The faculty and staff of Texas Tech Urology would like to welcome you to our department. We know that you will have several questions. This manual is designed to help answer some of those questions. Please take the time to read over the manual and direct any concerns to Dr. Smith, Dr. Cammack or Judy Pierson.

The manual is available in “hard copy” in the coordinators office and online at:

http://www.ttuhscl.edu/som/urology/Residency.aspx
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On behalf of the faculty and staff of the Urology Department at Texas Tech University Health Sciences Center I would like to welcome you to Lubbock, to Texas Tech and to our Department. You are about to engage in the most challenging and rewarding phase of your medical training. You have worked hard and have accomplished much to get here, and we are proud to have you represent us.

Over the next five years you will learn the art and science of Urology and it is our goal that you leave our program with the knowledge and skill to be a confident, competent urologist, and most importantly, a compassionate and ethical physician. It is our responsibility that you receive all the resources and help necessary to achieve those goals. If you have need of additional support during your residency, we are available to help you in whatever way we can.

We are also concerned about your personal development and the welfare of your family and your relationships with your friends, and your community. It is vital that you balance your work and study with your other personal commitments. If you have any problems or requests with these aspects of your life, we are also available to assist you in whatever way we can.

This handbook outlines the organization of the program, our policies and procedures, and provides you with the contact information for individuals and services you will need during your residency. You are responsible for knowing the information in this handbook. Should you have questions about the content of this handbook, or if you have suggestions or improvements for this handbook please let us know.

Best wishes for your continued success,

Cynthia K. Smith, MD
Urology Program Director
MISSION STATEMENT

Texas Tech University Health Sciences Center
School of Medicine - Department of Urology
Lubbock, Texas

- Provide the highest standard of urological care in a compassionate and ethical manner.
- Pursue academic, clinical, and technical excellence.
- Foster an environment of intellectual curiosity.
- Promote leadership and mentorship at all levels.
Departmental Policy for Resident Supervision

Residents are supervised by the responsible attending based on their level of competence and years of training. Close supervision is appropriate in the beginning of training for teaching the core competencies and progressive autonomy is important towards the end of residency to foster independent, well-prepared graduates.

Residents will promptly contact the Chief Resident and the attending on call with any admissions, new consults, or significant changes in a patient’s status. Each patient on the Urology Service will be seen by a resident and an attending on a daily basis. The patient’s case will be discussed and appropriate documentation reviewed and signed by both the resident and attending. All surgical cases will be supervised by an attending and the case performed based on the resident’s level of training and preparation. A resident may not start a case without prior consultation and authorization by the attending of record. This authorization must include a discussion of how far the resident may proceed before the faculty member's physical presence in the operating room.
I. UROLOGY DEPARTMENT GUIDELINES FOR ALL HOUSEOFFICERS

THE FOLLOWING GUIDELINES PROVIDE THE STANDARD OPERATING POLICIES FOR UROLOGY RESIDENTS, NON- UROLOGY RESIDENTS, AND MEDICAL STUDENTS ROTATING ON THE UROLOGY SERVICE.

All residents must familiarize themselves with these policies and refer back to them as often as needed during the time they are on the service.

A. General Guidelines

1. **All residents** are strongly encouraged to purchase *Urology for the House Officer* by Michael T. Macfarlane, or *Pocket Guide to Urology* by Jeff A. Wieder, or a similar guide to urology prior to their rotation. These books are reasonably priced and are generally available in the HSC bookstore. These guides are small enough to fit in your lab coat pocket. They are a useful addition to your library even if you are not going into urology or a surgical specialty.

2. **Dress:** All residents are expected to be well groomed at all times. Clean lab coats are expected at all times. 3 lab coats are provided by the department. Cleaning is available through the department and coats should be cleaned on a weekly basis. Street clothes should be worn on clinic days when possible. If in OR, clean scrubs should be worn.

3. Phones receiving business e-mails should be pass code protected. If phone is lost/stolen, Information Technology MUST be notified immediately. Communication regarding patients should be held verbally between providers as much as possible. Texting Protected Health Information is not allowed. The department will provide access to a secure texting app. This app should be used for any patient related activity. Patient information may be e-mailed within the Texas Tech system to appropriate providers. Do not e-mail patient information outside of the Texas Tech system unless using encryption, you may call IT to get information on this.

4. The Department of Urology has a library located in the conference room within the clinic. **BOOKS CANNOT BE REMOVED FROM THE DEPARTMENT.** Please sign out any book you are borrowing.
5. Beepers: Each resident is expected to carry his/her personal pager at all times while on duty or on call. Communication by cell phone is acceptable, but is not an alternative to a pager.

6. All issues regarding residency operations are to be brought to the Program Director or Assistant Program Director.

7. The residency Program Coordinator, Mrs. Judy Pierson, is available to answer many questions residents might have about the operations and administrative policies of the Urology Department. Judy can be reached at 743-3400 extension 262.

8. Residents cannot take vacation without prior approval from the Urology Program Director. You contact Judy Pierson for the form. Vacations cannot be schedule in May or June due to multiple conferences that are attended by the residents. Vacations must be taken in 1 week blocks, however if you wish, one week of vacation can be split into 2.

B. Medical Students & Other Residents on Service

1. All efforts should be made to make medical students and visiting residents feel welcome and a part of the team. They are our guests. Residents are responsible for teaching medical students and guest residents.

2. All efforts will be made to incorporate medical students, PGY I house staff and visiting residents into the activities of the Department to include sharing of surgical procedures, didactics, and rounds.

C. On-Call and Admission Responsibilities

1. Every patient admitted to the urology service is assigned one attending surgeon. At all times, and for all types of patients, participating residents will act under the supervision and direction of the responsible attending surgeon.

2. Patients admitted during the day and after hours are generally admitted to the attending on call.

3. Faculty physicians take call one week at a time (Friday am – Friday am).

4. Consults must be completed within 24hrs unless they are called as an emergency. The emergency room consult must be completed within a 2 hour time frame. All consults and admissions must be discussed with the appropriate attending as soon as possible.

5. All residents are to round together and rounds are to be completed in time to start morning surgery.

6. House staff will round with the attending on call on a daily basis. The time for rounding will be determined by each attending.
7. All trauma consultations will be seen immediately if only to perform a quick assessment and recommend appropriate imaging studies prior to providing a complete consult.

8. **Always check with patients to ensure that they have not previously established care with a community urologist.** If the resident has already seen the patient and gathered information, it is appropriate to contact the community urologist (or their on call representative) and notify them of the patients' status. If you have any questions, please discuss with your attending physician.

9. Admissions after hours: All admissions after hours need to be discussed with the attending on call or the Chief Resident.

10. The attending must be notified immediately if surgery is anticipated or if any patient has an urgent or critical problem.

11. The urology resident is responsible for keeping the patient list on Power Chart up to date.

12. Follow-up appointments for patients seen in the Emergency Department or inpatients should generally be scheduled with the attending of record with the exception of pediatric patients who should be scheduled with Dr. Smith. Do not schedule follow-up appointments for adult patients with Dr. Smith without talking to her first. Patients should be given the date and time of their follow-up appointment at the time of discharge whenever possible. After hours or on the weekend, you may use the EMR “Communicate” function to request that an appointment be scheduled in clinic. Please direct this to Rebecca Casares and be sure to indicate any studies to be done.

13. Appointments during office hours for cystoscopy, urodynamics, or other clinic procedures can be made by calling the clinic and speaking with one of the nursing staff at 743-1851. **PLEASE NOTE THAT THIS NUMBER IS A PRIVATE NUMBER AND SHOULD NOT BE GIVEN OUT TO ANYONE!**

**D. Sign-Outs**

Effective communication regarding patient status and needs is essential to quality patient care. Attention to detail and a careful and complete sign-out at each stage will greatly reduce the likelihood of errors.

Sign-out should take place on three levels:

1. The Chief Resident will receive sign-out from the residents, with particular attention to potential "problems" on each individual service.

2. The on-call resident will coordinate with the Chief Resident and the attending on-call to review the entire patient list. A detailed sign-out is imperative. Sign-out between residents is to contain the following information:
a) Pertinent problems for each patient  
b) Labs to be checked upon during the night  
c) Radiographic studies to be reviewed during the night  
d) Basic trouble shooting.  
   If patient spikes, does he need to be cultured or has it already been done, etc.  
e) Vital signs  
f) Daily I/O's  
g) Current medications  
h) Current diet  
i) Current IV fluid administration  

3. On Friday, a transition of care conference will be held and will include the attendings coming off and going on-call, all residents, and pertinent faculty. Each patient will be discussed, labs and films reviewed, all plans for the patient will be discussed.

E. Ward Rounds  
1. **Rounds must be finished by 0645 to allow the resident in the operating room to be in the OR in a timely fashion.** This is especially important on Friday mornings so that residents and students can attend tumor board if a urology case is to be presented.  
2. The Chief Resident is responsible for organizing ward rounds each morning. This includes dividing the service as he or she sees fit for maximum efficiency.  
3. All residents must report any significant developments on active patients, post-operative patients, and patients on the consult service to the Chief Resident each morning.  
4. The Chief Resident is responsible for insuring that the faculty are given timely, current updates for each of their patients on the service.  
5. Post-operative patients and patients admitted directly to a specific attending are to be followed by the attending of record during the week. The attending on call will round on all other patients. All active in-patients must be seen by an attending every day.  
6. A progress note must be documented in the EMR on a daily basis. These notes need to be co-signed by the responsible faculty member each day.  
7. Resident schedules take precedence over rounding with faculty. Residents must be available for their assigned duties and not pulled out for rounding or surgery except for
exceptional circumstances, and then only with the concurrence of the attending supervising them at that time.

8. Faculty who desire to round separately with a resident will make rounds in the evening after clinic or surgery to avoid creating a conflict with the resident’s schedule.

9. If the on call resident is not available to see a consult (this pertains especially to Emergency Department consults and that attending will complete the consult), he or she must notify the Chief Resident of the problem so that arrangements can be made to have the consultation answered as quickly as possible. If no resident is available the Chief Resident is to notify the attending on call of the need for a consult.

10. Residents are not to be pulled away from the clinic except for emergencies.

11. All consults done must be forwarded to the coding department through the EMR on a daily basis so that we can bill appropriately

F. Documentation

Complete documentation is necessary for medical, legal, & billing purposes.

1. Notes & dictation should include the following information listed below.

   a) Medical students cannot document in the official record. Medical students may practice documenting under medical student power note. It will not be a part of the official record and does not need to be co-signed.

   b) Residents must document the chief complaint, HPI, medication, allergies, past medical history, physical examination, plan and diagnosis.

2. Attending’s must document an appropriate attestation statement on all of their patients for clinic, surgery, and inpatient service.

3. Residents cannot co-sign any notes for junior residents.

4. Patient Lists

   (The importance of an accurate, up-to-date patient list cannot be overemphasized). Information provided on the list should include a patient’s full name, location, medical record number, age, date of birth, attending surgeon and a brief description of his/her diagnosis. Lists are generated and stored in the EMR system where the patient’s chart may also be reviewed in detail. Residents should obtain remote access on their home computer in
order to be able to review patient record when on-call. This can be done through the UMC IT department. It is important that all patient information be protected in compliance with HIPPA.

**Please be cognizant of discussion of patients in public areas. Sign-outs should not take place in areas such as the cafeteria where discussions may be overheard. If patient lists are printed they should be discarded only in a protected health information bin or shredded.**

Check list for Urology
1) Residents give verbal checkout on each patient at each shift change.
2) Attendings are on for one whole week and on Friday afternoon a Transition of Care conference is held where all residents and faculty review and discuss each patient.

G. Surgery
1. All surgical procedures to include after-hours procedures are performed under the direct supervision of an attending faculty member.
2. Residents are to be present in the Operating Room and ready for the start of surgery by 0700 hrs. Monday through Thursday and after Tumor Board if Urology cases are presented on Friday.
3. Residents are expected to have studied the patient’s medical record and be able to discuss the condition necessitating surgery, procedure planned, performance of the procedure, and any possible complications and their solutions.
4. Residents must be **present at the time of induction and participate in positioning the patient and otherwise helping with insuring timely start of the procedure.**
5. **Residents must stay with the patient after the procedure and accompany the patient to the Recovery Room.**
6. The following guidelines apply to the start of cases:
   - PGY 1 – 3: Attending must be physically present before the start of any case. The resident cannot begin any portion of the procedure to include positioning of the patient.
   - PGY 4 – 5: Resident may begin actual instrumentation, but may not begin a critical portion of the procedure. The resident can start a case only after explicit discussion and approval by the attending of record as to what he/she may do prior to the physical presence of the attending.

