapy, and surgical oncology.

Surgical Skill and Knowledge

1. Develop an understanding of the indications and the ability to competently perform surgical procedures for the management for urinary stone disease, including the management of intraoperative and postoperative complications.
2. Develop the ability to competently perform surgical procedures for the treatment of benign prostatic hyperplasia
3. Develop the ability to competently apply the technical skills required for minimally invasive procedures in the diagnosis and treatment of urological malignancies including the management of postoperative complications.
4. Develop an understanding of the indications and the ability to competently perform surgical procedures for the management for urinary stone disease, including the management of intraoperative and postoperative complications

Achievable EPAs during Rotation

Transition to Discipline	Foundations	Core	Transition to Practice
TD1, TD2, TD3, TD4	F1, F2, F3, F4, F5, F6, F8	C1, C2, C3, C5, C6, C7, C8, C9, C10 (Senior), C11, C15, C17, C18, C19 (Senior)	Senior - P1, P2, P3, P4, P5, P6

Potential Diagnostic and Surgical Procedures Exposure

Common	Less Common	Diagnostic
Percutaneous nephroscopy and lithotripsy of the upper urinary tract	Cystoscopic/ureteroscopic stricture incision of the urinary tract	Rigid and flexible cystoscopy, and urethroscopy
Antegrade nephrostography	Suprapubic catheter insertion	Retrograde urethrography, cystography and pyelography
Complex urinary catheter insertion	Urethral dilatation and visual internal urethrotomy	Rigid and flexible ureteroscopy
Transurethral resection of prostate, using standard or alternative electrocautery or laser	Laparoscopic / Robot Assisted Pyeloplasty	
Transurethral fulguration of bladder lesions	Laparoscopic / Robot Assisted Adrenalectomy	
Ureteric catheterization, including insertion and removal of ureteral catheter/stent	Drainage/debridement of genital abscess	
Rigid ureteroscopy, lithotripsy, and basket extraction of calculi of the upper urinary tract	Cavernosal shunt: distal or proximal	
Retrograde flexible ureteroscopy/nephroscopy and lithotripsy of upper urinary tract stones	Repair of penile fracture	
Laparoscopic / Robot Assisted Nephrectomy: simple, radical	Urethral dilatation and visual internal urethrotomy	
Laparoscopic / Robot Assisted Partial nephrectomy	Ureteric reconstruction	
Laparoscopic / Robot Assisted Nephroureterectomy	Bladder Repair	
Laparoscopic / Robot Assisted Prostatectomy	Exploration for testicular torsion with or without orchidopexy	

Andrology and Functional Urology Rotation Objectives

Medical Knowledge

1. Develop an understanding of the pathophysiology and diagnosis of inflammatory and infectious conditions as they pertain to the urological patient.
2. Develop an approach to the management, follow-up and monitoring (for potential complications) of the urological patient with inflammatory or infectious conditions.
3. Develop an understanding of the etiology, pathophysiology, classification, and diagnosis of voiding dysfunction, urinary incontinence, female pelvic floor disorders, neurogenic bladder, and urethral stricture disease
4. Develop an understanding of the medical management of voiding dysfunction
5. Develop an understanding of the mechanisms, indications, and physiological effects of medical and surgical therapies for benign prostatic hyperplasia, urethral stricture disease and male incontinence.
6. Develop an understanding of the anatomy, physiology, etiology, pathophysiology, diagnosis, and medical/surgical management of the following:
    - **a.** Male in/fertility
    - **b.** Sexual dysfunction
    - **c.** Hypogonadism
    - **d.** Peyronie's Disease
    - **e.** Erectile dysfunction (including refractory cases)
    - **f.** Cutaneous lesions of the male genitalia.
    - g. Common benign scrotal conditions including hydroceles, spermatoceles, varicoceles, and chronic scrotal content pain
    - h. Urethral stricture diseases
    - i. Male and female incontinence
    - j. Overactive bladder
    - k. Neurologic lower urinary tract dysfunction

Surgical Skill and Knowledge

7. Develop the ability to competently perform surgical procedures for the treatment of benign prostatic hyperplasia
8. Develop the ability to competently perform open procedures related to sexual and gonadal function, and scrotal surgeries in a skillful and safe manner.
9. Develop competency in surgical anatomy, adapting to unanticipated findings and managing complications, while providing appropriate pre- and post-operative care.
10. Develop ability and competency in the medical and surgical management of lower urinary tract dysfunction, including male and female urinary incontinence (including sling procedures), neurogenic bladder, and associated complications.
11. Develop the ability and competency in performing and interpreting urodynamic studies, retrograde, and voiding cystourethrograms, and apply this information to guide patient care.
12. Develop competency in urethral repair including DVIU, urethroplasty, and fistula repair

Achievable EPAs during Rotation

Foundations	Core	Transition to Practice
F3, F4, F6, F7, F8	C2, C5, C6, C7, C8, C9, C13, C14, C15, C17	P1, P2, P3, P4, P5, P6

Potential Diagnostic and Surgical Procedures Exposure

Common	Less Common	Diagnostic
Urethral dilatation and visual internal urethrotomy	Transurethral resection of prostate, using standard or alternative electrocautery or laser	Urodynamic studies
Transurethral biopsy of bladder and urethra	Insertion of testicular prosthesis	Retrograde urethrography, cystography and pyelography
Drainage/debridement of genital abscess	Insertion of artificial sphincter	Rigid and flexible cystoscopy, and urethroscopy
Insertion of penile prosthesis	Male sling	
Varicocelectomy	Spermatocelectomy/hydrocelectomy	
Circumcision	Orchidectomy/orchidopexy	
Correction of Peyronie's curvature: plication, incision, and grafting	Cystectomy: simple and radical	
Complex urinary catheter insertion	Fistula repair	
Suprapubic catheter insertion	Augmentation cystoplasty	
Cystoscopic/ureteroscopic stricture incision of the urinary tract	Male sling	
Urethroplasty	Mid-urethral sling	
Transurethral injection of therapeutic substances into lower urinary tract	Repair of vesico-vaginal and/or urethro-vaginal fistula	
	Excision of urethral diverticulum	
	Transvaginal mesh excision/removal	
	Pubovaginal sling using autologous rectus fascia	
	Perineal urethrostomy	

Pediatric Urology Rotation Objectives

Medical Knowledge

1. Develop an understanding of normal genitourinary embryology and the consequences of resultant congenital abnormalities.
2. Develop an approach (pathophysiology, diagnosis and management) to common pediatric urological conditions including oliguria & anuria, undescended testicle, testicular torsion and phimosis.
3. Develop an understanding of the pathophysiology, diagnosis, and management of urinary tract infections in the pediatric urologic patient (simple and complex).
4. Develop an approach to the pathophysiology, diagnosis and management of common pediatric urologic conditions including vesicoureteral reflux, hydronephrosis, enuresis, dysfunctional voiding, and incontinence.
5. Develop 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.
6. Develop an approach to urological emergencies, including GU trauma, testicular torsion, priapism, and septic renal colic, ensuring timely and appropriate care.
7. Perform a history and physical examination in neonates, infants, and children with emphasis on normal/abnormal growth & development.
8. Perform interview with parents with respect to childhood urologic health and disease, antenatal maternal and fetal health
9. Develop 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.
10. Develop an approach to urodynamic studies, including interpretation, in the pediatric urologic patient.

Surgical Skill and Knowledge

11. Develop an understanding of the surgical anatomy of and the surgical approaches to the scrotum, testis, cord structures, penis and inguinal canal.
12. Develop the ability to perform common urologic pediatric procedures such as circumcisions, orchidopexy and hydrocelectomy and manage potential complications.
13. Develop an understanding and approach to complex urologic pediatric procedures such as hypospadias repair, epispadias and exstrophy repair and management of potential complications.
14. Develop an approach to fluid and electrolyte management in the pediatric urology patient and dosing commonly used medications.

Achievable EPAs during Rotation

Transition to Discipline	Foundations	Core
TD1, TD2, TD3, TD4	F1, F2, F3, F4, F5, F6, F7, F8	C1, C2, C3, C4, C7, C8, C9, C11, C12, C13, C14, C15, C16, C17

Potential Diagnostic and Surgical Procedures Exposure

Common	Less Common	Diagnostic
Orchidopexy (Staged)	Hypospadias Repair: Proximal	Urodynamic studies
Hypospadias Repair: Distal	Pediatric Hernia Repair	
Circumcision	Spermatocelectomy	
Hydrocelectomy	Varicocelectomy	
Ureteric reconstruction	Uretero-ureterostomy	
Robot Assisted Laparoscopic Pyeloplasty	Laparoscopic Nephrectomy: simple	
	Augmentation cystoplasty	
	Epispadias/exstrophy repair	
	Exploration for testicular torsion +/- orchidopexy	

Transition to Practice Objectives

Medical Knowledge

1. Demonstrate ability to manage urological patients in outpatient clinics
2. Demonstrate the ability to coordinate, organize and execute a days of urological procedures
3. Demonstrate an understanding and contributing to the administrative operation of urological practice

Leadership

4. Demonstrates effective stewardship of healthcare resources. **(Senior)**
5. Demonstrates ability to manage team and effective delegation of graded tasks **(Senior)**
6. Demonstrate a successful implementation of a personal learning plan based on career goals
7. Demonstrates effective time management skills to integrate training, education and personal life.
8. Demonstrate an understanding of the administrative (including equipment cost and maintain) operation of urological practice
9. Demonstrate an understanding and time management of a urologic practice

Surgical Skill and Knowledge

1. Demonstrate ability to coordinate and execute endoscopy/cystoscopy days
2. Demonstrate the ability to coordinate, organize and execute a days of urological procedures
3. Demonstrate ability to manage complex intraoperative consultations

Achievable EPAs during Rotation

Transition to Practice
P1, P2, P3, P4, P5, P6

Potential Diagnostic and Surgical Procedures Exposure

Common	Less Common	Diagnostic
Site/Rotation Specific		

Urology Residency Rotation Guidelines

1. **Patient Rounding**
   - All residents must round on all patients at their assigned sites.
     - Exceptions: Residents on a Pediatric rotation are exempt.

2. Team Responsibilities (Pager Only)
During absences (vacation/coverage), junior residents that are present must forward the pagers to themselves.

2.1 Senior Residents
- VH and SJHC: Senior residents will lead management of their MRP's (Most Responsible Physician's) patients.

2.2 Junior Residents
- **SJHC Site:**
  - The most junior resident will handle the intake pager.
    - MIS patients: pages go to the junior resident on MIS rotation.
- **Andrology/Reconstruction:**
  - Ward patients: pages go to the resident on this rotation.
- **VH Site:**
  - Junior team members will receive pages for their assigned teams' patients.