H. Conferences and Didactics
1. All case conferences will be conducted to the highest standards. **Please make every effort to be on time or early to all conferences. Please come prepared.**
2. Conference attendance is mandatory and residents can be excused only with prior permission of the Program Director.
3. The Chief Resident is responsible for preparing and running all Friday conferences.
4. The PGY II (U1) is responsible for maintaining an up to date conference log and insuring that the log is present for conferences.
5. Interruptions during conferences should be kept to a minimum and cell phones and pagers of residents not on call turned off.
6. Tuesday AUA Core Curriculum- residents are responsible for reading and preparing the assigned AUA Core Curriculum material in advance. Residents should keep an up-to-date notebook of this information. Attendings will be responsible for the discussion of the assigned material.
7. The assigned attending will be responsible for the discussion of the conference material. Other faculty will attend as their schedule allows.
8. AUA updates and ERBU will be completed by the residents on a monthly basis. The chief resident will schedule this conference and this is to be done by the residents independently.

I. Procedural Skills/Case Logs
The ABU requires documentation of cases performed. This log is maintained on the ACGME web-site. These logs must be submitted for review by the Program Director on a monthly basis. You must be up to date on your case logs.

Incoming PGY II residents see Coordinator prior to entering cases to assure you have been transitioned from surgery to urology.

J. Discipline:

Urology residents at all times are expected to behave professionally and with the greatest respect for patients, families, staff, and their colleagues.

All residents must become familiar with the TTUHSC policies for disciplinary actions. (Adverse Actions page 13) These policies can be found at:

http://www.ttuhsce.edu/som/gme/documents/HS_PandP_s_070112.pdf

## II. PHYSICIAN AND RESIDENT LISTINGS

<table>
<thead>
<tr>
<th>Physicians Name</th>
<th>Pagers</th>
<th>Home &amp; Cell Phone #'s</th>
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<tbody>
<tr>
<td><strong>Faculty</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Werner deRiese, MD</td>
<td>741-7746</td>
<td>C: 790-8648</td>
</tr>
<tr>
<td>Chairman, Professor Urology</td>
<td></td>
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</tr>
<tr>
<td>Cynthia K. Smith, MD</td>
<td>721-3047</td>
<td>C: 970-417-1057</td>
</tr>
<tr>
<td>Associate Professor of Urology</td>
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<tr>
<td>Program Director</td>
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<tr>
<td>Michael R. Crone, MD</td>
<td>721-3093</td>
<td>C: 707-514-5081</td>
</tr>
<tr>
<td>Associate Professor Urology</td>
<td></td>
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<tr>
<td>Allan Haynes, MD</td>
<td>721-0490</td>
<td>H: 796-0183</td>
</tr>
<tr>
<td>Professor of Clinical Urology</td>
<td></td>
<td>C: 470-6231</td>
</tr>
<tr>
<td>Bernhard Mittemeyer, MD</td>
<td></td>
<td>C: 790-1523</td>
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<tr>
<td>Professor of Urology</td>
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<tr>
<td>Thomas Nelius, MD</td>
<td>721-0489</td>
<td>H: 792-0169</td>
</tr>
<tr>
<td>Associate Professor of Urology</td>
<td></td>
<td>C: 281-8402</td>
</tr>
<tr>
<td>Jonathan S. Vordermark, MD</td>
<td>743-8781</td>
<td>C: 790-0879</td>
</tr>
<tr>
<td>Professor, Urology &amp; Pediatrics</td>
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<tr>
<td>Stephanie Filleur, PhD</td>
<td>N/A</td>
<td>H: 792-0169</td>
</tr>
<tr>
<td>Assistant Professor Urology &amp; Dept. of Microbiology &amp; Immunology</td>
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<tr>
<td>J. Thomas Cammack, MD</td>
<td>721-3133</td>
<td>C: 830-370-3107</td>
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<tr>
<td>Associate Professor</td>
<td></td>
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<tr>
<td>Associate Program Director</td>
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<tr>
<td><strong>Residents</strong></td>
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<tr>
<td>Johnny “Trey” Hickson, MD</td>
<td>721-2081</td>
<td>C: 405-206-5106</td>
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<tr>
<td>Resident Physician</td>
<td></td>
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<tr>
<td>Natalie Gaines, MD</td>
<td>721-1982</td>
<td>C: 543-3545</td>
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<tr>
<td>Resident Physician</td>
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<tr>
<td>Brandon Trojan, MD</td>
<td>721-3214</td>
<td>C: 632-0269</td>
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<tr>
<td>Resident Physician</td>
<td></td>
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<tr>
<td>Lauren Underwood, MD</td>
<td>721-2309</td>
<td>C: 337-945-2123</td>
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<tr>
<td>Resident Physician</td>
<td></td>
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</tbody>
</table>
III. ADMINISTRATION AND FACULTY LISTINGS

A. Office of the Chairman
Bowie McGinnis: Department Administrator
E-mail address: bowie.mcginnis@ttuhsc.edu

Werner deRiese, M.D.: Department Chairman
E-mail address: werner.deriese@ttuhsc.edu

Maria Alaniz: Coordinator for administrative & business matters – Maria prepares all check requests, purchase orders and expense reimbursements. Maria provides academic and administrative support for Dr. Werner deRiese, Dr. Allan Haynes, Dr. Bernhard Mittemeyer, Dr. Thomas Nelius, and Dr. Stephanie Filleur.
E-mail address: maria.alaniz@ttuhsc.edu

B. Academic Offices.
The Urology academic office is located Texas Tech University Health Sciences Center, 3601 4th, 3B163 (Judy Pierson).
Office number: 743-3400 x 262.
E-mail address: judy.pierson@ttuhsc.edu.

Program Director
Cynthia K. Smith: Director of the Urology Residency Program and Associate Professor of Urology. Dr. Smith oversees the evaluation, guidance, and activities of the urology residents. Dr. Smith maintains an open door policy for problems, issues external to the program that are impacting on your training, or if you need feedback on any aspect of the program.
E-mail address: cynthia.k.smith@ttuhsc.edu

Associate Program Director
Dr. Tom Cammack is the Associate Program Director. He is also available for all resident concerns and problems if Dr. Smith is not available.
E-mail address: tom.cammack@ttuhsc.edu

Residency Coordinator
Judy Pierson: Judy oversees the on-call and rotation schedules with the residents, lectureships schedules, and resident vacation schedules. Judy is in charge of maintaining conference data/distributing conference calendars/schedules with the residents and all aspects of the residency program.
Office number: 806-743-3400 ext.262
E-mail address: judy.pierson@ttuhsc.edu
<table>
<thead>
<tr>
<th>Position</th>
<th>Contact Information</th>
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</thead>
<tbody>
<tr>
<td>Clinic Charge Nurse – Melinda McKinnon, RN</td>
<td>743-1851 or 743-3400 ext 235</td>
</tr>
<tr>
<td>Urodynamics</td>
<td>743-1851 or 743-3400 ext 243</td>
</tr>
<tr>
<td>Clinic/Follow-up Appointments</td>
<td>743-3400 ext 224, 221, 222, 223, or 225</td>
</tr>
<tr>
<td>Clinic Supervisor – Rebecca Casares</td>
<td>743-3400 ext 226</td>
</tr>
<tr>
<td>Schedule Office Procedures</td>
<td>743-1851</td>
</tr>
<tr>
<td>Billing – Staci Thomas</td>
<td>743-3400 ext 233</td>
</tr>
</tbody>
</table>
IV. Curriculum

The Urology Residency Program at the Texas Tech University Health Sciences Center School of Medicine is a five year long program that includes a PGY I year in the Department of Surgery at Texas Tech and four years in the Department of Urology at Texas Tech.

The PGY I year is spent with the Department of Surgery, but is designed by the Urology Program Director to give the resident a firm foundation in the principles of surgery to include pre- and post-operative management, and the diagnosis and management of common surgical problems. A strong exposure to the management of surgical emergencies, trauma and intensive care medicine is provided. We feel that an exposure to these disciplines is a fundamental part of the education of the urologist and necessary for the resident to understand the principles of urology that the resident will be exposed to during the remainder of his or her residency.

The next four years are devoted to learning the scientific and clinical basis of the specialty of urology to include a thorough exposure to the principles of research relevant to the specialty and the anatomy, physiology and path-physiology of the renal, genito-urinary, and male reproductive systems. Residents have the opportunity to participate in on-going urological research and are required to contribute to the body of urological knowledge in the form of basic science or clinically orientated research or case reports, literature reviews, or clinical studies.

During the course of the residency, residents participate in a comprehensive didactic program that includes thorough review of the foundational textbooks of urology and the current urological literature. Instruction in fields necessary to the urologist to include urological imaging and urological pathology is also provided. The didactic portion of the residency is conducted in weekly conferences, assigned reading and independent study. Emphasis is given throughout the residency to performing well on the annual Urology In-Service examination and the certification examinations given by the American Board of Urology. AUA Core Curriculum is followed and can be accessed at www.auanet.org

Urology Coordinator - Judy Pierson initiates AUA membership.

The focus of this program is primarily clinical, with a robust and broad exposure to and participation in all aspects of clinical urology. Residents participate directly in all phases of the clinical
care of urological patients to include performing or assisting in all urological surgical procedures performed at University Medical Center Hospital and supporting institutions. Residents are closely supervised at all times and decisions regarding patient management are discussed with the responsible faculty member. At the completion of the training program, residents are expected to be able to perform as an independent practitioner able to conduct the medical and surgical management of the complete spectrum of routine urological disorders.

At graduation, residents should have the necessary background to practice urology in the environment of their choice to include general or sub-specialty training, and/or an academic or research oriented career.

A. EDUCATIONAL PHILOSOPHY

Residents are first and foremost, here to learn the science and art of urology. Participation in didactic activities and scholarly endeavors including conferences and meaningful clinical and surgical experiences take precedence over service obligations and repetitive or menial clinical duties.

Educational and patient care activities are conducted with continuous attention to the six core competencies as described by the Outcomes Study endorsed by the ACGME. You must be familiar and able to discuss these core competencies. www.acgme.org

Our program seeks to integrate all resources of the Health Sciences Center at Texas Tech University, the University Medical Center Hospital, the Southwest Cancer center, Covenant Health System, Lubbock Veteran’s Center Outpatient Clinic, North Star Surgical Center, Grace Medical Center, and Lubbock Heart Hospital. Our program is committed to providing an opportunity for residents to perform progressively more independent decision-making and clinical activity in a culture of strong and committed mentorship.

Residents should have a broad exposure to all aspects of medical, surgical and other interventional modalities. Residents should be exposed to the greatest variety of pathology and surgical techniques possible, but should also have a strong sense of the limitations of medical and surgical intervention based on their skills, the resources and limitations of their particular work environment, and most importantly the social, cultural and personal concerns and desires of the individual patient.
B. EDUCATIONAL GOALS
1. The primary goal of this residency program is to produce excellent urologists able to practice urology in any environment or geographic location of their choice.
2. Graduates will have the necessary didactic, technical, and clinical exposure to meet the requirements for certification by the American Board of Urology.
3. Graduates interested in pursuing a career in academic medicine, medical research, or fellowship training within a sub-specialty of urology will have the appropriate preparation for additional training or successful entry into their chosen career path.
4. All graduates will have a broad exposure to and understanding of the moral, ethical, and regulatory aspects of establishing and conducting a successful urologic practice. This includes education in medical administration leadership, interpersonal-communication skills, the tenants of lifelong professional development, and the ability to function successfully in today’s medical environment.

C. DESCRIPTION OF EACH ROTATION SITE
1. Texas Tech (Adult & pediatric): The urology clinic has the capability to perform flexible cystoscopy; bladder, renal, testicular and prostate ultrasound and urodynamics to include video. Minor procedures such as vasectomies and prostate biopsies are performed in the clinic. Residents participate in their own continuity clinic and learn the outpatient management of urologic disease and clinic based diagnostic and minor surgical procedures. A faculty member is always present and all patients are seen by the resident and the attending physicians.
2. Lubbock VA Clinic: This clinic provides outpatient care for veterans in our immediate region. This clinic is held every other Tuesday and Thursday and is covered by the PGY-2 resident.
3. Fundamentals of Research Course: This course takes place during the PGY 2 year. The course director is Stephanie Filleur, PhD provides instruction in areas ranging from current technologies in basic sciences research, principles of animal and human research, biostatistics, and current research initiatives in the departments of Urology, Microbiology and Immunology, and Physiology.
4. Research: (PGY 2 All day research on Wednesdays). All residents are expected to be involved in a clinical or basic science research project throughout their residency. Residents are required to prepare a minimum of one project for publication or presentation during their residency and ideally one project per
year. Residents must include their plans for research in their annual written goals and discuss their needs for time and support with the Program Director. If at all possible, funding will be provided to allow residents to travel to present papers accepted at scientific programs.

5. **Urodynamics:** The PGY II resident attends the urodynamic clinics held on Monday afternoon under the direction of Dr. Cynthia Smith. These clinics include performance of standard and video-urodynamic studies. Residents are involved in all phases of the procedures to include performance and interpretation of the results. These studies include adult and pediatric patients.

6. **Skills Enhancement:** During the PGY II year the resident works with the Director of the Surgical Skills Center, Kevin Rush in the Department of Surgery to develop basic laparoscopic skills. At the end of these sessions the resident is expected to become “Fundamentals of Laparoscopic Surgery” certified. This will require the resident to take a test and pay a fee to receive this certificate. They have until the completion of their residency in urology. The resident also works with Dr. Michael Crone to learn basic microsurgical skills. The PGY II resident should access the AUA online education courses and complete these by the end of the year (see listing under primary responsibilities for PGY II).

www.auanet.org

7. **Community Urology:** Residents work with private urologists who are on the clinical faculty for 3 to 6 months in their PGY IV year. The resident spends their time with Drs. Britton and Spore from Cornerstone Urology. Dr. Britton is the Site Director. During the 4th year the resident learns about private urology. They experience private practice office management, introduction to hospital protocol, exposure to female and oncologic surgeries. Ability to have exposure to robotic procedures in urology.
V. PRIMARY RESPONSIBILITIES FOR EACH YEAR LEVEL

A. PGY I

1. This resident is under the supervision of the Department of Surgery, but is expected to attend all urology conferences within the constraints of their other general surgery duties and duty hour restrictions. They are expected to study for and take the Urology In-Service Exam on the 3rd Saturday in November.

B. PGY II

1. General:
   - Daily rounds with Urology Team
   - Continuity of Care clinic on Monday a.m. with faculty mentors
   - Urodynamic Clinic Monday afternoon with Dr. Cynthia Smith. Will need to complete minimum of 10 UDS studies and analyze. Please give report to Judy Pierson for addition to your portfolio
   - Tuesday Pediatric clinic with Dr. Smith
   - Research lab on Wednesday all day. Supervisor Stephanie Filleur, Ph.D. At the end of year, the resident will give a report to the group on research activities during the year.
   - Thursday adult operating room
   - Friday am pediatric operating room with Dr. Smith
   - “Surgical Skills Laboratory” Work with Kevin Rush on laparoscopic basic technique. Sim center basic laparoscopic skills. You will need to contact Kevin to set up time to do the skills labs and you can contact the SIM center for after hours access to the lap mentor.
   - Become eligible for “Fundamentals of Laparoscopic Surgery” certification. It is recommended that you obtain this certification. You will need to use your own funds to take the test. Should be completed by the end of residency.
   - Completes the “Ethics modules provided by the American Urological Association (AUA). This is under online learning on the AUA website. Please take tests and print out CME certificate to give to Judy Pierson to add to your portfolio
   - Completes the online learning module on GU Pathology found on the AUA website. Give certificate to Judy Pierson
   - Attends the Basic Science course at the University of Virginia, Charlottesville, Virginia.
   - The department initiates candidate membership for each incoming resident in the American Urological Association.
   - Grand Rounds presentation one per year. You will select a faculty mentor and meet with them to discuss your topic.
This should be a thorough review of the up-to-date literature and evidence-based treatments. Dress appropriately for the presentation, practice, and give a polished presentation.

- Attendance and participation at weekly teaching conference on Friday pm, AUA core curriculum on Tuesday at 5pm, all scheduled Journal Clubs, AUA update and EBRU sessions. Notes should be kept for your work on AUA core curriculum topics
- In-service exam once yearly in November
- Keep all records up to date according to hospital policy.

C. PGY III
- Daily Rounds with Urology Team
- Attends VA outpatient clinic two days per week every other week. Supervised by Dr. Mittemeyer.
- Continuity clinic on Monday all day with faculty mentor
- Adult Operating room on Wednesday and on Alternating Thursdays
- Friday a.m. Operating room or Procedure clinic.
- Continues with on-going research activities and has at least one manuscript completed for publication or presentation.
- Expected to teach medical students and junior house staff and non-urology residents rotating on the service
- Completes the online modules for laparoscopic surgery and robotic surgery found on the AUA website. Please complete the tests and print the CME certificates. Give them to Judy Pierson to place in your portfolio
- Attendance and participation at weekly teaching conference on Friday pm, AUA core curriculum on Tuesday at 5pm, all scheduled Journal Clubs, AUA update and EBRU sessions. Notes should be kept for your work on AUA core curriculum topics

D. PGY IV
- In addition to daily ward/clinic duties
- For months at UMC: Monday Pediatric operating room/or research Tuesday adult OR, Wednesday OR peds or adult, Thursday OR, Friday am OR. The PGY-4 should seek out any procedures in Clinic that they need experience in.
- Completes one manuscript for publication or presentation
- Attends the AUA Annual meeting during 4th year.
- Attends the AUA Board Review Course
- Grand Round Presentation
- Participates in 3-6 month rotation with Cornerstone Urology supervised by Dr. Carl Britton and Dr. Scott Spore
Attendance and participation at weekly teaching conference on Friday pm, AUA core curriculum on Tuesday at 5pm, all scheduled Journal Clubs, AUA update and EBRU sessions. Notes should be kept for your work on AUA core curriculum topics

E. PGY V

- PGY V – Patient Rounds
- Continuity of care clinic all day Monday
- Tuesday and Thursday Operating Room
- Wednesday Administrative time to prepare conferences and study time to prepare for Boards
- Friday am Administrative time and Procedure clinic
- Responsible for the administration of the urology service to include case scheduling, distribution of workload amongst residents, resident call schedules, and assignment of cases.
- Responsible for directing day-to-day activities of each service and distributing in-patient care duties between junior residents.
- Oversees care of critically ill patients admitted to the hospital.
- Insures all consults are promptly evaluated and patients on consult service seen on a regular basis. The chief resident is also responsible for notifying the attending on-call for seriously ill patients.
- Responsible for organizing and conducting all didactic and recurring conferences in collaboration with the Program Director.
- Responsible for assigning case presentations involving the adult urology service, teaching medical students to include insuring that they successfully complete the study guide given to all medical students on the urology service.
- Participates as the Urology Department representative to the House Staff Council.
- Holds monthly resident meeting with concise minutes given to Judy.
- Completes one manuscript for presentation or publication.
- Develops a written personal plan to prepare for the written and oral portion of the AUA Board Certification Examination to be discussed with the Program Director not later than December of their PGY V year.
- Attendance and participation at weekly teaching conference on Friday pm, AUA core curriculum on Tuesday at 5pm, all scheduled Journal Clubs, AUA update and EBRU sessions. Notes should be kept for your work on AUA core curriculum topics
VI. Resident Evaluations

A. Resident Evaluation Process

1. Residents are evaluated in a variety of ways and intervals. Evaluations are generated from patients, nursing staff, urology faculty and others. These evaluations monitor the resident’s progress in all six of the Core Competencies. The ACGME Milestones will be assessed by the Clinical Competency Committee every 6 months. Some evaluations are just a snapshot of an individual encounter or procedure and some are a summation of performance over time. The residents also have the opportunity to evaluate the faculty and the training program. All evaluations are confidential and used exclusively to improve the training program and insure that each resident is making appropriate progress. Evaluations the residents complete are anonymous and residents should not hesitate to give honest, pertinent feedback when asked to evaluate the faculty or the program.

2. It is mandatory that residents take the responsibility to have evaluations completed and submitted in a timely fashion. Evaluations such as observed patient encounters and surgical evaluations are meant as a teaching vehicle and should be discussed with the attending filling out the form so that the resident can get maximum teaching benefit from the encounter.

3. The results of evaluations will be reviewed individually with residents at least semi-annually.

4. Evaluation forms are included in the appendix.

The Urology Milestone Project – (ACGME)

The Milestones are designed only for use in evaluation of resident physicians in the context of their participation in ACGME accredited residency or fellowship programs. The Milestones provide a framework for the assessment of the development of the resident physician in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.

The Texas Tech University Health Sciences Center Department of Urology will use milestones along with other evaluation tools listed in this handbook to decide on resident advancement. It will not be used as the sole deciding factor for advancement.
<table>
<thead>
<tr>
<th>Annual Program Evaluation</th>
<th>Annually (May)</th>
<th>Faculty – Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faculty Evaluation</td>
<td>Quarterly (Sept/Dec/March/June)</td>
<td>Residents</td>
</tr>
<tr>
<td>NAS Quarterly Summary Faculty Eval of Residents</td>
<td>Quarterly (Sept/Dec/March/June)</td>
<td>Faculty</td>
</tr>
<tr>
<td>Operative Performance Evaluation</td>
<td>Weekly – 1 evaluation per resident/per week</td>
<td>Faculty</td>
</tr>
<tr>
<td>Observed Patient Encounter Form</td>
<td>Weekly – 1 evaluation per resident/per week</td>
<td>Faculty</td>
</tr>
<tr>
<td>Patient Evaluation</td>
<td>Monthly</td>
<td>Random Patients</td>
</tr>
<tr>
<td>360 Evaluation</td>
<td>Bi-Annually (Dec 1st &amp; June 1st)</td>
<td></td>
</tr>
<tr>
<td>Urology Service Evaluation</td>
<td>End of Rotation</td>
<td>Medical Students – Rotating Residents</td>
</tr>
<tr>
<td>Faculty Evaluation</td>
<td>End of Rotation</td>
<td>Medical Students – Rotating Residents</td>
</tr>
<tr>
<td>Self-Assessment</td>
<td>Bi-Annually (Dec 1st &amp; June 1st)</td>
<td>Residents</td>
</tr>
</tbody>
</table>
B. OPERATIVE SKILLS ASSESSMENT
Residents must keep a record of cases done as the surgeon and as an assistant /primary surgeon (all cases). These cases are log on the ACGME website: Data Collection Systems – Resident Case Log System – Login

It is imperative that the chief residents review their index cases with the Program Director on at least a quarterly basis. This is to ensure that the surgical experience of the chief resident is well rounded and that there will be no deficiencies in their training.

The guidelines for filling out the SOL pertaining to each case are reviewed with the residents on a yearly basis at the beginning of the year. The following are generic guidelines:

1. One should be considered the operative surgeon, as opposed to the assistant, in a case if the resident does at least 50% of the case. If there is any question, ask the appropriate attending.
2. For multiple procedures on the same patient, it is allowed that multiple residents may be primary surgeons. For instance, if one resident does a cystectomy and the other resident does the diversion, each can be a counted as a surgeon for that particular procedure.