3. On-Call Admissions (Pager Only)

3.1 VH Site
- Two alternating intake teams will handle patient rounding.
- The senior resident of the intake team will manage:
  - Patients admitted during intake week.
  - Patients admitted the preceding weekend.

3.2 UH Site
- The senior resident on rotation will lead management of all on-call admissions.

3.3 SJHC Site
- The senior resident on MIS rotation will lead management of all on-call admissions.

4. Off-Site OR Coverage
- Residents at the **receiving site** will cover any faculty operating at alternative locations. The residents for the faculty will remain on rotation site for other clinical activities.

5. Night Float and Vacation Coverage (clinical duties)

5.1 Float Rotation
- Float rotations are designed to cover junior residents on night float and vacations.

5.2 Senior Vacation Coverage
- **MIS Senior** vacation
  - ***MIS Junior/Float** covers
    - Andrology/Recon Resident to provide Senior Support for on-call responsibilities

- **Andrology/Reconstruction Senior** vacation
  - *MIS Senior to determine coverage
- **VH Senior** vacation
  - Alternative Team Senior covers
- **UH Senior vacation**
  - UH Junior/Float resident covers
- **Pediatrics** vacation
  - **Float Rotation** resident
    - If not available, then **Pediatric Fellow coverage**
      - If not available, then intake VH junior covers

5.3 Junior Away/Night Float/Vacation Coverage

- **MIS Junior** vacation
  - *MIS Senior/Float covers
- **VH Junior** vacation
  - Alternative Team Junior covers
- **UH Junior vacation**
  - UH Senior/Float resident covers

6. Coverage Rules

6.1 Intra-Site Coverage

- Allowed within the same hospital:
  - Seniors may cover another team's OR within the site, if:
    - Senior on another team is on vacation
    - Discussion has been had with the other team's senior
    - Faculty has approved

6.2 Inter-Site Coverage

- Not permitted between hospitals unless part of a TTP rotation.
  - ***Exception for PGY5 of 2025-2026 Year**

7. Academic/Free Days

It is the responsibility of the resident and faculty to identify any days where the resident has no clinical activities.

If there are no scheduled clinical activities for your team, then the resident is expected to attend any clinics that are occurring at their site that do not have resident coverage and if all clinics are covered then they should be second assist in the OR for the other team's OR (but cannot take over the case from the primary resident assigned to that OR).

The rotation supervisor should be aware of the placement of the residents during these days.

8. Program Leadership Clause

- **All SENIOR** residents on their first day of the rotation will meet with the site lead for an orientation to discuss objectives, expectations and assessments.
    - **All residents to have mid-rotation ITER and final ITER**
        - Site lead to meet with residents if concerns on mid-rotation evaluation.
- If any issues, ambiguities, or unaccounted circumstances arise that are not explicitly addressed in these guidelines, residents must immediately contact Program Leadership for clarification and resolution.
- This ensures seamless workflow and proper oversight.

8. Transition to Practice Rotation

- The timing of the block to be determined by the resident
    - To be scheduled once resident has been promoted to Transition to Practice by Competency Committee
        - AND completed both written and oral Royal College Examination.

9. **Weekly Schedule**

The senior resident on the team is responsible for assigning all of the residents for the clinical activities and sending out an email to all staff with the upcoming weeks schedule

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 assessments and making recommendations of a resident's progression towards achieving competency. The CC can make decisions regarding individual EPA achievements and provide recommendations about progression, promotion, as well as requirement for an enhanced educational plan (EEP), remediation, probation and/or dismissal.

The CC can also make recommendations on promotion to senior residents, eligibility for certification and readiness for independent practice. The RPC reviews the recommendations from the CC and approves, revises or overturn them, as well as develop the enhanced educational plans, remediation plans and probation plans based on CC recommendations.

The CC is chaired, although not always, by the current Assistant Program Director (APD) and includes a minimum of three divisional faculty, preferably 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.

Understanding the Resident Progression Process

Resident progression is a structured and comprehensive evaluation process designed to ensure residents meet the competencies and milestones required at each stage of their training. The CC is guided by the national specialty competency framework and includes specialty-specific milestones and EPAs by stage which have been established by the specialty committee as well as relevant university and Royal College assessment policies. The evaluation process integrates multiple sources of data and compares each resident's performance:

1. Over time (longitudinally)
2. In relation to their peers
3. Against the historical performance of previously progressed residents
4. To the expected level of training

Role of the Competence Committee (CC)

The Competence Committee (CC) plays a central role in determining progression. The CC meets three to four times per academic year to review each resident's file (also known as a portfolio).

- Primary and Secondary Reviewers:
  Each resident's portfolio is reviewed in detail by a *primary reviewer*, who conducts an in-depth evaluation, and a *secondary reviewer*, who provides additional insight and validation. These reviewers are assigned *randomly* for the academic year and are reassigned randomly at the start of each new year to ensure impartiality and diverse perspectives.CC Meeting Discussions:
  During the CC meetings, the reviewers present their evaluations, and all CC members contribute to a thorough group discussion to finalize judgments about each resident's progression status. The CC will also report to the resident areas of strength, areas for improvement and assist in setting goals for the next CC meeting.
- All committee discussions are strictly confidential and are only shared on a professional need-to-know basis.

- Committee decisions will be based on the assessment evidence available in the resident's file at the time of the committee meeting and not based on any 'hearsay' that may be introduced during the discussion at the meeting from different members.
- Committee decisions will operate with the intention of a growth mindset with the aim of supporting each trainee to achieve their own individual progression of competence.
- Following discussion of the resident's performance by the primary and secondary reviewer a motion will be made by the primary reviewer proposing a progress status for the trainee going forward. The motion must by seconded and achieve a majority of votes to be approved. 50% attendance of competency committee members will be required to achieve quorum.
- The competency committee will be minuted by the Program Administrator.

Metrics Used to Evaluate Progression

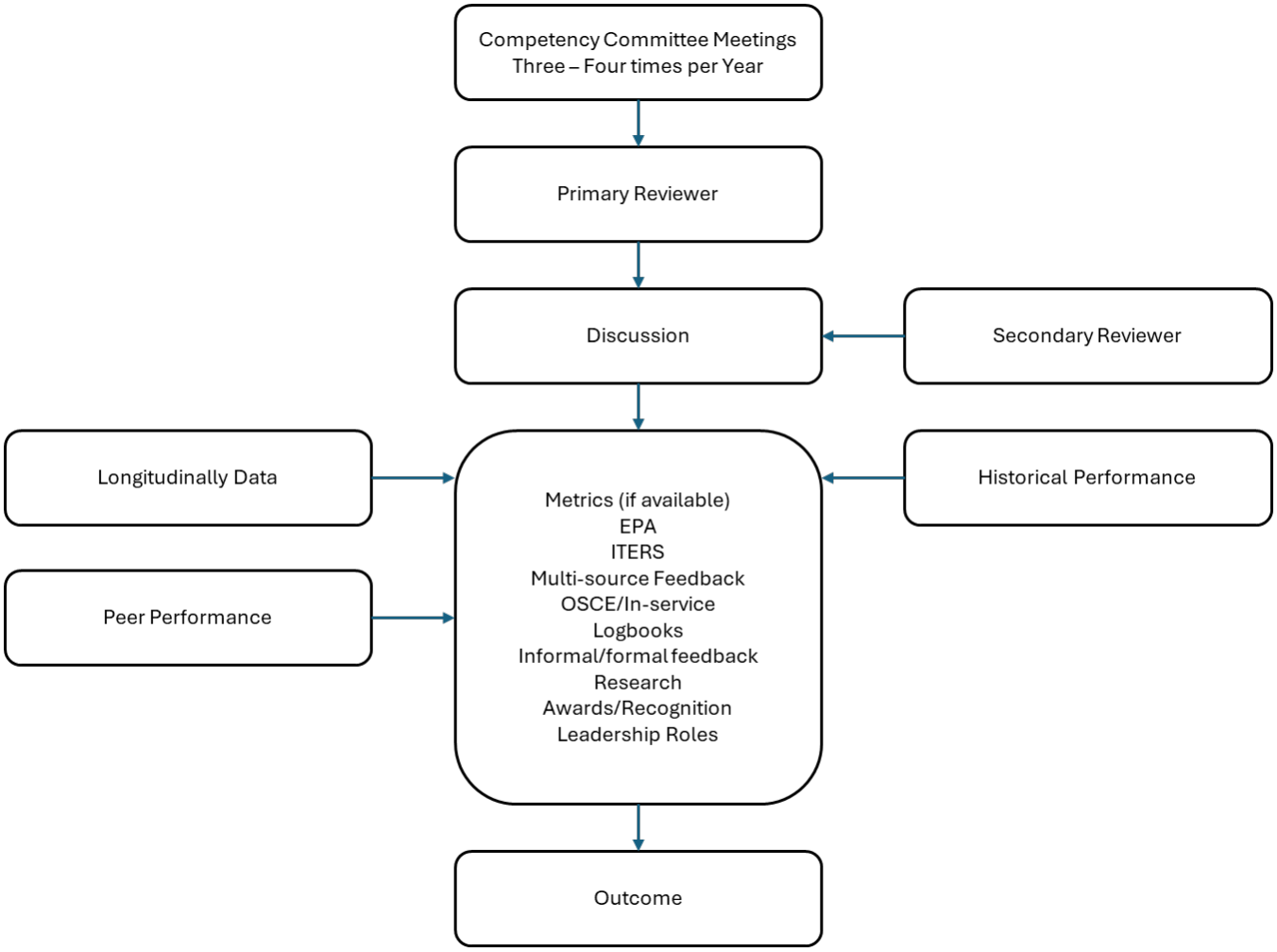
The CC uses a wide range of quantitative and qualitative data points to assess progression, including but not limited to:

- Entrustable Professional Activities (EPAs)
- In-Training Evaluation Reports (ITERs)
- Multi-source Feedback (MSF) including self-evaluations, peer assessments, and evaluations from allied health care professionals (if available)
- Objective Structured Clinical Exams (OSCEs)
- Written and Oral Exams – Including annual national exams where applicable such as the annual AUA in-service exam and the Queen's Urology Exam Skills Training (QUEST) exam
- Procedural logbooks
- Performance during resident presentations including grand rounds, journal club, resident seminars and state of the art lectures
- Feedback – Both formal and informal, verbal or written.
- Scholarly Project Progress including research activities and presentations at urological research meetings
- Awards/Recognitions/Leadership Roles

The resident will receive a report with the following outcomes:

1. Progressing as expected
2. Not progressing as expected
3. Failure to progress
4. Progress is accelerated
5. Inactive

Flowchart



Progression to Senior

The criteria is as follows:

- Complete surgical foundations EPAs (includes TD)
- Complete C1 and C2
- No failed rotations in the past 12 months
- No remediation in past 12 months
- PLP – for discussion based on objectives
- Two successful on-call staff evaluations near the end of PGY2 ryear (email to PD/APD to approach the faculty to give their comments)

CC Evaluation Outcome Reports

Once approved by the RPC, individual residents will receive a notification letter with their progression status and the specific assessment metrics that were used to determine their progression. These reports will be available to the residents 1 week following the RCP meeting. In addition, the letter will also outline areas of strengths, areas of focus for improvement, and suggestions of goals to set for their performance for the next CC meeting. It is strongly encouraged that residents review their notification letters closely and discuss them with their faculty mentors to help facilitate their growth. Residents who are determined to be ‘'not progressing as expected’ or ‘failing to progress’ will be required to meet with the program director and/or assistant program director to review their performance and determine next steps.

Accelerated Progress

For residents whose progress is accelerated they may be promoted to the next stage of training earlier than expected if recommended by the CC and approved by the RPC. Or they may remain at their current stage of training and undertake an action plan of accelerated learning. The resident will meet with the program director and/or assistant program director to develop an enhanced learning plan to focus on obtaining specific goals related to their accelerated progress. This may include targeting more advanced EPAs and training experiences, taking on additional educational roles for junior learners, undertaking an intensive research project in an area of interest, focusing on a subspecialty of interest for preparation of fellowship and/or independent practice, or having additional opportunities of autonomy/independence as part of transition to practice.

PGME Reporting

The program must report the following decisions by the CC and RPC to the Associate Dean of PGME:

- Remediation
- Probation
- Suspension
- Dismissal
- Failure of a training experience (block or longitudinal rotation or ITER)
- 'Failure to Progress' decision in CBD programs
- Requirement for an Enhanced Education Plan (EEP)
- Decisions of resident appeals to the RPC (see PGME Appeal of Assessment Policy)

The programs must also report the following to the Associate Dean, PGME:

- Breach of professional conduct (note that a breach of professional conduct may result in remediation, probation or dismissal from the residency program)
- Serious concerns relating to patient care or safety involving the resident (note that patient safety concerns may result if remediation, probation or dismissal from the residency program).

Incomplete Clinical Education Experiences

It is critical that a resident obtain sufficient clinical experience to meet objectives and competencies of training. Assessment of a resident's performance will be based on the resident's performance and experience. If a resident is absent for part of a clinical training experience due to illness, leave, or holidays, etc., the program director may determine that the clinical experience of the resident was insufficient for attainment of the required competencies and/or objectives, and resident assessment. The following are the criteria as dictated by the PGME regarding decisions for EEP, remediation, probation and dismissal.

Appeals Process

A resident may appeal the following:

- End of rotation (block) assessment such as an ITER having an overall assessment statement of "Does Not Meet Expectations"
- Summative assessment of "Failure to Progress" from a Competence Committee
- Decision to require remediation or probation
- Decision that the resident's remediation or probation program was unsuccessful
- Denial of promotion to the next level or stage of training

- Refusal by a program to certify that the resident has acquired competencies of the specialty or subspecialty, or to affirm resident's readiness for independent practice or certification examination
- Dismissal

A resident may not appeal the following:

- Requirement for an Enhanced Education Plan
- Determination that an Enhanced Education Plan was unsuccessful
- Assessments that are formative in nature (such as a single EPA)
- Assessment decision of 'not progressing as expected'
- ITER that is 'borderline' but with specific performance deficiencies

In-Training Evaluation Report (ITER)

In-Training Evaluation Reports (ITERs) are formal assessments completed at the end of each rotation. They are essential tools for tracking resident progress and ensuring alignment with the rotation specific objectives of each rotation. ITERs reflect a comprehensive summary of resident performance based on direct observation, clinical interactions, and professional conduct throughout the rotation.

Evaluation Process

At the end of each rotation, feedback is gathered from all faculty members with whom you worked. This feedback is then collated by the site lead who completes the ITER using the Elentra online platform.

Who Completes ITERs?

Designated assessors are responsible for finalizing ITERs at each hospital:

- Pediatric Urology – Dr. Peter Wang
- UroOncology Team 1 – Dr. Melissa Huynh
- UroOncology Team 2 – Dr. Nicolas Power
- Endourology – Dr. Stephen Pautler
- Andrology/Reconstruction – Dr. Jeffrey Campbell
- Transplant – Dr. Alp Sener
- University Hospital – Dr. Patrick Luke
- Urology Float – Triggered by Resident to assessor at rotation locations
- Urology Community – Triggered by Program Administrator to assessor
- Urology Elective – Triggered by Program Administrator to assessor
- Transition to Practice – Triggered by Program Administrator to assessor
- Urology Research Elective – Triggered by Program Administrator to assessor

They collect faculty input, provide a unified assessment, and facilitate your feedback discussion.

Timing and Format

End-of-Rotation ITERs

These are completed within **two weeks** of the rotation's end. It is the **resident's responsibility** to schedule an **end-of-rotation meeting** with the appropriate site lead to review and discuss performance.

Mid-Rotation ITERs

For rotations lasting **two months or longer**, a **mid-rotation evaluation** is also required to ensure timely feedback and course correction if needed.

Resident Responsibilities

- **Initiate** and arrange a feedback meeting with the site lead at the end of each rotation.
- **Review** the rotation-specific objectives in advance and reflect on them throughout the rotation to help guide performance and self-assessment.

Documentation

All ITERs from **urology-specific rotations** will be compiled and included as an **appendix** to this handbook. Reviewing past ITERs can provide insight into expected competencies and help guide your development across the training program.

Sources: Appendix Appeals Policy and Assessment Policy from PGME

Revised 2025.05.20
Approved: 2025.06.23

EDUCATIONAL EXPECTATIONS (YEAR-SPECIFIC) FOR RESIDENTS

The following expectations have been developed to guide Urology residents at UWO in progressing through their clinical training, ensuring that responsibilities and skills are graduated as they advance through each rotation and year.

ALL RESIDENTS

- Residents **MUST** complete faculty and rotation evaluations. The Department of Surgery Education Office distributes these. These evaluations are confidential and anonymous.
- Residents are **EXPECTED** to attend any other learning opportunities if they have completed their assignment of the day. They are not to leave the hospital if there are still clinics/ORs they can attend during the rotation.
- 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 to progress.
- Two OSCE's will be held per year, and attendance is **MANDATORY.**
- PGY2 – 5 residents are expected to present a research project at the annual Resident Research Day and, whether presenting or not, attendance at such research is **MANDATORY.**

Urology PGY 1-3 (Junior Residents)

Clinical Responsibilities

Junior residents are integral members of the hospital-based team, collaborating with senior/chief residents and consultants. They are involved in all aspects of patient management, including:

- Outpatient clinics
- Emergency Department
- Inpatient Wards
- Operating rooms
- **Emergency Management:**
  Junior residents should be capable of managing urologic emergencies such as:
  - Urinary retention
  - Acute renal colic
  - Difficult catheterization
  - Acute scrotal pain
  - Priapism
  - Renal failure
- **Pre- and Post-Operative Care:**
  - Junior residents should be competent with uncomplicated pre/postoperative care.

As junior residents, all cases are to be reviewed with senior residents or the consultant.

Reading and Study Schedule

- **Required Reading:**
  Residents are expected to gain knowledge from sources including:
  - Campbell's Urology
  - American Urological Association (AUA) Updates
  - AUA Core Curriculum
  - Review articles from the Journal of Urology

- **Study Plan:**
  A reading plan has been provided to guide residents through Campbell's Urology, with the goal of completing all required reading by the beginning of PGY4. Residents should also review AUA updates and Journal of Urology articles from the past five years. A steady study schedule is recommended to ensure adequate preparation for the Royal College exam.

Clinical Teaching Responsibilities

- **Teaching Role:**
  Junior residents are expected to mentor and teach clinical clerks rotating through the service, contributing to their clinical education.

Research Expectations

Annual Research Project:

Junior residents are required to undertake a research project each year, which will be presented at the annual Residents' Research Day. These projects should also be considered for submission to national or international meetings.

PGY2 – 5 residents are expected to present a research project at the annual Resident Research Day

Conference Attendance:

If a resident's paper is accepted for presentation at a meeting, they are entitled to attend, provided they are in good standing within the program and there is adequate resident coverage for safe patient care. Please see section on conference attendance below. Conference expenses will supplemented by the Division of Urology.

Urology PGY 3-4 (Senior Resident)

Clinical Responsibilities

After promotion to senior resident, residents are expected to achieve greater independence in both clinic and the inpatient settings. By the end of this period, residents should demonstrate clinical competence across all areas of urology. Specific objectives include:

- Effectively managing more complex urological conditions.
- Independently conducting initial assessments for inpatient consultations or assisting junior residents in these assessments.
- Attending outpatient clinics when not scheduled for OR duties.

Taking charge of the inpatient ward when they are the most senior resident on the team.

- **Inpatient Management:**
  - Daily rounds with junior residents to ensure comprehensive patient care.
    - Ensure communication about patient care to staff is performed in a timely manner (as stipulated on rotation handbook)
  - Maintain awareness of all inpatient and emergency room consultations.
  - Review and discuss management plans with all residents on the team and appropriate staff.

- **Operating Room Focus:**
    - Prioritize time in the operating room, gaining experience in a wide range of surgical procedures.

Clinical Teaching Responsibilities

Senior residents are integral to the educational development of junior residents. Responsibilities include:

- Supervising and discussing all inpatient and emergency room consultations with junior residents before consulting with the attending urologist.
- Acting as a mentor and guide for junior residents, fostering a collaborative learning environment.

Research Expectation

Senior residents are expected to continue or initiate research projects, with the following goals:

- Presentation of research findings at the annual Residents' Research Day.
- Submission of research for presentation at national and international meetings.
- Publication of research outcomes in peer-reviewed journals.

Reading and Study Plan

To prepare for the Royal College examination in Urology, residents should:

- Follow the program's structured reading plan, focusing on key resources such as Campbell's Urology, AUA Updates, and review articles from the Journal of Urology.
- Create and adhere to a steady study schedule, ensuring comprehensive coverage of required material.
- Aim to complete all reading by the beginning of the PGY4 year, in preparation for the Royal College exam.

Career Planning

Residents should begin planning for post-residency training and career opportunities by mid-PGY3 year. Key steps include:

- Initiating fellowship applications, with a focus on early planning, particularly for U.S. positions.
- Securing a fellowship by the end of the PGY4 year to ensure a smooth transition to advanced training.

Urology PGY5 (Chief Resident)

Clinical Responsibilities

As the Chief Resident, the PGY5 resident holds primary responsibility for the inpatient ward and consultations. Key clinical objectives include:

- **Inpatient Management:**
    - Daily rounds with junior residents to ensure comprehensive patient care.
        - Ensure communication about patient care is performed in a timely manner (as stipulated on rotation handbook)
    - Maintain awareness of all inpatient and emergency room consultations.
    - Review and discuss the management plans with both senior and junior residents.