A completed and signed SOL must be given to the Program Director prior to graduation. All cases must indicate resident as primary surgeon or assistant surgeon.
# C. RESIDENT EVALUATIONS CORE COMPETENCY MATRIX

<table>
<thead>
<tr>
<th>Eval. Times</th>
<th>Patient Care</th>
<th>Medical Knowledge</th>
<th>Practice-Based Learning &amp; Improvement</th>
<th>Interpersonal &amp; Communication Skills</th>
<th>Professionalism</th>
<th>System-Based Practice</th>
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<tbody>
<tr>
<td>Observed Patient Encounter</td>
<td>Weekly</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Operative Performance</td>
<td>Weekly</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Patient Resident Evaluation</td>
<td>Bi-Monthly</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Didactic Presentation Evaluation</td>
<td>(random)</td>
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<td>X</td>
<td>X</td>
</tr>
<tr>
<td>End of Rotation Evaluation</td>
<td>Bi-mo, monthly</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Quarterly Summary Faculty Evaluation of Residents</td>
<td>Quarterly</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Semi-Annual Evaluation - Resident</td>
<td>Dec</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>360 Evaluation</td>
<td>Bi-Anually</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Self-Assessment</td>
<td>Bi-Anually</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Case Logs (ACGME system)</td>
<td>Viewed monthly &amp; Reviewed Bi-Anually</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Service Exam</td>
<td>Annual</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Evaluation - Resident</td>
<td>Annual – June</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Annual Evaluation - Faculty</td>
<td>Annual – June</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>End of Year Program Evaluation</td>
<td>Annual – June</td>
<td>X</td>
<td>X</td>
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</tr>
</tbody>
</table>
## VII. CLINIC AND SURGERY SCHEDULES

### LEVEL PGY 2 - U1 July 1 - June 30

<table>
<thead>
<tr>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>Site 1 - Resident Cont. of Care Clinic</td>
<td>Site 1 - Pediatric Clinic - V</td>
<td>Site 1 - RESEARCH</td>
<td>Site 4 - OR</td>
</tr>
<tr>
<td>PM</td>
<td>Site 4 - UroDynamics</td>
<td>Site 1 - Pediatric Clinic - S Site 1 5pm AUA CC</td>
<td></td>
<td>Site 1 -CONFERENCE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>Site 1 - Resident Cont. of Care Clinic</td>
<td>Site 2 - VA Alter. Site 4 - OR Site 1 5pm AUA CC</td>
<td>Site 2 - VA Alter. Site 4 - OR</td>
<td>Site 4 - OR / Site 1 - PROC. CLINIC</td>
</tr>
<tr>
<td>PM</td>
<td>Site 1 - RESEARCH</td>
<td></td>
<td>Site 4 - OR</td>
<td>Site 1 - CONFERENCE</td>
</tr>
</tbody>
</table>

### LEVEL PGY 3 - U2 July 1 - June 30

<table>
<thead>
<tr>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>Site 1 - Resident Cont. of Care Clinic</td>
<td>Site 4 - OR PEDI Site 1 - RESEARCH</td>
<td>Site 4 - OR</td>
<td>Site 4 - OR</td>
</tr>
<tr>
<td>PM</td>
<td>Site 1 - RESEARCH</td>
<td>Site 4 - OR PEDI Site 1 - RESEARCH Site 1 5pm AUA CC</td>
<td>Site 4 - OR</td>
<td>Site 1 -CONFERENCE</td>
</tr>
</tbody>
</table>

### LEVEL PGY 4 - U3 July 1 - June 30 OCT/NOV/DEC - Drs. Britton & Spore

<table>
<thead>
<tr>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>Site 4 - OR PEDI Site 1 - RESEARCH</td>
<td>Site 4 - OR PEDI Site 1 - RESEARCH Site 1 5pm AUA CC</td>
<td>Site 4 - OR</td>
<td>Site 4 - OR</td>
</tr>
<tr>
<td>PM</td>
<td>Site 4 - OR</td>
<td></td>
<td>Site 4 - OR</td>
<td>Site 1 -CONFERENCE</td>
</tr>
</tbody>
</table>

### LEVEL Chief Resident PGY 5 - U4 July 1 - June 30

<table>
<thead>
<tr>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>Site 1 - Resident Cont. of Care Clinic</td>
<td>Site 4 - OR Site 1 5pm AUA CC</td>
<td>Site 1 STUDY Admin TEACHING</td>
<td>Site 1 -ADMIN</td>
</tr>
<tr>
<td>PM</td>
<td>Site 1 - Resident Cont. of Care Clinic</td>
<td></td>
<td>Site 4 - OR</td>
<td>Site 1 -CONFERENCE</td>
</tr>
</tbody>
</table>

Site 1 - Texas Tech University HSC - Urology
Site 2 - VA Outpatient Clinic
Site 3 -
Site 4 - University Medical Center
VIII. Conference Schedule
A minimum of three and one-half hours are devoted to conferences each week. This does not include the time residents spend in the course “Introduction to Research” during the PGY II year. The Tumor Board conference is held weekly every Friday morning at 0700 in the Southwest Cancer Center conference room, residents attend if Urology cases are to be presented. The majority of conferences are held Friday afternoon in a designated room (1C102). The uro-pathology conference is held in room 1A115 in anatomic pathology. The uro-radiology conference is held in 1C102 on the second Friday of each month (no conf on the quarterly schedule for Uro/Neph conference. The urology/nephrology conference is held quarterly in 1C102. AUA updates are done at the combined monthly resident meeting at a location TBA. Journal club is held four times per year. Evidenced Based Review of Urological Literature is held on the third Friday of each month. Residents are required to present Grand Rounds each year.
## MASTER CONFERENCE SCHEDULE

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Target Audience</th>
<th>Time</th>
<th>1ST WEEK</th>
<th>2ND WEEK</th>
<th>3RD WEEK</th>
<th>4TH WEEK</th>
<th>5TH WEEK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly – Tuesday</td>
<td>All Residents</td>
<td>5-6:30 PM</td>
<td>Urology Core Curriculum</td>
<td>Urology Core Curriculum</td>
<td>Urology Core Curriculum</td>
<td>Urology Core Curriculum</td>
<td>Urology Core Curriculum</td>
</tr>
<tr>
<td>Weekly - Friday</td>
<td>Urology Cases to be presented only - All Residents</td>
<td>7-8 AM</td>
<td>Tumor Board</td>
<td>Tumor Board</td>
<td>Tumor Board</td>
<td>Tumor Board</td>
<td>Tumor Board</td>
</tr>
<tr>
<td>Weekly Friday</td>
<td>All Residents</td>
<td>2 – 4 PM</td>
<td>Uro-Path</td>
<td>Uro/Rad</td>
<td>Morbidity &amp; Mortality</td>
<td>Case Conference</td>
<td>Case Conference</td>
</tr>
<tr>
<td>Quarterly – Friday</td>
<td>All Residents – week depending on schedule</td>
<td>2 – 3 PM</td>
<td>Neph/Uro</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarterly – Tuesday</td>
<td>All Residents</td>
<td>6 – 8 PM</td>
<td>Journal Club - Varies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly – Friday</td>
<td>All Residents</td>
<td>2 – 2:15 PM</td>
<td></td>
<td></td>
<td></td>
<td>EBRU</td>
<td></td>
</tr>
<tr>
<td>Monthly</td>
<td>All Residents</td>
<td>PM</td>
<td>Resident Meeting /AUA Updates</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarterly – Tuesday</td>
<td>All Residents</td>
<td>5:30 – 7 PM</td>
<td>Resident Grand Rounds – Week dependent on schedule</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CITI – online training for research  
Annual Billing Compliance – now online

Annual:  
Fatigue  
Radiation Safety

Quality Care & Patient Safety – residents are scheduled through GME - class is done by UMC

Yearly – Interprofessional Teamwork – Institutional in October

Teaching Residents to Teach / Teaching Residents to Learn – Class is done by GME office.  
Laparoscopic Skills lab – Kevin Rush in General Surgery.
FACULTY CONFERENCE LEADERS

<table>
<thead>
<tr>
<th>Conference</th>
<th>Site</th>
<th>R / O</th>
<th>Frequency</th>
<th>Conference Leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUA Core Curriculum</td>
<td>TTUHSC</td>
<td>R</td>
<td>Weekly</td>
<td>Assigned Faculty</td>
</tr>
<tr>
<td>Urology Grand Rounds (Residents)</td>
<td>TTUHSC</td>
<td>R</td>
<td>Monthly – 4times per year</td>
<td>Dr. C. Smith</td>
</tr>
<tr>
<td>1 - annually</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morbidity &amp; Mortality</td>
<td>TTUHSC</td>
<td>R</td>
<td>Monthly</td>
<td>Dr. C. Smith &amp; Dr. Cammack</td>
</tr>
<tr>
<td>Uro-Pathology</td>
<td>TTUHSC</td>
<td>R</td>
<td>Monthly</td>
<td>Dr. Suzanne Graham (Pathology)</td>
</tr>
<tr>
<td>Case Conference</td>
<td>TTUHSC</td>
<td>R</td>
<td>Monthly</td>
<td>Dr. C. Smith &amp; Dr. Cammack</td>
</tr>
<tr>
<td>Nephrology/Urology</td>
<td>TTUHSC</td>
<td>R</td>
<td>Quarterly</td>
<td>Drs. S. Prabhakar (Nephrology), Dr. C. Smith</td>
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<tr>
<td>Uro-Radiology</td>
<td>TTUHSC</td>
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<td>Monthly</td>
<td>Drs. Quatromman &amp; Dr. Smith</td>
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<td>EBRU</td>
<td>TTUHSC</td>
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<td>Dr. C. Smith</td>
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<tr>
<td>Journal Club</td>
<td>TTUHSC / TBA</td>
<td>R</td>
<td>Quarterly</td>
<td>Assigned Faculty</td>
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A. Conference Descriptions

1. **AUA Core Curriculum**: This conference is conducted weekly. The AUA's Urology Core Curriculum is the most comprehensive reference guide available detailing the knowledge necessary to deliver quality urological care. There are 14 categories and 51 sub-sections, which contain additional content sections, of the core curriculum. They will be divided weekly. A list will be generated and distributed to all Faculty, Residents, and Community Urologist. Faculty and Community Urologists will be asked to sign-up to (lead) a review and discussion.

   The Faculty Leader is asked to facilitate the curriculum and to add any additional experience or resources to that conference. This curriculum will be covered within approximately a two year time frame. Each Faculty leader will be asked to generate 5 board-formatted multiple choice questions prior to their assigned week.

2. **Tumor Board**: (if Urology Cases presented) This weekly conference is held every Friday morning. It is supervised by the Director of the Southwest Cancer Center, Dr. Everardo Cobos, (Chief, Oncology/ Hematology Division, Department of Internal Medicine at Texas Tech), and Dr. Werner de Riese. During this conference patients with newly diagnosed tumors and patients who are established patients who have developed multi-disciplinary issues that require review of their status are presented to the medical, radiological and surgical specialists dealing with tumors at UMC and TTUHSC. Their clinical presentation is correlated with the relevant imaging and histopathology studies and a course of treatment is developed. This conference exposes the residents...
to an excellent forum in which to learn Uro-pathology and Uro-radiology as well as the management of urological malignancies. Residents also learn to interact with their peers in other disciplines as well as the selection of appropriate imaging and diagnostic studies for patients with malignant diseases. The participation of non-clinical support personnel (social work, chaplains, etc.) also provides an exposure to the humanistic and ethical issues involved in the care of the patient with cancer.

3. **Morbidity and Mortality:** The M & M conference is held on a monthly basis and is designed to provide a forum to present complications, untoward outcomes and deaths on the service. The resident involved in the care of the patient presents a concise summary of the patient’s hospital course and the nature of the complication or death. The resident who was most intimately involved with the patient is responsible for discussing how the incident could have been handled differently and the management of complications to include review of the recommended literature of each case. The impact of all six core competencies are discussed and documented by using a standardized form. This conference gives the residents and faculty an opportunity to improve patient care and our practice environment by initiating, if appropriate, a performance improvement initiative.

4. **Uro-pathology:** This monthly conference is conducted jointly with the department of pathology faculty and residents. It provides a forum to correlate the clinical aspects of selected cases with the histo-pathological and laboratory findings. Residents present the clinical history for each case and the histo-pathological material available is reviewed by the pathology staff. When appropriate, a more formal didactic format gives the urology residents a deeper understanding and knowledge of the pathology of genito-urinary disorders. In addition, residents are expected to review any biopsy or other tissue samples with a member of the pathology department prior to presenting the patient at a pre-op conference or tumor board. This conference helps prepare the residents for their board examinations in urology as well as their clinical practice.