- **Operating Room Focus:**
  - Prioritize time in the operating room, gaining experience in a wide range of surgical procedures.
  - Ensure a balanced exposure to ambulatory care, particularly in the spring of the final year, to prepare for the Royal College exam.

Delegation and Teaching:

Delegate minor procedures to junior residents, focusing personal efforts on more complex surgeries where competence has not yet been fully achieved

Teaching and Mentorship

The Chief Resident plays a crucial role in teaching and mentoring junior residents and clinical clerks. Key teaching responsibilities include:

- **Rounds Preparation:**
  - Assist in the preparation and case selection for Grand Rounds, M&M Rounds, Radiology, and Pathology Rounds.
- **Role Modeling:**
  - Serve as a role model for junior residents, demonstrating professionalism and clinical excellence.
  - Teach minor surgical skills to junior residents and clinical clerks.

Research Responsibilities

Chief Residents are expected to contribute significantly to academic research. Key objectives include:

- **Project Completion:**
  - Aim for the culmination of ongoing research projects with the goal of acceptance at major urological meetings and subsequent publication.
- **Research Presentation:**
  - Prepare and present research findings at the annual Urology Residents' Research Day.

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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 a 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

- Develop 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 residents at 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 the operating room or outpatient clinic starts.
- **Patient Problem List**: Review and update each patient's problem list during rounds.
- **Task Delegation**: Most senior residents at the rotation assigns 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 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. Ensure continuity of postoperative care.

Inpatient or Emergency Room Consultations

- **Timely Response**: Accommodate consultation requests promptly. 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**: Attend Tuesday morning academic half-day sessions, arriving promptly at 6:45 am. Attendance is mandatory

- **Resident Seminar Series**: Each resident must prepare for their assigned seminar. Contact the supervising faculty to review the presentation at least 2 weeks prior to presentation.
  - Please ensure to send PA objectives and presentation.

Journal Clubs

- **Participation**: Attend and participate in all scheduled Journal Clubs.
- **Preparation**: Residents will be assigned to prepare a summary of articles before 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.

Expectations and Responsibilities for Ambulatory Clinic

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 for 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.
5. **Consultant Interaction**
    - Consultants will repeat parts of the history and physical for rapport and verification.
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**
    a. **If Patient Present**
    - Use simple language, maintain eye contact and seek clarification as needed.
8. **Dictation of Consultation Notes**
    - Please CC family physician and relevant allied healthcare professions on the 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.

Expectations and Responsibilities for Operating Room

1. **Punctuality**
    - OR starts at 8:00 AM, except at 9:00 AM on Wednesdays
        - Please be in the OR 10 – 15 minutes prior to 8:00 AM.
    - Notify the consultant if you cannot be on time.
2. **Pre-operative**
    - Prepare for the cases of the day
        - Familiarize yourself with the patients
            - Review all the imaging and other relevant investigations
        - Ensure you read up on the pathology and indications of each case
        - Ensure 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 name and glove size is on the board, request any special equipment that might 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 get feedback on with an EPA before the start of the day so 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.
        - I.e. Make consultants aware if this is the first time you've performed the procedure or performed the procedure with the particular 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 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 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 doing other others or while you are finishing closing and can therefore answer it yourself in a timely fashion. Before starting the case, you can ask nursing staff if they can return pages 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

Urology Royal College Exam

The Royal College Examination in Urology assesses a candidate's clinical competence and readiness to enter clinical practice. The exam is developed and reviewed by the Urology Examination Board, comprised of practicing Canadian physicians who are recognized content experts. The examination is also reviewed for quality, translation accuracy, and editorial consistency.

Starting Early:

- **PGY1 Year:**
  - Although the first year is often considered the "off-service" rotation year, it is critical to begin urology reading during this time. Waiting until the PGY2 year will likely make the final years more stressful due to the large volume of material to cover.

Organizational Tips:

- Develop a filing system as early as possible to track important references and handouts on specific topics. The program has provided a sample reading schedule below for guidance.

Core Urology References:

- Campbell-Walsh-Wein Urology - 12th Edition
- AUA Updates
- CUA Guidelines
- AUA Guidelines
- CUAJ Review Articles
- Journal of Urology Review Articles
- AUA Core Curriculum

Key Urological Periodicals:

- Journal of Urology ("The Journal")
- Urology ("Gold Journal")
- Contemporary Urology
- Journal of Endourology
- Canadian Urological Association Journal

Clinical Practice Guidelines:

- Up-to-date clinical practice guidelines published by the **CUA** and **AUA** should be an integral part of your study materials.

Format of the Examination in Urology - 2024

The exam content is based on a blueprint reflecting the Competencies in Urology and the required depth of knowledge. Candidates are strongly encouraged to familiarize themselves with the blueprint and competencies to ensure the examination reflects relevant clinical practice.

Overall Format of the Examination

Component	Format	Number of Items	Total Test Time
Written	Paper 1: MCQ	~100-120	3 hours
Written	Paper 2: MCQ	~100-120	3 hours
Applied	OSCE	6 stations x 20 min	2 hours

Passing Criteria: Candidates must achieve a minimum passing score of 70% for each component.

Decoupled Exam: The written and applied components are decoupled. If a candidate passes the written component but fails the applied component, they will not need to retake the written component in subsequent attempts.

Written Examination

Objective of the Written Examination: The written examination measures the knowledge and application of knowledge necessary for functioning as a competent specialist in Urology. Most questions focus on the Medical Expert role, though other intrinsic CanMEDS roles (Communicator, Professional, Health Advocate, Leader, Collaborator, Scholar) may also be assessed.

Content of the Written Examination: The content is structured to ensure balanced coverage of relevant domains:

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	0-10%
The ranges are approximate and may vary slightly.	

Scoring of the Written Examination:

- Multiple-choice questions are scored automatically through the online exam platform.
- The written exams are combined to create one overall score, with a required passing score of 70%.

By following these study objectives, utilizing the recommended resources, and understanding the exam format, you will be well-prepared to meet the challenges of the Royal College Exams in Urology. This comprehensive approach will support your success in both the written and applied components of the examination.

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
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	
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.

RESIDENT WELLNESS INFORMATION

Wellness Representatives 2025-2026:

- **Aurinjoy Gupta** - Urology Resident Wellness Representative/Champion
- **Dr. Peter Wang** - Urology Faculty Wellness Representative

Website: Urology Resident Wellness

Taking Care of Yourself
If you encounter difficulties during your residency and prefer not to speak with the Residency Program Director, you can reach out to the following contacts:

London:

- **Dr. Robert Stein** - Associate Dean, Learner Experience
  - Email: robert.stein@lhsc.on.ca
- **Dr. Laura Diachun** - Assistant Dean, Postgraduate Learner Experience
  - Email: laura.diachun@sjhc.london.on.ca
- **Ms. Pam Bere** - Manager/Counsellor, Learner Experience
  - Phone: 519.661.2111 x 86250
  - Email: pamela.bere@schulich.uwo.ca

Windsor:

- **Ms. Stephanie Coccimiglio**
  - Phone: 519.253.3000 x4302
  - Email: learnerexperience@uwindsor.ca
- **Dr. Tyceer Abouhassan** – Faculty Advisor, Learner Experience
  - Email: tyceer@gmail.com

Ontario Medical Association: Physician Health Program

- **Website:** php.oma.org
- **Phone:** 1-800-851-6606
- **Email:** joy.albuquerque@oma.org

Additional Support

- **Postgraduate Medical Education Office:**
  - Phone: 519.661.2019
  - Email: postgraduate.medicine@schulich.uwo.ca
- **LHSC Employee Assistance Program:** https://homewoodhealth.com/home/services/employee-health-workplace-wellness-efap/efap-plans-employee-counselling/
  - Phone: 1-800-265-8310
- **Western University Ombudsperson:**
  - Phone: 519.661.3573
  - Email: ombuds@uwo.ca

Protecting Yourself and Taking Time Off
The **PARO 24 Hour Helpline** is available for any resident, partner, or medical student who needs assistance. It is confidential and administered by the Distress Centre of Toronto.

- **Phone:** 1-866-435-7362 (1-866-HELP-DOC)

WESTERN UROLOGY RESIDENCY PROGRAM

SAFETY POLICY

Developed: February 21, 2024
Approved: June 19, 2024
Date of Next Scheduled Review: February 2025 (then q2 years afterwards)

Preamble

The Western Urology program is committed to providing a safe learning environment for all postgraduate medical trainees. The Western Urology program agrees to adhere to the "PGME Safety Policy." The purpose of the Western Urology program's policy is to augment the PGME policy by identifying program-specific safety risks. This policy will be incorporated into Western Urology's resident handbook, which all residents are required to read at the beginning of the academic year.

Policy and Resource References

- PGME Safety Policy
- PGME Fatigue Risk Management Guidelines
- London Health Sciences Center Policies and Procedures Website (Intranet)
- PARO-OTH Agreement on Pregnancy

Definitions

Physical safety: an environment free of harm or injury, threats of harm or injury, or near harm or injury, which may be inflicted by a person, substance, object, hazard, or occupational practice.[1]

Psychological safety: promotes workers' psychological well-being and actively works to prevent harm to worker psychological health, including neglect, reckless, or intentional ways.[2]

Professional safety: conflict in ethical/religious beliefs, adverse event or critical incident report, confidentiality of personal information, medical legal liability coverage (CMPA) and threat of medical legal action.

Policy Statements

1. The Western Urology program commits to providing all trainees with a full disclosure of potential safety risks and appropriate education prior to involvement in activities that may pose a safety risk. Program-specific safety risks not covered by the PGME Safety Policy are identified below.

Physical safety:

Physical Safety: Reporting Protocols

Trainees are to refer to PGME Safety Policy for reporting protocols work-based physical injury and infectious disease exposure such as needlestick and sharps injury.

Ergonomics

Trainees are required to complete training modules on ergonomics.

Travel and on-call work.

In addition to the PGME Safety Policy, trainees are responsible for assessing their fitness and personal safety such as driving post-call shift.

1. They are to notify the program or program administrator before or after for Uber reimbursement or taxi voucher to assist in the trainee returning home safely.

Trainees are to familiarize themselves with:

1. PGME Fatigue Risk Management Guidelines

Trainees are to complete the following Fatigue Risk Management Module by PGME:

2. https://rise.articulate.com/share/IsFyjacLnCVzzZnfNUoLGEDbxZfiGX0L

Ionizing Radiation Safety (X-ray Safety)

Trainees in Urology are required to familiarize themselves with radiation safety, which includes understanding the occupational risks while working with x-ray (or devices), precautions, strategies for minimizing exposure.

The trainees are to complete the following:

1. Complete all radiation safety training modules assigned by LHSC/SJHC
    a. Modules on ME(MyEducation): https://ilearn.lhsc.on.ca/Saba/Web/Cloud
    b.
        i. Radiation Safety for Non-Device Operators
2. Read the Radiation and X-ray safety policies and manuals:
    a. Radiation Safety Policies (need hospital login)
3. Obtain Radiation Monitoring Badges (Dosimeters)
    a. Dosimeter Request Form
4. Pregnancy
    a. If you are pregnant or may be pregnant, please inform the program and the Radiation Safety Officer as soon as possible.
5. Radiation Safety Officers:
    a. LHSC and SJHC

Laser Safety

Trainees in Urology are required to familiarize themselves with laser safety and be certified in the safe clinical use of lasers.

The trainees are to complete the following:

1. In PGY1 or PGY2, the resident is to attend a Laser Safety Course (In-person OR online)
    a. This is arranged by the Laser Safety Officer
    b. After attending the course, the residents are to complete a preceptorship form and submitted to the Laser Safety Officer
    c. Files of completion are kept at Medical Affairs
2. Laser Safety Officer
    a. Jaunita Charter
3. References
    a. Appendix 1: Safe Use of Laser Policy

Pregnancy

Trainees who are pregnant or who are contemplating pregnancy should contact PGME, the program and/or Learner Experience for accommodations (radiation/laser safety) and modified work requirements as they progress through pregnancy. The trainee should also be familiar with the PARO-OTH agreement as it pertains to modified call requirements.

Psychological safety: Reporting Protocols

The trainee is to refer to PGME Safety Policy regarding psychological safety and reporting protocols. In addition to reporting options listed in the PGME Safety Policy, Western Urology Program also provides their trainees the following for reporting safety concerns with the learning environment pertaining to concerns of discrimination, mistreatment, intimidation and harassment, psychological illness, substance abuse and inequity in the workplace.

These concerns can be discussed using the following (both confidentially and not confidential as per the wishes of the trainee):

1. Bi-annual review of performance with Program Director
2. Annual Resident Survey (Program Evaluation)
3. Formal/informal discussion with resident representative to the RTC
4. Formal/informally with assigned mentor

Safety concerns will be documented, respecting trainee privacy when possible or preferred, and discussed at the RTC level to remediate.

Professional safety:

There are no speciality-specific elements that differs from the PGME Safety policy pertaining to professional safety.

Appendices

1. Appendix 1: Safe Use of Laser Policy

Workplace Violence Prevention (WVP):

WVP training should be completed during onboarding.

Staff who do not complete training during this period will need to attend the full 8-hour course at a later date.

Please contact the Program Administrator should you need to book Workplace Violence Prevention Training.

Important Numbers:

Security (at all sites):

Emergency: 55555

Non-Emergency: 44555

WESTERN UROLOGY RESIDENCY PROGRAM CONFLICT OF INTEREST POLICY

Policy on Interactions between Schulich School of Medicine & Dentistry and Pharmaceutical, Biotech, Medical Device, Medical/Dental Supply, and Research Equipment Supplies Industry ("Industry")

Purpose

The purpose of this policy is to establish guidelines for interactions between the Schulich School of Medicine & Dentistry (Schulich), its faculty, staff and learners, and representatives of the pharmaceutical, biotech, medical device and research equipment industries ("Industry"). While interactions with Industry can be positive and benefit Schulich's mission, relationships with Industry must be above reproach. Potential and real conflicts of interest must be recognized and managed appropriately and must not endanger patient safety, the integrity of our research or educational programs, or the reputation of the institution or its faculty.

Overview

Ethical standards require that Schulich faculty, staff, and learners avoid conflicts of interest, improper relationships, and other interactions with Industry that may suggest the appearance of a conflict of interest or an improper relationship. A conflict of interest is defined as a situation that occurs when there is a divergence between an individual's private interests and their general professional obligations such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by considerations of personal gain, financial or otherwise. The Canadian Medical Association notes that conflicts of interest may be real, potential, or perceived, and may exist even if no unethical or inappropriate act results from the conflict. Individuals must consciously and actively divorce decisions related to clinical care, education, or research from any perceived or actual benefits expected from any company. When real or perceived conflicts of interest arise, they must be addressed appropriately.

Scope

This policy applies to all Schulich faculty, staff and learners. The term "faculty" includes all those with a Schulich academic appointment, including adjunct and part-time faculty members and those at distributed sites. The term "learners" includes all undergraduate graduate, postdoctoral, and professional (MD and DDS) students, as well as residents and fellows.

When in affiliated institutions, faculty and learners will abide by the relevant guidelines of those institutions or, where no such guidelines apply, by the standards set in this document.
Where two policies or guidelines exist (including this policy), faculty and learners must abide by the higher standard of the two.

- All medical faculty are required to abide by the CMA Guidelines for Physicians Interactions with Industry: https://policybase.cma.ca/en/permalink/policy14454
- All dental faculty are required to abide by the CDA Code of Ethics.
- All faculty, whether full time or adjunct, must follow these guidelines whenever and wherever they are engaged in teaching responsibilities for Schulich or using their Schulich credentials.
- This policy is to be applied in conjunction with and does not supersede Western University policies and procedures governing conflicts of interest
- (www.uwo.ca/univsec/pdf/policies_procedures/section3/mapp34.pdf) and, for faculty who fall under the UWOFA collective agreement, does not supersede the *Conflict of Interest and Conflict of Commitment* Article of the UWOFA collective agreement
- Faculty who fall under the UWOFA collective agreement are not authorized on their own to enter into contracts with Industry unless the contract is for private consulting; that is, faculty members cannot commit the corporate university in a contract, a confidential disclosure or a material transfer agreement with an outside interest or use their Schulich credentials in such contracts.
- If a faculty member is unsure about a situation, it is recommended they contact the WORLDiscoveries office of the University.
- Interactions between faculty, students and staff and industry that are prohibited within the Schulich School of Medicine and Dentistry and its affiliated teaching hospitals are also prohibited off-site.

1. Fees, gifts etc to individuals

Other than consulting arrangements permitted below, staff, practicing physicians and dentists, as well as medical and dental learners, must not accept a fee, personal gift or equivalent benefit of any value from industry. Physicians, dentists and learners should be aware that acceptance of gifts of any value has been shown to have the potential to influence clinical decision-making.

2. Pharmaceutical samples

Pharmaceutical samples may be of benefit to patients who might not otherwise be able to afford a needed medication. They may also be useful for therapeutic trials. For these reasons, such samples are acceptable, but only if they are not given directly to a physician, dentist or learner. This may be achieved by an arm's length arrangement with an individual in a physician's or dentist's office or by a centrally managed system. Voucher systems, where available, are preferred.

3. Site access by pharmaceutical representatives and dental supply representatives

Access by pharmaceutical representatives to individual physicians and dentists is by appointment or invitation and only in an area where or when patients are not present. Any involvement of learners in such activities must be under the supervision of a faculty member and approached as an educational opportunity.

4. Site access by device manufacturers' representatives

Site access by sales and marketing representatives are not permitted in patient care areas where such exist at
Schulich, except to provide in-service training on devices and other equipment, and then only by appointment. These individuals will only be present during patient care if there is a role in device preparation or
implementation that is critical to proper patient care and with prior disclosure and signed consent by the patient or substitute decision maker. Any learner interaction with such industry representatives will be for educational purposes only and then only under faculty supervision. Affiliated institutions have their own guidelines with respect to access by device manufacturers that must be followed.

5. Continuing Professional Development/Continuing Medical Education/Continuing Dental Education

All CPD/CME/CDE programs offered/endorsed by Schulich are subject to audit to ensure compliance with the standards for accreditation by the Committee on Accreditation of CME (CACME), Royal College of Dental Surgeons of Ontario (RCDSO), and American Dental Association/Continuing Education
Recognition Program (ADA/CERP). Industry support for CPD/CME/CDE may be provided to Schulich, to an individual Department/Division, or to the CPD Office, but must not be given to an individual faculty member, staff, student or trainee. All educational programs will meet CACME/RCDSO/ADA/CERP standards. The content of all educational activities must be determined by the program planners or the committee members. Industry sponsors of educational programs may

not determine the content or selection of speakers for educational programs and must not be members of the scientific planning committee.

In the case of CPD/CME/CDE activities, the organization of events must comply with policies of the CPD Office and meet the accreditation standards of the Royal College of Physicians and Surgeons and/or the College of Family Physicians of Canada or Royal College of Dental Surgeons of Ontario. At no time will a faculty or staff member make available a list of students or CPD/CME/CDE participants with contact information to any external individuals or organizations.

6. Industry funding for educational Undergraduate, Graduate and Postgraduate programs

All funding accepted from Industry for educational programming must be provided in the form of an unrestricted educational grant. Schulich's Undergraduate, Graduate and Postgraduate medical and dental education programs will not solicit or accept direct funding from Industry for their educational activities. Funds for educational activities may be provided to the School of Medicine & Dentistry or to an individual department or division, but must not be given to an individual faculty member, staff, student or trainee.

7. Participation in industry-sponsored programs

Faculty and learners are prohibited from attending non-CPD/CME accredited events that are marketed as CPD/CME. Industry sponsorship of journal clubs must follow the general guidelines of accredited CPD/CME events in that the content is to be determined by the learners and/or their faculty supervisors. There must be no overt or covert advertising or marketing taking place during these activities. Further,

faculty and learners are prohibited from accepting payment for simply attending a CPD/CME event or accepting gifts at such as covering fees for events. With the exception of presenting research results from industry-sponsored projects faculty should not participate in 'speaker's bureaus' which are often more about marketing than education. A speaker's bureau is defined as an arrangement whereby a speaker is under contract to a company, and thus acts as an agent of the company, AND the speaker does not have editorial control of the content.

8. Industry-sponsored scholarships and other educational funds for trainees

Sponsored scholarships and other educational funds such as fellowships are a welcome way for Industry to support education. Such donations must be made centrally to the administration of Schulich or an affiliated hospital and it must be clear that there is no *quid pro quo (a favour for a favour)* expectation or commitment.
Support provided through affiliated hospitals is governed by hospital rules around such arrangements. Selection of recipients of such support will be done without Industry involvement.

9. Food

Unless attending an approved CPD/CME/CDE event faculty, staff, or learners should not accept Industry-provided food or meals within Schulich or off-site. An approved event is one which has received CPD/CME/CDE accreditation, or is compliant with section #8*: Industry sponsored scholarships and other educational funds for trainees.* Grants for in-services can be received to provide simple refreshments. Within affiliated institutions, the relevant institutional policies will apply.

10. Professional travel

Unless for legitimate reimbursement for contractual services, Industry funding for travel by faculty, staff, and learners is not acceptable.

11. Ghostwriting

Ghostwriting occurs when a paid professional writer, whether or not medically or dentally trained, writes something that is credited to someone else. All Schulich personnel must take repsonsibility for the content of any publication, presentation or slides presented in their name. Under no circumstances will faculty, students or trainees be listed as co-authors on professional presentations of any kind, oral or written, that are ghostwritten by any party.