5. **Case conference:** This conference, held 1 to 2 times per month) allows the residents to discuss, in depth, selected complex urological patients with Dr. C. Smith and the urological faculty. The chief resident is responsible for selecting cases for in-depth review. The discussion can be centered on the clinical presentation and management of a problem (patient care & medical knowledge), ethical, social or outpatient management issues (interpersonal and communication skills, professionalism, system based practice), or other relevant aspects of caring for the patient. The relevant basic science and published literature (medical knowledge, practice based learning and improvement) may also be the focus of the conference. Pediatric cases include discussion of aspects relating to all of the General Competencies as they apply to the management of children, their families, and the health care system.

6. **Nephrology/Urology Conference:** This quarterly conference is supervised by Dr. Sharma Prabhakar, Chief, Nephrology Division, and Department of Internal Medicine and Dr. C. Smith and Dr. Cammack (Urology). Patients from the Urology, Nephrology, or Transplant services are chosen for presentation and discussion based on joint involvement or joint interest. The
Two conferences the Nephrology fellows coordinate and two conferences are coordinated by Urology residents.

7. **Uro-Radiology**: This conference is held 1 time per month. The conference is attended by an attending Radiologist and Urology Department members and residents. Chief Resident is responsible for generating a list of cases and forwarding this information to Dr. Quattromani, Chief of Radiology. This conference is designed to help residents with the nuances of different radiologic procedures used in urology.

8. **Grand Rounds**: Quarterly, residents are assigned dates for a formal grand rounds presentation covering a specific topic relevant to recent clinical problems. Subjects for the grand rounds are determined annually based on topics suggested by community and faculty urologists, and residents. Subjects are determined by performance on in-service examinations, unusual or complex cases seen by the service, reviews of a particular subject required by the Specialty Specific Requirements or Urology (geriatrics, radiation safety, fatigue and stress, etc).

9. **Journal Club Conference**: This quarterly conference is conducted off campus at various sites. Community urologists are invited to participate. Residents participate by presenting cases from our institution and interpreting x-rays and analyzing cases. A few highly selected articles are chosen for the residents to present and to be discussed. This forum allows the residents to apply the knowledge they gained in their “Principles of Research” course. The articles are reviewed from the standpoint of study design and validity as well as the practical and scientific knowledge provided. This forum gives the residents an opportunity to develop a deeper understanding of the role of peer-reviewed literature both for purposes of applying that information to patients they currently care for and also a method for developing the habits necessary for their continuing education once they leave their residency.

10. **Evidence Based Review of Urologic Literature** - This is an activity through the AUA website. The articles are reviewed from the standpoint of study design and validity as well as the practical and scientific knowledge provided. This forum gives the residents an opportunity to develop a deeper understanding of the role of peer-reviewed literature both for purposes of applying that information to patients they currently care for and also a method for developing the habits necessary for their continuing education once they leave their residency.

11. **Other Resources:**

**AUA Updates**: This is done monthly along with the monthly resident meeting at a location TBD. Residents review weekly AUA Updates from the AUA website.

**AUA SASP**: The AUA SASP are reviewed periodically and available for all residents in the resident library.

**SpacedEd**: [www.spaceded.com/](http://www.spaceded.com/) Daily Urologic Courses available

**AUA online Education**: All residents are asked to access the modules on AUA online Education and complete these as soon as possible during residency. The AUA Guidelines are reviewed as they are updated and residents are asked to review previously published guidelines found on the AUA website.
IX. POLICIES AND PROCEDURES

A. General Policies and Procedures

GME Policy & Procedures (Institutional)
http://www.ttuhsc.edu/som/gme/policies.aspx
HouseStaff
http://www.ttuhsc.edu/som/gme/documents/HS_PandP_s_070112.pdf
Department of Urology Policy & Procedures
http://www.ttuhsc.edu/som/Urology/
ACGME Program Requirements & Common Program
Requirements Urology & Pediatric Program

B. The following sections are policies and procedures specific to the
Texas Tech University Health Sciences Center Department of
Urology.

1. Administrative Issues
   All problems regarding scheduling or personnel (both House Staff and
   Ancillary) should be referred to the program director. With regard to
   requests for changes in the published rotational schedule, a written
   change request form must be signed by the program director and the
   resident(s) involved in the change.

2. DUTY HOURS & FATIGUE

   DUTY HOURS
   Urology residents take call from home. Home call is not subject to the
   every third night limitation. However home call must not be so
   frequent as to preclude rest and reasonable personal time for each
   resident. Residents taking home call are provided with 1 day in 7
   completely free from all educational and clinical responsibilities,
   averaged over a 4-week period.

   Continuous on-site duty must not exceed 24 consecutive hours. If a
   resident has been on duty in excess of 24 hours, they may remain on
   duty for up to 6 additional hours to participate in didactic activities,
   transfer care of patients, conduct outpatient clinics, and maintain
   continuity of medical and surgical care. No new patients may be
   accepted after 24 hours of continuous duty.
a) When averaged over a four-week period, total hospital, and clinic activities should not exceed 80 hours per week. In-house call can occur no more frequent than once every 4 nights, averaged over a 4 week period.

b) Residents must have 1 full (24 hr) day without duty per week averaged over a 4 week period.

c) Residents should not work more than 30 consecutive hours. After 24 hours, resident cannot be scheduled for a duty which sees new patients.

d) Residents must have at least 10 hours off for rest and personal activities between all daily duty periods.

FATIGUE
The program director and faculty monitor the demands of home call and insure that scheduling adjustments are made to mitigate excessive service demands and/or fatigue. The PGY IV and V level residents back up the junior level residents for major cases or complex problems. They are not expected to respond to routine urologic consultations or problems.

Back-up support will be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care. The request for back-up support will be directed to the Program Director, Assistant Program Director, or Department Chairman.

Resident call rooms are provided for naps prior to going home. Also, taxi vouchers are available.

Weather and Disaster Situations
All residents will follow the Graduate Medical Education Policy and Procedures regarding their duties and location to report to for weather or disaster situations. All residents can sign up for the texting of all weather related closures/situations at the HSC. If there are any questions regarding closures, please contact the Program Director.

3. Moonlighting
Urology Residency training requires significant and prolonged efforts to develop clinical skills and to master a large fund of medical knowledge. Outside activities such as moonlighting should not interfere with the residents' training responsibilities. The Department of Urology has the following guidelines for moonlighting.

Completion of a urology residency is a full-time endeavor. This program does not permit resident moonlighting!
4. **Charts**
   The medical chart is essential to quality patient care. Notes should be thorough, accurate and clearly legible. As a legal record, the dating and timing of entries is mandatory. Under no circumstances should charts be altered, i.e., addition or deletion of backdated notes or orders. Medical students may document only in specified notes. These notes are not part of the patient record and do not need to be signed, but should be reviewed by a resident for teaching purposes. Charts should effectively convey a patient’s course, not only to the primary service but also to consulting services. Importantly, the medical chart permits reimbursement by third party payers.

Prior to the anticipated day of discharge, consider the potential need to consult necessary ancillary services (Social Services, Physical Therapy, etc.), which may render follow-up care on an outpatient basis. All necessary paperwork should be completed at this time.

**Clinic notes must be complete within 5 business days of patient appointment.**
**Hospital notes must be completed daily and attested by attending on the same day.**

5. **Discharge Summaries**
   As part of a complete medical record, the discharge summary should accurately portray the notable events of a patient’s hospital course. This document serves to inform subsequent providers of surgeries, complications, and discharge instructions. **All discharge summaries are to be dictated within forty-eight hours of discharge.**

**Dictation prior to discharge is optimal and strongly encouraged.**

Maintaining medical records is the responsibility of all residents. In order to remain current and avoid accruing delinquent charts, residents must check the power chart system and requests charts to be brought to the department on a weekly assigned day. Failure to remain current results in notification to the involved attending surgeon and automatic suspension of the attendings admitting and booking privileges. Should the resident's delinquency reach this stage, operative privileges will be immediately suspended until all records are current. (See section XI for the mandatory elements of a discharge summary)

6. **Operative Notes**
   **Notes must be dictated within 24 hours of procedure.** See section XI-D for components of the operative note.

7. **Dress Code**
   Urology residents should appear professional and well-groomed at all times. Such behavior reflects attention to detail and inspires confidence in patients and families. White coats, if worn, must be
clean. Operating room attire is restricted to the operating room, and overnight/weekend call. When dressed in scrubs, a clean white coat should always be worn outside of the operating room.

8. Benefits

**1st YR (PGY 2) RESIDENTS:** AUA Membership dues paid annually. Paid support for the Charlottesville Basic Science Course

**2nd YR (PGY 3) RESIDENTS:** AUA Membership dues paid annually

**3rd YR (PGY 4) RESIDENTS:** AUA Membership dues paid annually. $1,000 allowance for the AUA Annual Meeting

$1000 allowance for the AUA Board Review

**4th YR (PGY 5) RESIDENTS:** AUA Membership dues paid annually.

**ACLS COURSE:** Paid renewal every 2 years. Residents are required to take the initial course before beginning their PGY 2 year.

**LAB COATS:** 3 coats per resident, thereafter replaced on an **AS NEEDED** basis

**MEALS:** $40 month (no accrual) - Urology Residents

**PHOTO COPYING PRIVILEGES:** Copies & transparencies for conferences as long as cost is not excessive.

**TRAVEL:** For **APPROVED** additional educational and scientific meetings ONLY. You have to notify Program Director and Residency Coordinator 1 ½ month in advance of travel in order for it to be approved. Also, you pay your own way then submit receipts for reimbursement – if approved. Travel & accommodations will be reimbursed for one approved meeting per year to present a manuscript/poster.

9. Leave: Vacation-Sick-Educational

*Approved by the Program Director, residents’ vacation schedules will be complete at the beginning of each year.*

**FOR APPROVAL OF ALL LEAVE REQUESTS**

You must go to Residency Coordinator, Judy Pierson and fill out leave form/clinic cancellation form (it will be sent to Patient Services Supervisor - allowing her to block your clinic time). Vacations must be approved by the Program Director. Applications must be submitted **at least 60 days in advance**. You must provide the name of the doctor that will provide clinic call coverage for you.

a. **VACATION:**

Each Resident - 15 working days per year – non-accruable (only 1 week can be split into 2 leave times)

b. **SICK:**

Each Resident - 12 working days per year – accruable

c. **EDUCATIONAL LEAVE:**

1). Residents will be granted additional Educational Leave for essential examinations, such as Step III of the USMLE (if necessary).
2). Residents may attend professional meetings up to 5 working days per year.
3). Residents may present information at professional meetings regardless of their current clinical responsibility provided they identify adequate coverage. In these cases, the resident should limit his/her absence from his/her clinical responsibility to the shortest time necessary to travel to the meeting, make the presentation, and return to Lubbock. If the presentation is at the request of the department, it will not be counted against the allotted educational leave. If the conference is at the request by the resident, it will be counted against their allotted educational leave or none is available, it will be counted towards their vacation leave.
4). Residents in the PGY-IV and V year applying for fellowships positions may have 7 days of Educational Leave for both professional meetings and fellowship interviews. Time required beyond 7 days should be taken from vacation. Residents will need to find coverage when on in-patient services

10. Patient Load
Residents must balance the need for patient care responsibilities with their own educational responsibilities and their own needs for good mental and physical health. Patient loads will clearly depend on the complexity and severity of the medical problems in hospitalized patients. If patient load is excessive, the attending faculty will be responsible for additional patients. In the event the resident is confronted with an unmanageable patient load, the attending on service will provide patient care if patient load increases and becomes unmanageable. Residents who are concerned about their patient load should first discuss the problem with the Chief Resident who will then immediately notify the Program Director. If the problem is not satisfactorily resolved, the resident must immediately inform the Program Director or Assistant Program Director.

11. Performance Standards
a. OBJECTIVE
All residents completing Urological Residency Training should have the clinical skills and overall medical competence necessary for certification of their clinical competence to the American Board of Urology, should demonstrate moral and ethical behavior, and should have a reasonable expectation of passing the certifying examination of the American Board of Urology

b. STANDARDS
1) Satisfactory ratings on all evaluations
   Rationale
a) The Board will not admit residents with unsatisfactory evaluations to the qualifying examination.
b) An unsatisfactory rating usually indicates significant performance problems.