12. Purchasing

Decisions relating to the purchasing of equipment and services must be free of bias. If Schulich personnel, or their direct family members, have financial interests in the pharmaceutical, device, or medical or dental equipment industry, they must declare this interest and excuse themselves from decisions related to any purchases related to these conflicting interests. In situations in which a person's expertise is needed to evaluate a product or service and in which that person has any ties, these conflicts of interest must be declared to those responsible for making the final decision.

13. Consulting relationships

Faculty members have special knowledge and competencies and it is a reasonable expectation that they will share this knowledge and skill with others, including with Industry. Consulting contracts may only be entered into after discussion with the faculty member's Dean, Chair, or their delegate and completion of any other applicable process required under the UWOFA collective agreement or *Conditions of Appointment for Physicians (2018)* or successor documents . Such contracts must provide details on specific tasks and deliverables, and the payment must be commensurate with tasks assigned. Arrangements that pay faculty or other Schulich personnel without clearly defined associated duties are considered gifts and are prohibited. Schulich reserves the right to require faculty and employees to amend their consulting agreements to bring them into line with this policy. These relationships are to be declared on the annual COI form.

14. Educational materials

Faculty may wish to enter into agreements with Industry to develop educational materials. The content of any materials produced must not give the impression that Schulich approves of or endorses a specific product, service or treatment.

If the faculty member is covered by the UWO Collective Agreement (UWOFA) and if the work can be classified as 'a major paid professional activity' then UWO must be involved in negotiations. Any income accruing from the content, organization and the medium for delivery of all educational material produced by faculty must be established by a tripartite agreement involving the faculty member(s), Industry partner and UWO. No contract will be negotiated that would interfere with the right of any Schulich student to defend their thesis.

15. Philanthropic gifts

Gifts of a philanthropic nature from Industry to a faculty member, Department or Division must be made through the Schulich Development Office or that of an affiliated hospital. There must be no possibility of a *quid pro quo* arrangement.
Research
Research will be conducted in a manner compliant with the Tri-council Policy Statement titled: Ethical Conduct for Research Involving Humans.

The fundamental principle underlying all research must be freedom to do unbiased research and to disseminate, without restriction, the results obtained. Before signing any Industry contract, the ownership and/or the flow of revenues from the project must be clearly stipulated. If there is any uncertainty, it is strongly recommended that the researcher consult with the WORLDiscoveries Office, Chair or institute director for guidance.

No research contract or arrangement should be entered into that limits the right to publish or to disclose the results of the study or report adverse events which occur during the course of the study. Remuneration for participating in research must not constitute enticement, but may cover reasonable time and expenses. Receiving remuneration for simply finding research subjects, so called finder's fees, is not permitted.

Before commencing an Industry-funded research study, the researcher must ensure that there is a signed tripartite agreement satisfactory to the researcher, the Industry partner, and the institution(s) in which the research will be conducted. This agreement must outline the responsibilities and accountability of each party, and reference the institutional policies by which the study will be conducted. Any funding associated with that industry project must be used specifically for that project until such time as the work is complete.

Professional Development

Schulich commits to developing educational programs for faculty and learners at all levels to raise awareness of possible challenges to professionalism presented by relationships with Industry. These programs will be developed, regularly monitored and evaluated under the direction of the appropriate education decanal leader who will be accountable for them. This is in keeping with Schulich's commitment to a culture of professionalism.

Reporting

All faculty relationships with Industry must be disclosed to the Department Chair (or in the case of the Chair, to the Dean) on an annual basis. Any changes to such relationships will be reported when they occur. Each Department Chair will then provide an annual Conflict of Interest (COI) report to the Dean that summarizes the disclosures for their department.

The presence of relationships to Industry that pose an actual or potential conflict of interest as defined in this policy will be disclosed verbally or by slide to learners in lectures, seminars, workshops, and other educational activities. This disclosure will encompass current relationships

and those within the past 5 years, and must include the name of the commercial interest and the nature of the relationship. Information that an individual has no relevant financial relationship must also be disclosed. Faculty and learners will abide by the disclosure rules of sponsoring organizations at national and international meetings and in publications.

Procedures for Known or Suspected Policy Breaches

Any known or suspected breach of this policy should be reported to the Department Chair (in relation to faculty), Vice Dean (students), Program Director (residents) or staff leader (staff).

The Department Chair will include, in their annual COI report to the Dean, a summary of suspected breaches and of actions taken to address them.

For issues that cannot be resolved at the Department level, or if the Department Chair is directly involved in the suspected breach of this policy, the Dean's Office must be notified.

Suspected breaches of this policy may be investigated and, where appropriate, addressed through the applicable disciplinary processes for the faculty member, staff or learner based on the applicable collective agreement, *Conditions of Appointment (2018)* or other applicable process.

Enforcement of this policy will require a flexible approach, given the variability in context, circumstances, and seriousness of breaches that may occur. Generally, the initial approach should be educational, and enforcement should only proceed to greater sanctions if educational approaches have failed.

Approved by Joint Schulich Council, May 5, 2022.

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)

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 residents 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.

Date of last revision: 2020.02.05
Approval RPC: 2025.06.23

Division of Urology Vacation Protocol

(Applies to On-Service Urology Residents)

Vacation/Academic Leave Request Submission:

- Residents must submit their vacation or academic leave request to the Urology Program Administrator (PA) via email at least 4 weeks prior to the proposed start date of the leave.
- Vacation requests on off-service rotation must be submitted to off-service coordinator, program administrator and urology chief resident at least 4 weeks in advance.
- Verbal vacation or education/conference requests will not be granted; all requests must be submitted in writing as outlined above.

Review Process:

- Upon receiving the request, the PA will forward it via email to the Chief Resident for review.
- The Chief Resident will assess whether the request can be accommodated, considering the number of residents on rotation at that site during the requested period.
- The Chief Resident must respond to the PA within one week of receiving the request.

Approval/Denial:

- If the request is approved by the Chief Resident, the PA will document the time away and notify the requesting resident that the time has been approved.
- If the request is denied, alternative dates will be proposed to the resident for consideration, and the Program Director (PD) will be notified.

First-Come, First-Served Basis:

- Requests are approved on a first-come, first-served basis. Residents should allow up to two weeks for the approval process to be completed and for notification of the outcome.

Vacation Entitlement:

- Residents are entitled to 4 weeks (28 days) of paid vacation per academic year. Each week of vacation consists of 7 consecutive days, including 5 working days and 2 weekend days.
- Residents are entitled to 5 consecutive days off during the 12-day period encompassing Christmas Day and New Year's Day. These days do not count as vacation. Residents are not provided additional in lieu of holiday time worked over this period.
- Residents should be mindful that taking more than a week off a 4-week rotation (especially one that is offered once during training) may impede their ability to meet the educational objectives of the rotation, as well as limit the program's ability to accurately and meaningfully evaluate their performance.
- If a resident is scheduled to work on a recognized holiday, they are entitled to a paid day off in lieu of the holiday. This lieu day must be taken within ninety (90) days of the holiday worked and at a time mutually agreed upon.
- Carry-over of vacation: Residents may carry over a maximum of 2 weeks of vacation into the next academic year if a previous vacation request was denied and there was no alternative date available.. Residents, however, cannot 'bank' vacation time for future years.

Professional Leave:

- In addition to vacation entitlement, residents are granted up to 7 working days of paid educational leave per year. This leave can be used for attending conferences, courses, or other educational activities.
- Educational leave must be pre-approved following the same process as vacation requests, ensuring that professional and patient responsibilities are met to the satisfaction of the hospital department head.

Exam Leave:

- Residents are entitled to paid leave for the purpose of taking any Canadian or American professional certification examination, such as Royal College examinations, LMCC, etc.
- This leave includes the exam date(s) and reasonable travel time to and from the exam site.
- Exam leave is in addition to other vacation or educational leave entitlements.

RC Exams for Chief Residents:

- Each Chief Resident is granted two additional weeks of study leave—one week prior to each Royal College exam.
- This study leave is non-transferable and cannot be used as vacation time or re-allocated.

2014.05.22 Developed
20191106 Reviewed by RTC, no changes
2025.06.23 Revised and Approved by RPC

Guidelines for Resident Travel/Conference Expenses

Annual Funding Overview (July 1 - June 30):

- **All PGY Levels:** Up to $2,000 CAD per annum.
- **Eligible Meetings:** AUA, CUA, ISSM, Northeastern Section, or other urology-related conferences.

Conditions:

- Abstracts must be submitted to the program before the meeting.
- All residents must be in academic good standing
- All residents must request permission from the program before attending a meeting.
- Priority is given to residents who are presenting and to PGY4s.

Additional Meeting Attendance:

- Residents wishing to attend additional meetings to present research must consult with their research supervisor before submitting an abstract.
- The research supervisor may provide financial support. This should be confirmed in writing well before the meeting.
- If multiple residents are involved in a research project, only the resident most responsible for the work will receive financial assistance.

Presentation Definition: A "presentation" refers to a podium talk or a moderated poster session where a verbal report is given. Unmoderated poster sessions are not eligible for financial support.

- Funding requests to research supervisors made after the meeting will not be approved.

Expense Claims:

- The maximum allowable claim for expenses is $2,000 CAD per annum.
- Residents must complete a travel expense form and submit receipts, along with the abstract if applicable, to the Program Administrator.
- If sharing a room, all names must be on the receipt, and only the share of the room expenses can be claimed.
- Each resident must submit their own receipts; attributing expenses to another resident's annual allowance is not permitted.

Non-Reimbursable Expenses:

- Personal costs such as entertainment and alcohol will not be reimbursed.
- Travel, accommodation, and meal expenses are covered only for the resident. Expenses for family members are not covered.

Reimbursement Guidelines:

- **Airfare:** Reimbursement is for Advanced Purchase Economy Class rates (lowest fares). Flights should be booked as early as possible to secure the lowest rates.
- **Accommodation:** Reimbursement will cover the standard single-room rate, preferably shared accommodation with other residents.
- **Currency Conversion:** When expenses are incurred in the US or foreign currency, conversion should be done using rates obtained from UWO Finance Exchange.

Cash Advances:

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

Carry Forward of Funds:

- Unused funding from one year cannot be carried forward to a future year.

Time Off for Meetings:

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

Reimbursement Process:

- To claim reimbursement, email receipts and a summary of expenses to the Program Administrator.

Revised:
2021.10.04
2023.09.12
2024.08.26
2025.06.23

The Dr. Gerald Brock Resident Career Development Award

Overview:

- One award is provided per academic year for urology residents.
- The award supports:
  - Primarily presenting at specialty international conferences (excluding AUA, CUA, or NSAUA).
  - Short-term international electives.
  - Educational courses (e.g., POCUS, robotics) that align with individual career plans/goals.
- **Award Amount:** Up to $5,000 CAD per year.
  - Unused funds will be carried forward to the following year.
- **Additional Funding:** For residents presenting at an international conference, this award may be used in addition to the annual travel allowance provided by the Division of Urology.
- **Application Deadline:** April 1 each year (for the academic year July 1 to June 30).
- **Adjudication:** Applications are reviewed by members of the Residency Program Committee (RPC).

Eligibility Criteria:

- All urology residents, regardless of PGY level, are eligible.
- For specialty international conferences:
  - Research must have been conducted by the resident.
  - The research must be accepted for presentation as a podium or moderated poster.
  - Unmoderated poster sessions are not eligible for support.
  - Retroactive support will be considered for specialty conferences occurring within the academic year.
- For courses or international electives:
  - The resident must confirm acceptance by the receiving institution.
  - Prior approval from the resident's home institution is required.
  - Retrospective support will not be granted.
- **Priority:**
  - Residents who have not received a travel award in the past two years.
  - The award will not be granted for presenting the same research at multiple conferences.

Application Requirements:

- **Essay:** A 1000-word (maximum) essay describing how attending the course, specialty conference, or elective will benefit the resident’s academic career.

For Specialty International Research Conferences:

- Accepted abstract, including the acceptance letter detailing the presentation format.
- Details of the conference/course (topic, name, date, location).
- One-page outline of the proposed manuscript (including introduction, materials and methods, results, discussion, and a brief list of references).
- Letter of support from the research supervisor.

For International Electives:

- Acceptance letter detailing the institution, date, duration, and supervisor of the elective.
- Confirmation that the supervisor at the receiving institution agrees to submit a formal evaluation of the elective rotation.
- Letter of support from the Program Director.

Post-Elective/Conference Requirements:

- Within 30 days (about 4 and a half weeks) of returning from the conference or elective, residents must submit:
    - A 250-word description of what they learned from the conference/elective/course.
    - A travel expense form with original receipts (flights/mileage, accommodation, and meals).
    - **Note:** Personal costs, such as entertainment expenses, will not be reimbursed. Currency conversion for expenses incurred in the US or foreign currency should be done using rates obtained from UWO Finance Exchange: https://www.uwo.ca/finance/travel/docs/us.txt

Special Circumstances:

- 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).

Cash Advance:

- If a cash advance is needed to cover certain expenses before the meeting, residents should contact the Program Director to discuss.

Revised 2024.08.26, 2025.06.23

Urology Resident Elective Policy – Clinical/Research

(Applies to On-Service Urology Residents)

Eligibility and Review

- Research and Clinical Electives will be granted only to residents in good standing within the program.
- The resident's standing will be reviewed 2-3 months before the scheduled elective. If the resident is not in good standing, the elective may be cancelled, and the resident will be placed back into the rotation schedule at one of the Urology hospital sites.

Elective Proposal Submission

- Proposed electives must be submitted in writing to the PD/APD and the Program Administrator for approval at least eight (8) weeks before the start of the elective.
- Each proposal must include:
    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, which must include a statement confirming:
        i. Acceptance of your elective request.
        ii. Agreement to complete and return an evaluation upon completion of the elective.

Special Elective Requests

- Elective requests that do not encompass a full block (e.g., concurrent clinical electives, split time between research and clinical work) must be pre-approved a minimum of 8 weeks (about 2 months) in advance by the Program Director, Assistant Program Director, and the elective supervisor.

Research Electives

- For research electives, a mid-elective progress report must be provided to the elective supervisor and Program Director for review.
- An end-of-elective report detailing the work accomplished is also required.
- A four (4) week reading/study block is not an acceptable substitute for a dedicated research rotation.

Vacation During Electives

- Any vacation during a research or clinical elective must be approved according to the vacation policy.
- Approval from the elective preceptor for the vacation time is also required.

Attendance and Participation During Research Electives

- During research electives, the resident must remain in the city and be available to:
    a. Attend all educational events.
    b. Participate in call duties.
    c. Regularly check in with their preceptor.

See next page for form to be submitted

2014.05.22 Updated: 2019.09.03
Revised: 2020.11.13, 2023.04.26

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 before each month (e.g., the June schedule by May 1). The schedules 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 must ensure adequate daytime and on-call coverage during the resident examinations, educational courses, the American Urological Association and Canadian Urological Association meetings, adhering to PARO guidelines.
- *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

- *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.

- *Rounding Stipend*
    - Residents who have been approved for senior call may **volunteer** to assist the on-call team by rounding at their current assigned site on the weekend. If this occurs, the rounding resident is responsible for rounding on the patients at their site, communicating with the appropriate staff, and ensuring complete handover to the on-call team for any patient issues. The rounding resident should not see any new consults. Residents are entitled to receive an additional rounding stipend two times per month.

Revised: 2024.08.14
Approved: 2025.06.23

Urology Chief Resident Expectations and Guidelines

1. Call Schedule:

The monthly call schedule must be finalized and distributed no later than one month in advance.**2. Master Rotation Schedule:**

- Master rotation schedule to be completed by the program and submitted to Chief residents for review.
- The master rotation schedule, provided by the Department of Surgery, should be reviewed and approved as early as possible, ideally by mid-May.
- The schedule should ensure that all residents receive equitable exposure.

3. Float Resident:

- The chief resident is responsible for assigning the weekly tasks/daily assignment of the resident on a float rotation. The float resident should primarily be assigned to cover residents who are on night float and/or vacation.

4.Vacation Requests:

- Vacation requests should be approved promptly
- Vacation requests must be approved in a manner that ensures a sufficient number of residents for delivery of safe patient care, with an overall minimum number of 8 residents (which may vary depending on teams and variability of resident numbers per rotation, exception for conferences), including off-service residents, required to be scheduled in the city for daytime clinical activities.
- Per PARO guidelines, residents must submit vacation requests at least 4 weeks before the proposed start date.

5. Conference Attendance:

- At least six residents must remain in the city during conferences (except to above).
- Priority for conference attendance is as follows:
    i. Fellowship interviews
    ii. Podium presentations (documentation of acceptance may be requested by the program)
    iii. Moderated poster presentations
    iv. First come, first served (with PGY5s given the lowest priority)
    v. Residents must be in good standing with the program to attend conferences

6. Scheduling Disputes:

- In cases where junior residents are needed to cover different sites, PGY5s must discuss and agree on the changes. These changes must then be approved by the Assistant Program Director and/or Program Administrator before the Chief Resident communicates the final decision to the affected junior resident

7. Conflict Resolution Among Chief Residents:

- Any disagreements between Chief Residents should be handled professionally and with mutual respect. Under no circumstances should aggressive or derogatory language be used.
- If a disagreement cannot be resolved among the Chief Residents, the Program should be called in to assist in reaching a resolution.

8. Grand Rounds and Resident Seminars:

- The Grand Rounds schedule should be planned well in advance, with at least four residents assigned each day. A backup resident should also be scheduled weekly.
- Seminar topics must be provided to the Program Administrator in a timely manner to facilitate the scheduling of consultants.

9. Radiology and M&M Rounds:

- PGY5 residents are responsible for tracking and compiling cases for Radiology and M&M Rounds.
- Radiology cases must be sent to the radiologist one week in advance.
- PGY5 residents are expected to present cases they were directly involved in during M&M Rounds.

Revised 2024.08.26
Revised & Approved: 2025.06.23

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.
    - Supervise a resident seminar and/or present a topic of their choosing on academic half day.

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.

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: 2025.06.23

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. 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. During the clinical elective, PGY5 residents are not responsible for rounding, consults, or other daily clinical activities.

2.3 Transition to Practice (TTP):

- Residents must complete a TTP rotation and attain the required competencies and objectives of the rotation in order to successfully complete residency (TTP Guidelines Appendix).

3. Call Schedule

- **Pre-Exam Call Reduction:**
  - PGY5 residents are allowed to stop taking call one month before the written exam date (subject to operational requirements).
  - 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.

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 consultants.
- **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 prior to 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).

DIVISION OF UROLOGY SOCIAL MEDIA COMMITTEE - TERMS OF REFERENCE

Committee members: Staff supervisor
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 suggests 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, including politics, policies, public health issues, etc.

ROBOTIC TRAINING FOR UROLOGY RESIDENTS

The purpose is to set out an organized approach to teaching complex urologic robot assisted laparoscopic surgery to residents.

Goals

1. To train residents in the safe operation of the Da Vinci Robot.
2. To improve resident comfort and knowledge of the Da Vinci Robot.
3. To train residents in the steps of robot assisted laparoscopic pyeloplasty.
4. To train residents in the steps of robot assisted laparoscopic radical prostatectomy (RARP).

Background

There are currently 11 Da Vinci robots in Canada. These are all located at training centres. Currently at UWO, urology residents gain exposure to cases by attending cases being performed. Initial involvement has included first assisting in cases as the bed-side surgeon. Dr. Pautler has run a urologic laparoscopy course with live porcine laparoscopic surgery at CSTAR (2008) and prior to that at SJHC (2004). Dr. Sener has run a laparoscopy and Single-port access course at CSTAR (2009).

The use of the Da Vinci robot has increased in Canada with >1000 RARP having been performed. This surgery is very complicated and is difficult to teach within the current constraints of the health care system. Major issues include:

1. The increased operative time required for trainees to become proficient in the use of the robot for the procedure.
2. The long waiting lists for prostate cancer surgery and provincial reporting necessitate proficiency in the operating room.
3. The relatively low number of robot assisted pyeloplasties, limits the ability of residents to get experience with a relatively safe operation.
4. The lack of available jobs at centres with surgical robots limits the interest of trainees in becoming proficient.
5. The patient safety concerns with the increased risks of complications observed in the learning curve for RARP.
6. The current Da Vinci robots at the two London hospitals do not support a teaching console. The newest version of the robot has a teaching console and should be considered a priority from a teaching perspective.
7. The commercially available simulator for robotic urologic surgery is not compatible with the models in London.

Robotics Training Curriculum in Urology at Western

To overcome these issues, we have developed a step-wise approach to teaching surgical robotics to the UWO urology residents.