Process
a) Any unsatisfactory rating by a faculty member on a resident’s evaluation form will trigger a review of the problem with the program director, the chief resident, the resident, and the faculty member. If the rating is correct, then corrective measures will be identified and instituted. Future evaluations will be critically reviewed to determine whether or not this problem has been corrected.
b) A second unsatisfactory rating will trigger a repeat review and analysis of the problem. The resident will be issued a written warning regarding his performance. Corrective measures will be identified and instituted. Future evaluation will be reviewed monthly with the program director for the next three months.
c) A third unsatisfactory rating will trigger a repeat review and analysis of the performance problem. The resident will be placed on probation (see 3). Corrective measures will be identified and instituted. Future evaluations will be reviewed monthly with the program director for six months.

2) Clinical Skills
   Rationale
   Residents must demonstrate expertise in patient assessment, including thorough and well documented histories and physical examinations.

Process
a) Each PGY II resident will perform a directly observed history and physical on a new patient annually. It is the resident’s responsibility to notify the designated faculty member of this requirement and insure that the faculty member provides a written evaluation of the residents history & physical exam to the residency coordinator.
b) Written records (histories, physical examinations, clinic notes, and progress notes) must steadily improve during the 3-year program and ultimately reflect high quality and thorough patient evaluation and assessment.

3) Advanced Cardiac Life Support and Advanced Trauma Life Support
   Rationale
   The American Board of Urology requires proficiency in advanced trauma life support. The Texas Tech University Health Sciences Center institution requires basic life support, advanced cardiac life support, and cardiac defibrillation. Certification documents are required in these areas.
Process
a) Residents must maintain ACLS certification. ACLS certification is renewed every 2 years.

b) Residents without up-to-date certification will have 30 days to obtain certification.

4) Educational Responsibilities

Rationale
The American Board of Urology requires each resident to have a significant fund of knowledge and to develop methods for maintaining this fund of knowledge. Urology residency training implies participation in as many educational activities as possible. Failure to participate in on-going departmental activities cannot be justified.

Process
a) Residents will attend at least 60% of the required conferences (after correction for vacation and special rotations).

b) Residents who do not maintain a 60% meeting average over 3-month periods will be issued a written warning.

c) After two written warnings, residents with persistent attendance problems will be placed on probation (see 3).

5) Medical Records

Rationale
The American Board of Urology, UMC, and TTUHSC require timely and legible records as one indicator of professional attitude and behavior. Proper records are essential for patient care.

Process
a) Residents will maintain records, including all dictations and signatures, on a timely basis.

b) Attending physicians are ultimately responsible for record completion.

c) Residents with persistent delinquencies resulting in faculty suspension by Medical Records will receive two written warnings and then probation (see 3).

6) In-Service Examination

Rationale
The in-service examination allows residents to identify areas of strengths and weaknesses and allows the resident to compare his/her overall performance with other residents at similar levels of training.

Process
a) Residents at all levels will take the in-service examination in November of each year. All residents will review their in-service scores with the program director.

b) PGY IV residents below the 50th percentile for all PGY IV residents will review their test results with the Program
Director to identify areas of weakness. They must then develop a plan which has a reasonable expectation for correcting these weaknesses. This plan should involve individual faculty members who will serve as mentors and advisor.

c) PGY IV residents below the 30th percentile may have a serious deficiency in their fund of knowledge. These residents must review their areas of weakness and present a detailed plan for improvement. PGY III or IV residents who have scores below the 20th percentile probably cannot pass the American Board of Urology, given their current fund of knowledge. These residents will need intensive and prolonged preparation for the American Board of Urology. These residents must increase their performance over the 30th percentile on the in-training exam taken during the PGY V year to assure approval for taking the ABU certifying examination.

7) Ethical and Moral Behavior

Rationale
The ABU expects all candidates to exhibit appropriate moral and ethical behavior in the clinical setting.

Process
a) Each resident should demonstrate integrity, respect, and compassion when providing medical care. These attitudes will be assessed by the residents’ action and behavior at work. Input will come from patients, nurses, other residents, and faculty.

b) Residents’ appearance shall be of professional standards in physical and verbal expression to include appropriate dress and grooming. Interaction with other residents, faculty, students, staff, and hospital personnel will be of the utmost professional standards.

c) Residents with unacceptable behavior patterns will receive counseling, written warnings and eventually probation if problems persist. This evaluation is admittedly subjective and will utilize all resources available to make proper decisions.

8) Resident Files and Portfolio’s
The master resident’s notebook will be maintained in the Department of Urology Residency office by the residency coordinator.

All residents will maintain a portfolio on the New Innovations online web system. Hard copies will also be updated in the master resident notebook.
### c. Case Logs

As part of your development as a surgeon, we expect you to become competent in certain basic urologic procedures. You must request an attending physician to assess your competency in these procedures by completing an Operative Performance Evaluation. The core procedures listed below and divided into Pediatric and Adult cases.

<table>
<thead>
<tr>
<th>PEDIATRIC:</th>
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<tr>
<td>Hydrocelectomy/</td>
<td>Ureteroneocystostomy</td>
</tr>
<tr>
<td>herniorrhaphy</td>
<td></td>
</tr>
<tr>
<td>Orchiopexy/Orchidopexy</td>
<td>Circumcision</td>
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<table>
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<th>ADULT:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Circumcision</td>
<td>Prostatectomy, radical</td>
</tr>
<tr>
<td>Cystoscopy</td>
<td>Renal surgery, partial or total nephrectomy</td>
</tr>
<tr>
<td>ESWL</td>
<td>Hydrocele repair</td>
</tr>
<tr>
<td>Female incontinence, sling</td>
<td>Transrectal ultrasound/prostate biopsy</td>
</tr>
<tr>
<td>Lymphadenectomy, pelvic</td>
<td>Transurethral prostate surgery</td>
</tr>
<tr>
<td>Penile prosthesis implantation</td>
<td>Transurethral resection bladder tumor</td>
</tr>
<tr>
<td>Percutaneous renal surgery</td>
<td>Ureteroscopy</td>
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Competency to perform each category a case must be demonstrated for promotion and graduation. (Competency is determined by the Faculty who observes/assists with the type of case in question and submits a completed Surgical Evaluation form to Judy.

These certifications for individual procedures can be done at any time that a resident feels comfortable with his/her abilities to perform and understands a particular case. The resident will be assessed on their knowledge of anatomy, technique, their choice of instruments and handling, their behavior and demeanor in the operating room, and their use and respect for ancillary OR support staff.

The Surgical Operative Logs (SOL) is an integral part of the Residency Program. They are required to be filled out on a regular basis in order to comply with the guidelines set forth by the Residency Review Committee. It is expected that a completed operative log be updated at least monthly.

1) Failure to keep logs up to date may result in suspension of operative privileges.

2) Residents will review their case logs with the Program Director every six months as a part of their formal semi-annual evaluation.
3) At the conclusion of the residency, each chief resident must provide the Program Director with the **SIGNED** surgical log documenting his/her 48 months of clinical urology operative experience. It is the resident's responsibility to keep copies of dictated operating room reports on all cases in which he/she is listed as the responsible surgeon. The operative log submitted to the RRC must be countersigned by the Program Director who will attest to the accuracy of the data submitted. Logs without BOTH the resident and Program Director signatures will be returned.

4) In most cases a resident cannot obtain credit as surgeon for more than one operation unless the procedure is a multi-component operation. For example, the resident who performs a radical nephrectomy cannot take credit for a nephrectomy, adrenalectomy, and a retroperitoneal lymphadenectomy. Some multi-component operations that incorporate individual procedures that are commonly performed as individual operations such as pelvic lymphadenectomy can be credited as separate procedures.

Approved Examples of Exceptions:

<table>
<thead>
<tr>
<th>Operations</th>
<th>Report</th>
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<tbody>
<tr>
<td>Radical Retropubic Prostatectomy</td>
<td>1 Radical prostatectomy and 1 Pelvic lymphadenectomy</td>
</tr>
<tr>
<td>Radical Cystectomy with urinary continence diversion or reconstruction</td>
<td>1 Radical cystectomy and: 1 Pelvic lymphadenectomy and either: a.) conduit, ileal or colonic; b.) any continent cutaneous diversion c.) orthotopic neobladder, any type</td>
</tr>
<tr>
<td>Urinary Diversion with Transureteroureterostomy</td>
<td>1 Transureteroureterostomy and 1 Ureteroneocystostomy with bladder flap</td>
</tr>
</tbody>
</table>

5) In certain circumstances two residents can claim credit for separate portions of a procedure. For example, when one resident is performing a radical prostatectomy, he can permit another resident to make the incision and perform the pelvic lymphadenectomy before performing the radical prostatectomy. In this case, one resident is the assistant on the lymphadenectomy and the surgeon on the prostatectomy, and the other resident is the surgeon on the lymphadenectomy and the assistant on the prostatectomy.

In cases where a bilateral operation is performed, two residents can obtain credit for unilateral procedures, e.g. bilateral orchiopexy, adrenalectomy, simple nephrectomy, ureteral re-implantation. The resident who performs 50% or more of a case is considered the surgeon. Assistant refers only to first assistant
6) If you have any questions about entering cases please check with Dr. Smith.

d. **Probation**

**Rationale**
Residents who are placed on probation have a serious performance problem and have a high likelihood of not being certified as clinically competent to the American Board of Urology.

**Process**

a) Residents may be placed on probation after they have received a written warning(s) regarding a deficiency in performance but fail to correct this deficiency. At the time of probation, measures for corrections will be identified and instituted. Follow-up evaluation and reassessment will occur monthly for three months by the Program Director.

b) Residents may be placed on a second probationary period if the same deficiency persists after the initial probationary period, or if a new deficiency which has been preceded by written warning(s) occurs during or after the initial probationary period. They may be asked to leave the program at the end of the annual contract if satisfactory progress has not been made. They may be asked to extend their training for six to twelve months, depending on the deficiency and evidence for progress and improvement.

c) Department policies will be consistent with institution policies.
12. Reading List

General Urology

Pediatric Urology

Uro-gynecology
2. Urogynecology & Reconstructive Pelvic Surgery, MD Walters, MM Karrow
3. Urodynamics, Paul Abrams
4. Female Urology, Urogynecology, and Voiding Dysfunction, SP Vasavada, RA Appel et al

Additional Suggested Reading
b. CT Urography: an atlas., 2007, S. Silverman, R. Cohan, *2007 edition - available in print and online (through Books@OVID) at the TTUHSC Library
r. Handbook of Urology, 2004, 3rd edition, Siroky, Oates, Babayan, *3rd edition - available in print and online (through Books@OVID) at the TTUHSC Library

UROLOGY - RESIDENT LIBRARY

ADULT & GENERAL UROLOGY
Smith’s General Urology 15th Edition – Tanago
Urology Pearls – 2000 – Resnick, Schaeffer (3 in Library a/b/c)
20 Common Problems in Urology – 2001 – Teichman
Handbook of Urology 3rd Edition – Siroky, Oates, Babayan
Urology – An Illustrated Color Text – Bullock, Doble, Turner, Cuckow
Handbook of Urology 3rd Edition – Oates
Penn Clinical Manual of Urology – Hanno, Malkowicz, Wein
Urology Secrets – 3rd Edition – Martin I. Resnick, MD & Andrew C. Novick, MD
Gray’s Anatomy – The Anatomical Basis of Clinical Practice – 14th Edition – Susan Standring
The Interstitial Cystitis Survival Guide – 2000 – Moldwin
Smith’s General Urology 16th Edition – Tanago, McAninch
The Little Black Book of Urology – 2nd edition- Daniel K. Onion
CONSULTS
The 5-Minute Urology Consult – April 2000 – Gomella
The 5-Minute Urology Consult – April 2000 – Gomella

FEMALE & GYNECOLOGY
Female Urology, Urogynecology, and Voiding Dysfunction – 2005 – Vasavada, Appell, Sand, Raz
Female Urology – 3rd Edition – Shlomo Raz and Larissa V. Rodriguez