This approach includes 3 phases:

1. Didactic teaching, hands-on dry lab experience.

During this time the residents will come familiar with the robot and it's components.

a. Read the *AUA Handbook of Laparoscopic and Robotic Fundamentals* available:
https://university.auanet.org/core/makepdf.cfm?sectionid=129

b. Read the attached documents on the steps of the procedure for the Laparoscopic Nephrectomy and Laparoscopic Suturing and Knot Tying.
c. Complete the online training model provided by Intuitive Surgical.

daVinci Standard System Online Material:

daVinci Standard Online Module:
http://www.intuitivesurgical.com/assets/training_materials/dV_Standard/Fundamentals_Standard/Fundamentals_Standard.htm

daVinci Standard Module Exam:
http://www.intuitivesurgical.com/assets/training_materials/dV_Standard/Fundamentals_Exam_Standard/Fundamentals_Exam_Standard.htm

A passing mark of 80% must be obtained from the online exam. The certificate of completion must be printed off and copies given to the program director for your training file.

d. The resident will demonstrate proficiency in robot set, handling, instrument changes, suturing, and troubleshooting. The residents will be required to attend the didactic experience (ideally, the Intuitive surgery course at an approved training centre). Thereafter, the residents will work in pairs. Two hours per session (ideally weekly), for a total of 10 hours of dry lab experience. The residents will need to be proficient with tasks including suturing (continuous and interrupted, knot tying, passing rings, pattern cutting, and vesico-urethral anastamosis on a model as assessed by one of the attending surgeons and the program director.

2. Animal lab component.

During this phase, the residents will operate on live pigs. As an animal model for prostatectomy is not available, porcine pyeloplasty and partial nephrectomy will be used for training purposes. The residents will be required to perform the surgery and be judged as proficient by the evaluators (a robotic surgeon and the program director).

3. Transfer to the operating room phase.

During this time the residents will be required to be first assistant on 10 cases of RARP. If they are deemed proficient, they will then begin console surgery. The console surgery may be either RARP or RA pyeloplasty. For RA pyeloplasty, the residents will sequentially complete the following steps:

a. Mobilization of the lower pole and pelvis
b. Dissection of the UPJ
c. Pyelotomy
d. Spatulation
e. Reanastamosis

For RARP, there are 9 steps that will be mastered sequentially starting with the easiest steps of the procedure. In order of ease:

a. Dropping of the bladder
b. Opening endopelvic fascia
c. Control of the dorsal venous complex
d. Node dissection
e. Dividing the bladder neck
f. Apical dissection
g. Dissection of the seminal vesicles
h. Pedicle and nerve sparing
i. Anastamosis

During the RARP cases, the ideal situation is to have a resident or fellow who has prior experience with robotic surgery (at a higher level of training) at the bedside as well during the case. The novice resident will start with second assisting, then progress to first assist. With a second resident/fellow present, this will allow transition to the console for the novice resident.

The Residents will track the number of cases they are involved in and the capacity (ie: bedside assist, console including which steps). The case log should be initialed by the attending robotic surgeon at the completion of the day. This will aid in potential future credentialing scenarios.

Future Plans

As new procedures and/or robots become available, this curriculum for teaching robotic surgery will be re-evaluated. In the future, the robotic surgeons will advocate for the purchase of a DaVinci Si robot with a teaching console. This will greatly enhance teaching of surgical procedures in urology.

Approved: 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 Centres 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)

Appendix A: Enhanced Educational Plan, Remediation Plan, Probation Plan

APPENDIX A: ENHANCED EDUCATION PLAN, REMEDIATION PLAN AND PROBATION PLAN COMPARISON CHART

	Enhanced Education Plan	Remediation Plan	Probation Plan
Definition	Individualized plan designed to assist residents in correcting identified areas for improvement without significant changes to the clinical or academic curriculum.	Remediation is a formal period of targeted training with a specific focus on areas where a resident is experiencing difficulties or demonstrating a lack of skills, knowledge or gaps in professionalism. The goal of remediation is to maximize the opportunity for a resident to successfully complete the residency program. The clinical and academic curriculum may be modified, for example with repeat rotations or new training experiences.	Probation is a period of training during which a resident is expected to correct serious weaknesses that are impacting the ability to successfully complete the residency program. Probation implies the possibility of dismissal from the program if sufficient improvement in performance is not identified by the end of the probation period. Probation is a critical period where training experiences, supervision and assessment may be highly modified to focus on specific areas for improvement.
Triggers for plan (include but are not limited to)	Possible triggers for EEP include, but are not limited to: • Borderline ITER • 'Not progressing as expected' assessment by CC • Less than satisfactory assessment(s) as defined by the program • Professionalism concerns • Review of a successful remediation or probation where an EEP is required to provide further areas for monitoring and assessment.	Possible triggers for remediation include, but are not limited to: • Failed rotation (or block) • Unsatisfactory ITER • 'Failure to progress' assessment by CC • Repeated difficulties in one or more competencies across training experiences • Unsatisfactory outcome or 'failure to progress' during or following an EEP • Professionalism or patient safety concerns	Possible triggers for probation include, but are not limited to: • Unsatisfactory or 'failure to progress' assessment during or following a remediation period • A prior remediation or probation period for the same concerns, even if the prior plan was successfully completed • Critical incident related to professionalism and/or patient safety

Appendix A: Enhanced Educational Plan, Remediation Plan, Probation Plan (continued)

Plan Requirements (see PGME Plan Templates)	• Duration • Training experiences (rotations or blocks) • Supervisor(s) • Objectives • Expectations • Monitoring of progress • Potential outcomes or consequences • Assessment methods • Additional supports (for example mentor, academic advisor, Learner Experience, PARO)	• Duration • Training experiences (rotations or blocks) • Supervisor(s) • Objectives • Expectations • Monitoring of progress • Potential outcomes or consequences • Assessment methods • Additional supports (for example mentor, academic advisor, Learner Experience, PARO)	• Duration • Training experiences (rotations or blocks) • Supervisor(s) • Objectives • Expectations • Monitoring of progress • Potential outcomes or consequences • Assessment methods • Additional supports (for example mentor, academic advisor, Learner Experience, PARO)
Assessment	Formal review with written documentation at minimum every 4 weeks (end of block).	As required in the remediation plan. At minimum formal review and written documentation of resident progress is required every 4 weeks.	As required in the probation plan. At minimum formal review and written documentation of resident progress is required every 2 weeks.
Length of plan	1 – 3 blocks with extension of up to 6 blocks if improvement is demonstrated.	2 – 3 blocks, with extension to 6 blocks at the discretion of the RPC if there is evidence of some improvement or new deficits are identified during the remediation period.	2 – 3 blocks with an extension to a maximum of 6 blocks when there is evidence of some improvement in the deficits being assessed. Extension of the probation plan must be approved by the Associate Dean PGME.
Consequences of unsuccessful plan	Remediation Note that a plan may be considered unsuccessful at any time during the plan.	Extension of remediation plan Probation Note that a plan may be considered unsuccessful at any time during the plan.	Extension of probation plan Dismissal from the program Note that a plan may be considered unsuccessful at any time during the plan.
Appeal	No appeal is available for the requirement for an EEP.	Appeal of requirement for remediation as per Appeal Policy.	Appeal of requirement for probation as per Appeal Policy.
Approval	Must be signed by the resident and the program director/delegate.	1. Draft remediation plan must be reviewed with the resident. 2. The resident will be provided the opportunity to submit additional information and/or input to the Advisory Board. 3. The final Remediation Plan (following feedback and approval of the Advisory Board) must be	1. Draft probation plan must be reviewed with the resident. 2. The resident will be provided the opportunity to submit additional information and/or input to the Advisory Board. 3. The final probation plan (following feedback and approval of the Advisory Board) must be reviewed

Appendix A: Enhanced Educational Plan, Remediation Plan, Probation Plan (continued)

		reviewed with the resident, signed by the resident to acknowledge receipt and understanding of the plan, and signed by the program director.	with the resident, signed by the resident to acknowledge receipt and understanding of the plan, and signed by the program director.
Advisory Board approval	Not required, however the program may request input from the Advisory Board for the EEP.	Required.	Required.
Extension of Training	An EEP is not expected to increase the duration of training.	An extension of training may be required (whether or not the remediation plan was successful). The decision regarding extension of training (whether the remediation blocks 'count' toward training requirements) will be made by the RPC after completion of the remediation plan.	Training during the probation period will not be counted towards completion of program training requirements. An extension of training will be required.
Electives	Electives may be available if they meet the requirements of the EEP.	Remediation should occur at the program home site(s). Electives will not be part of a remediation plan. If an off-site training experience is considered for a component of the remediation program this must be approved by the Associate Dean, PGME.	Electives are not permitted during the probation period.
Vacation	Vacations are available to the resident during an EEP at the discretion of the program.	Vacation is available but must be approved in writing by the program director. Any vacation, leave or time away from the program during the remediation period will not be counted as part of the remediation period.	Vacation is available but must be approved in writing by the program director. Any vacation, leave or time away from the program during the probation period will not be counted as part of the probation period.
'Moonlighting'	Moonlighting is not recommended during an EEP.	Moonlighting is not permitted during remediation.	Moonlighting is not permitted during a probation program.
Resident Information	All residents must be made aware of the Assessment and Appeals Policies, as well support and advocacy available from Learner Experience and PARO.		

Full policy is available at: 2021 PGME Resident Assessment and Appeals Policy.pdf

Appendix B: Transition to Practice Rotation Objectives

Overall Goal
Prepare residents for independent urology practice by developing clinical, administrative, and leadership skills, tailored to individual learning needs.

Clinical Objectives

4. **Demonstrate ability to manage urological patients in outpatient clinics**
    1. **Analyze** patient presentations and **formulate** management plans for urological conditions.
    2. **Apply** clinical reasoning to prioritize investigations and treatments.
    - **Assessment**: Observation in four clinics.
5. **Demonstrate ability to coordinate and execute endoscopy/cystoscopy days**
    1. **Perform** and **organize** cystoscopy procedures with safety and efficiency.
    2. **Evaluate** outcomes to refine procedural skills.
    - **Assessment**: Observation during two endoscopy days.
6. **Demonstrate the ability to coordinate, organize and execute a days of urological procedures**
    1. **Plan** and **lead** surgical lists, ensuring effective collaboration with the OR team.
    2. **Demonstrate** technical and leadership skills in core urological surgeries.
    - **Assessment**: Supervised autonomous OR sessions (minimum four).
7. **Demonstrate ability to manage complex intraoperative consultations**
    1. **Interpret** complex scenarios and **formulate** evidence-based recommendations.
    - **Assessment**: Two observed encounters or OSCE.
5. **Demonstrate an understanding and contributing to the administrative operation of urological practice**
    1. **Manage** patient communication, triaging, billing, and result reviews.
    2. **Critique** workflows to improve service efficiency.
    3. **Coordinate** scheduling and **mentor** junior learners in clinical and interprofessional care.
    4. **Prepare** and **deliver** educational sessions on key urological topics.
    - **Assessment**: Supervisor evaluation and 360-degree feedback.
6. **Develop and implement a personal learning plan based on career goals**

1. **Identify** gaps, **design** a tailored learning plan, and **implement** it.
2. **Evaluate** progress toward goals.

- **Assessment**: Mentor and supervisor review.

Customization for Individual Needs

- **Select** targeted experiences (e.g., robotics, ESWL) to address gaps.
- **Integrate** these into the rotation for skill acquisition.
- **Assessment**: Progress reviewed during bi-annual evaluations.