GENERAL SURGERY
Current Surgical Therapy – 9th Edition – Cameron

HOUSE OFFICER - MacFARLANE
Urology – House Officer Series 4th Edition – Macfarlane

KIDNEY / RENAL TRANSPLANT / DIALYSIS
A Clinician’s Guide to Donation and Transplantation – 2006 NATCO
Clinical Transplants 2007 – J. Michael Cecka and Paul I. Terasaki
Handbook of Nephrology & Hypertension – 5th Edition – Christopher S. Wilcox & C. Craig Tisher

PATHOLOGY
Atlas of Nontumor Pathology – Non-Neoplastic Kidney Diseases – D’Agati, Jennette, & Silva
AFIP Atlas of Tumor Pathology Series 4 – Tumors of the Kidney, Bladder, and Related Urinary Structures – Murphy, Grignon, & Perlman
AFIP Atlas of Tumor Pathology Series 4 – Tumors of the Adrenal Glands & Extraadrenal
    Paraganglia – Ernest E. Lack, M.D.
Atlas of Tumor Pathology 3rd Series – Tumors of the Testis, Adnexa, Spermatic Cord, & Scrotum – Ulbright, Amin, & Young
Atlas of Tumor Pathology 3rd Series – Tumors of the Prostate Gland, Seminal Vesicles, Male Urethra, & Penis – Young, Srigley, Amin, Ulbright, and Cubilla


**PEDIATRIC**  
Handbook of Pediatric Urology – Baskin, Kogan, Duckett  
Handbook of Pediatric Urology – 2nd Edition – Baskin, Kogan  
Hinman’s Atlas of Pediatric Urologic Surgery 2nd edition – Frank Hinman, Jr., & Laurence S. Baskin  

**PROSTATE**  
The ABC’s of Advanced Prostate Cancer – 2000 – Moyad, Pienta  
100 Questions & Answers about Prostate Cancer – Pamela Ellsworth, M.D., John Heaney, MD, & Cliff Gill  
Contemporary Issues in Prostate Cancer/a Nursing Perspective – Held-Warmkessel  
Guide to Surviving Prostate Cancer 2nd edition – Dr. Patrick Walsh

**RADIOLOGY**  

**URODYNAMICS**  
Urodynamics Made Easy – Chapple, MacDiarmid  
Managing and Treating Urinary Incontinence 2nd edition – Diane Kaschak Newman, RNC, MSN, CRNP, FAAN & Alan J. Wein, MD, PhD

13. **Standardized Tests and Certifications**

a) USMLE Step 3 is an institutional requirement and must be passed by the end of the PGY I year.

b) IRB Certification  
PGY I residents must complete the human research training requirements for IRB certification during the PGY I year.

c) BLS/ACLS Institutional Requirement  
Must be obtained prior to beginning their PGY I and must be maintained throughout their training.

d) In-Service Examination  
All residents are required to take the annual Urology in-service examination which is given in November. Performance on this examination is discussed with the Program Director to identify areas of weakness and develop a plan to correct any deficiencies.

e) American Board of Urology: Board Certification  
Residents are responsible for becoming familiar with the eligibility criteria and processes for obtaining Board Certification from the AUA. The Program Director is available to discuss this process and assist with preparing for the examination. Residents need to include a plan for preparing for their Board Certification examination as a part of their PGY V goals.

X. Security
Prevention of theft and vandalism is the responsibility of everyone. Personal belongings brought to the hospital, including coats, bags, books, etc., should be securely stored.

XI. Appendices
A. Campbell-Walsh (online access – e-mailed)
B. Covenant Medical Center/Lakeside – Delinquent Charts
C. Surgical Patients seen in the ER – Letter from Dr. Allan Haynes
D. DVT Prophylaxis
E. Antimicrobial Prophylaxis for Urologic Procedures – Chart
   www.auanet.org antibiotic prophylaxis-pocket table
F. Dept. Operating Policies – Procedures (full Dept. P&P e-mailed)
G. Evaluation forms
H. Leave form
I. New Innovations Instructions – login – all instructions on areas below are accessible under the help key in the far upper right corner of the web page.
   Logging Duty Hours, Completing Evaluations, What is a Portfolio?, Scholarly Activity, What is Journaling?, etc
Excerpt from Section 8: Rules and Regulations - Covenant Medical Center/ Covenant Lakeside

9. Any chart will be delinquent when:
   a) The history and physical are not present within twenty-four (24) hours of admission.
   b) Any portion of the chart is incomplete fifteen (15) days after the date of discharge.

10. A delinquent record that lacks a history and physical will be handled separately from all other records. The Director of Medical Records, or his designee, will notify the physician of his suspension from the Hospital. A written notification from the Chief of Staff will follow. The Director of Medical Records will notify the appropriate departments.

11. Any Practitioner with a delinquent chart will be notified by letter from the Quality Review Committee liaison physician. If those records are not completed within seven (7) days, a letter will be faxed from the Chief of Staff notifying the Practitioner of automatic suspension of all Hospital privileges, except for the care of patients presently hospitalized under his care at the time of the suspension and the responsibilities for emergency call as assigned on the call schedule.

12. In extenuating circumstances, as determined by the Chief of Staff, suspension may be deferred until the next meeting of the Medical Executive Committee, at which time a decision as to the disposition of the suspension will be made.

Rules and Regulations - Covenant Medical Center/ Covenant Lakeside

13. Each practitioner will be prompted to review and complete their patient’s medical records in an electronic format Horizon Patient Folder. All Charts that require completion, correction, or a final electronic signature will be ‘flagged’ automatically upon ‘log in’. If the Medical Records HPF staff cannot make a record available to a Practitioner, a new available date will be entered into the computer for that record, giving the Practitioner an additional seven (7) days to complete the record.

14. When Medical Records determines that the record has not been satisfactorily completed, the physician will have (7) days to complete the records. If the physician fails to complete the records within the (7) day period, the physician’s name will automatically be re-posted to the suspension list.

15. When a Practitioner has been on the suspension list for thirty (30) consecutive days, he will receive a one-month reminder letter from the Chief of Staff.

16. After forty-five days of continuous suspension, the Chief of Staff will notify the suspended Practitioner that failure to complete the delinquent records within sixty (60) days of continuous suspension will result in referral of the matter to the MEC.

17. If a physician does not complete all delinquent medical records within sixty (60) days of continuous suspension, his Medical Staff membership and clinical privileges will be terminated, unless he can provide evidence that extenuating circumstances have prevented completion of the record(s). Such termination will entitle the Member to his procedural rights under the Fair Hearing Plan of these Rules and Regulations.
April 9, 2009

Joe Sasin, M.D.
Emergency Medicine
602 Indiana Avenue
Lubbock, TX 79415

Dear Dr. Sasin:

I am writing this letter with the support of the entire faculty of the Department of Urology. As you are aware there has been some concerns regarding surgery patients that have had recent surgical procedures by the Urologic Service and their follow-up care in terms of when they returned to the ER. Briefly, we would like to advise you that the policy of the Department of Urology is that any patient that has had surgical procedures performed within the previous 90 days and presents to the Emergency Room at UMC should have a consultation with the Urologic Service. It may well be that there is nothing we need to do but we feel this would insure that patients would not be admitted and a potential complication arise because we were unaware of the problems or unaware of the admission and therefore unable to provide appropriate urologic services to prevent problems related to the surgery that had occurred.

In summary, our policy would be that any time a patient who has had surgery by the Urologic Service within the previous 90 days is seen in the emergency room, the Urologic Service should be called or the urologic resident on call with the attending backing him should be called. We would appreciate very much if we could accomplish this and if there are any questions feel free to contact me.

Sincerely,

Allan L. Haynes, Jr., M.D. FACS
Chief Adult and General Urology

ALH:rrf
DVT Prophylaxis

September 11, 2009
DVT Prophylaxis Discussion

Concern: Urologic patients are a unique subset of surgical patients regarding DVT prophylaxis in that they undergo different procedures than other surgical patients (i.e. orthopedics or general surgery patients) and have unique problems concerning DVT prophylaxis. They are at higher risk of having complications from the prophylaxis concerning bleeding due to the vascular nature of the kidney and prostate and the abrasive effects of urine crossing the surgical site.

Area of conflict: The UMC Guidelines promote more aggressive DVT therapies that could be detrimental to urologic patients. Residents from other specialties who may be on rotation or are the primary service for the patient may not be aware of the special needs of urologic patients.

Area of discussion: What is the proper DVT prophylaxis for urologic surgical patients? Are there guidelines specifically for Urologists?

Discussion: The AUA Best Practice Statement concerning DVT’s was discussed at length as well as the UMC Guidelines.

Resolution: The AUA Best Practice Statement provides guidelines for DVT prophylaxis, but still relies on the decision making skills of the surgeon. It is our duty to provide education to the nursing staff and other residents who may be rotating on our service or providing joint care to our patients our specific guidelines concerning DVT prophylaxis.

WEBSITE: AUA Best Practice Statement – Prevention of Deep Vein Thrombosis in Patients Undergoing Urologic Surgery
http://www.auanet.org/content/media/dvt.pdf?CFID=1503271&CFTOKEN=57455969&jsessionid=8430a973f091e432f1b36e35791652f2d514
## Adult DVT Prophylaxis Guidelines and Orders

### CLINICAL RISK FACTORS FOR VTE

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>CLINICAL RISK FACTORS FOR VTE</th>
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<tbody>
<tr>
<td>Age &gt; 40 yrs</td>
<td>Active collagen-vascular disorder</td>
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<tr>
<td>ICU admission</td>
<td>Inflammatory bowel disease</td>
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<tr>
<td>History of VTE/PE (4)</td>
<td>Central venous line/catheter</td>
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<td>Obesity</td>
<td>Varicose veins</td>
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<td>Stroke (ischemic) or Paralysis (4)</td>
<td>Estrogen use</td>
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<td>Heart failure</td>
<td>Trauma (4)</td>
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<td>Chronic lung disease</td>
<td>Pregnancy</td>
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<td>Respiratory Failure</td>
<td>Hypercoagulability (4)</td>
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<tr>
<td>Pneumonia</td>
<td>Spinal cord injury (4)</td>
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<tr>
<td>Serious infections</td>
<td>Prolonged immobility (&gt;3 days)</td>
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<td>Malignancy (4)</td>
<td>Total =</td>
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### POSSIBLE EXCLUSION CRITERIA FOR PHARMACOLOGICAL VTE PROPHYLAXIS

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<tr>
<th>Exclusion Criteria</th>
<th>POSSIBLE EXCLUSION CRITERIA FOR PHARMACOLOGICAL VTE PROPHYLAXIS</th>
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<tbody>
<tr>
<td>Active bleeding</td>
<td>Active bleeding</td>
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<td>Hypersensitivity to heparin or LMWH</td>
<td>Hypersensitivity to heparin or LMWH</td>
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<td>Uncontrolled hypertension</td>
<td>Uncontrolled hypertension</td>
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<td>Coagulopathy</td>
<td>Coagulopathy</td>
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<tr>
<td>Heparin induced Thrombocytopenia (HIT)</td>
<td>Heparin induced Thrombocytopenia (HIT)</td>
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<tr>
<td>Recent intraocular or intra-cranial surgery</td>
<td>Recent intraocular or intra-cranial surgery</td>
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<tr>
<td>Spinal tap or epidural anesthesia within 24 hr</td>
<td>Spinal tap or epidural anesthesia within 24 hr</td>
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<tr>
<td>Surgical procedures placing the patient at high risk for bleeding</td>
<td>Surgical procedures placing the patient at high risk for bleeding</td>
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### RISK FACTOR STRATIFICATION

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<th>Level of Risk</th>
<th>Risk Factor Stratification</th>
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<tr>
<td>Low Risk</td>
<td>Any patient with &lt; 2 risk factors</td>
</tr>
<tr>
<td>Moderate Risk</td>
<td>Any patient with 2 risk factors; Minor surgery in patients with additional risk factors; Non major surgery in patients aged 40-60 yr with no additional risk factors; Major surgery in patients &lt;40 yr with no additional risk factors</td>
</tr>
<tr>
<td>High Risk</td>
<td>Any patient with 3 risk factors; Non major surgery in patients &gt; 60 yrs with additional risk factors; Major surgery in patients &gt; 40 yrs with additional risk factors</td>
</tr>
<tr>
<td>Very High Risk</td>
<td>Any patient with ≥ 4 risk factors; Major surgery patients &gt; 40 yrs with history of VTE; CA or molecular hypercoagulable state; Hip or knee arthroplasty; Surgical repair of hip fracture</td>
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### THERAPEUTIC RECOMMENDATIONS

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<th>Level of Risk</th>
<th>Therapeutic Recommendation</th>
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<tr>
<td>Low Risk</td>
<td>Low dose unfractionated heparin 5,000 units q12h OR SCD</td>
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<tr>
<td>Moderate Risk</td>
<td>Low dose unfractionated heparin 5,000 units q8h OR Enoxaparin OR SCD</td>
</tr>
<tr>
<td>High Risk</td>
<td>Enoxaparin AND SCD</td>
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- Early ambulation: Consider elastic stockings

- Elastic stockings: Both legs Right leg Left leg
- Sequential compression device (SCD) for the leg/calf: Both legs Right leg Left leg
- Unfractionated heparin 5,000 units SC q12h
- Unfractionated heparin 5,000 units SC q8h
- Enoxaparin 40 mg SC q24h
- Enoxaparin 30 mg SC q12h (knee replacement, hip replacement/fracture, trauma)
- Enoxaparin 30 mg SC q24h (creatinine clearance < 30 ml/min)

- Other: 

---

*These recommendations are intended as a guideline only and may not be appropriate for all clinical situations. Clinicians should use professional judgment when making decisions.*
TTUHSC - Urology Faculty Evaluation by Residents and Students

Please rate the urology faculty member in the following areas:

**Unsatisfactory:** Several behaviors performed inadequately or missed (ratings 1, 2, or 3)

**Satisfactory:** Most behaviors performed acceptably (ratings 4, 5, or 6)

**Superior:** All behaviors performed very well (ratings 7, 8, or 9)

### Systems-Based Practice

1) Interest in Teaching

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### Practice Based Learning & Improvement

2) Ability to teach surgical technique

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<th>Unsatisfactory</th>
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### Professionalism

3) Commitment to the educational program and advances your medical knowledge

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### Interpersonal & Communication Skills

4) Ability to motivate

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### Professionalism

5) Approachability / Availability / Receptiveness to questions

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### Patient Care

6) Ability to teach bedside

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7) Overall value to the residency program

- UNSATISFACTORY
- SATISFACTORY
- SUPERIOR
- N/A

8) Comments

Comments:

Remaining Characters: 5,000

Return to Questionnaire List
Quarterly Summary Faculty Evaluation of Urology Residents

[Subject Name]
[Subject Status]
[Subject Program]
[Evaluation Dates]

Evaluator

[Evaluator Name]
[Evaluator Status]
[Evaluator Program]

PATIENT CARE

1) Obtains accurate and pertinent history and physical exam

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2) Obtains, performs, and interprets appropriate diagnostic tests and procedures

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3) Can generate an appropriate differential diagnosis

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4) Can develop patient care plan and perform appropriate patient counseling

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Comments
5) Identifies and manages intra-operative and post-operative complications

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Comments

6) Performs open surgical procedures

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Comments

7) Performs endoscopic of the upper and lower urinary tract

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Comments

8) Performs laparoscopic/robot/assisted surgical procedures

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Comments

9) Performs office based procedures

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Comments
### SYSTEMS-BASED PRACTICE

**10) Works effectively within and across the health care system**

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**Comments**

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**The physician**

1. Coordinates the interprofessional care team by (a) anticipating the need for mult-disciplinary involvement; and (b) skillful, respectful interaction with all team members; and complies with communication protocols

2. Plans for appropriate post-hospitalization care of the patient

**11) Considers costs and benefits of tests & treatments; adheres to established patient care pathways; does not order unnecessary tests; uses appropriate billing codes for outpatient visits & surgical procedures**

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**Comments**

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**The physician**

1. Has knowledge of urology billing codes

2. Understands reimbursement principles

3. Efficiently uses laboratory testing, complex studies, and equipment necessary in the care of individual patients

**12) Works in inter-professional teams to enhance patient safety**

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**13) Uses technology to accomplish safe health care delivery**

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PRACTICE BASED LEARNING & IMPROVEMENT

The physician
1. Capably uses the EHR and CPOE to care for patients and communicate essential information with other members of the health care team
2. Identifies flaws in decision support systems, automated care pathways, or system alerts

14) Improves via feedback and self-assessment

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15) Determines how learning deficits or weaknesses can be addressed; seeks feedback; does extra reading & surgical practice when needed; seeks information from the literature; critically appraises research evidence for applicability to patient care; uses information technology (IT) resources to aid learning

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16) Acquires the best evidence

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Examples:
Uses the National Guidelines Clearing House to contrast clinical practice guidelines on interstitial cystitis by different professional organizations
Employs Clinical Queries filters in PubMed to search for randomized controlled trials on adjuvant radiation therapy

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17) Can evaluate medical evidence for validity and applicability to individual patients

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Example:

Has an understanding of the following concepts related to study design and hypothesis testing:
- Using "best evidence" from observational studies if randomized clinical studies are not available or feasible
- The influence of multiple comparisons of study results
- Type I and Type II error

Able to apply study results in the context of existing literature and project likely impact on clinical practice

18) Improves the quality of care for a panel of patients

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Example:

Self-identifies apparent overutilization of diagnostic imaging studies (i.e., CT scan, bone-scan) in patients with clinically localized prostate cancer. In partnership with others, leads a quality improvement initiative that includes dissemination of guidelines, as well as periodic practice audits

19) Participates in the education of other team members

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INTERPERSONAL & COMMUNICATION SKILLS

20) Communicates effectively with patients and families with diverse socioeconomic and cultural backgrounds

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Basic Patient and Family Interpersonal and Communication Skills

The physician

1. Listens actively, e.g., allows the patient to tell his or her story or to provide his or her perspective; does not interrupt and talk over
2. When explaining, presents small chunks of information at a time; avoids use of technical, medical words; paces speech appropriately (i.e., not fast)
3. Ensures that his or her message was understood, e.g., when applicable, the patient can repeat/summarize treatment options, the patient can describe signs that would signal a need to contact the physician, the patient can repeat home care instructions
4. Responds supportively and empathetically to patients’ emotions and concerns
5. Defuses emotionally charged situations to enable communication
6. Invites and encourages the patient and his or her family/advocates to participate in shared decision making
7. Allows the opportunity for patient questions throughout the encounter
8. Keeps patients and families up to date on care plans, test results, and health status during hospitalization
9. Demonstrates sensitivity to differences in patients, including race, culture, gender, sexual orientation, socioeconomic status, literacy, and religious belief
10. Utilizes translation services as needed to communicate with patients

21) Counsels, educates, and obtains informed consent

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1. Appropriately counsels patients about the risks and benefits of tests and procedures, highlighting cost awareness and resource allocation
2. Uses patient-centered approach (see above Basic Patient and Family Interpersonal and Communication Skills)

22) Communicates effectively with physicians, other health professionals, and health-related agencies. Writing diagnostic reports, Referral (oral and written), Consultations (oral and written), and Medical records

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1. Hand-written information is legible
2. Concisely provides key information organized in conformance with established protocols and standards
3. Information provided is complete and timely, i.e., meets the needs of the requestor/receiver and enables the next step in patient care to take place with full information and without rescheduling

23) Communicates effectively during care transitions and consultations with fellow residents.

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Patient Hand-over Skills
1. Uses multiple forms of communication, including both oral and written/electronic notes
2. Information transfer focuses on key status information and must-do actions
3. Invites questions
4. Confirms recipient’s receipt and understanding of information
5. Clearly delineates responsibilities
6. Provides information on the back-up plan should the recipient of the “hand-over” become unavailable
7. Follows a formalized protocol, including use of a regular quiet meeting place
8. Is patient-centered and does not appear rushed

24) Works effectively as a member or leader of a health care team or other professional group.
OR Team, Clinical team (Office, Inpatient, or Outpatient/Clinic), Professional work groups and committees (e.g., quality improvement, research)

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PROFESSIONALISM

Team Leader Skills—The resident physician
1. Shares plan with team
2. Invites input and involves others
3. Is appropriately assertive
4. Provides feedback
5. Initiates briefings, e.g., pre-operative and post-operative
6. Provides and solicits on-going updates so as to maintain situational awareness
7. Respectfully, directly, and proactively addresses behaviors and events that disrupt team functioning, e.g., conflict, individual disruptive behavior, failure to perform responsibilities
8. Acts as a spokesperson for the team when communicating with faculty members or other teams
9. Takes responsibility for the decisions and actions of the team

Demonstrates adherence to ethical principles

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25) Recognizes limits of his or her abilities
2. Asks for help when needed
3. Refers patients when appropriate
4. Exercises authority accorded by position and/or experience

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26) Demonstrates compassion, integrity, and respect for others

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1. Responds appropriately to patient and family emotions
2. Establishes rapport
3. Is respectful and considerate of patients, their families, and members of the health care team, e.g., responds to questions, concerns, and requests; does not make inordinate demands, avoids sarcasm and other forms of belittlement and displays of petulance
4. Responds to requests in a helpful and prompt manner
5. Is honest in interactions with others, and demonstrates honesty and truth-telling in interactions with patients, families, and other health care professionals, e.g., when communicating prognosis to patients and families, reporting on patient care activities in medical records or to supervisors, and in disclosing adverse events and medical errors

27) Demonstrates responsiveness to patient needs that supersede self-interest.

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1. Accepts responsibilities willingly
2. Is industrious and dependable
3. Completes tasks carefully and thoroughly
4. Accepts feedback
5. Takes on extra responsibilities when the need arises
28) Demonstrates respect for patient privacy and autonomy.

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1. Maintains patient confidentiality
2. Recognizes and supports patients' right to make own decisions

29) Demonstrates accountability to patients, society, and the profession.

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1. Takes responsibility for actions
2. Admits mistakes
3. Recognizes conflicts of interest that occur in practice and how to ethically respond to them, e.g., relationships with drug and device representatives, referrals to self-owned facilities, or revenue producing pressures by the hospital
4. Complies with health system, regulatory agency, and government performance and outcome reporting requirements for operative logs, medical records, and adverse events

30) Demonstrates sensitivity and responsiveness to diverse populations, including diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

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MEDICAL KNOWLEDGE

1. Sensitive to issues related to each patient's culture, age, gender, and disabilities
2. Recognizes ethical dilemmas related to patient diversity, e.g., patient rejection of treatment options due to religious or cultural reasons
3. Provides equitable care regardless of patient culture or socioeconomic status

31) Is able to identify & discuss pathophysiology of urologic disease processes; can intelligently discuss diagnosis, evaluation & treatment of common urologic disorders; applies knowledge to solve clinical dilemmas; understands rationale for varied approaches to clinical problems
32. Actively participates in AUA Core Curriculum and Urologic conferences

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Overall Comments:

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Return to Questionnaire List
Please evaluate your co-resident and give constructive comments.

1) Medical Knowledge

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2) Uses medical resources appropriately

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3) Performs procedures/surgery carefully and minimizes risk to patients

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4) Demonstrates integrity, empathy, and compassion for the patient

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5) Understands and appreciates the role of team members

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<th>Level</th>
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6) Responsive, cooperative, respectful

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7) Punctuality

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8) Clinical judgment: puts together the whole picture

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<th>Level</th>
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9) Teaching Ability

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<td>Novice</td>
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</tbody>
</table>
10) Leadership Skills
   Novice 1
   Competent 8
   Advanced 9

11) Reliability to complete tasks as a team
   Novice 1
   Competent 8
   Advanced 9

12) Preparation of conferences
   Novice 1
   Competent 8
   Advanced 9

13) Comment
    Comments

Remaining Characters: 5,000

Return to Questionnaire List
RESIDENCY COMPETENCY EVALUATION SYSTEM - UROLOGY  
PROGRAM EVALUATION BY RESIDENTS

[Subject Name]  
[Evaluation Dates]  
Evaluator  
[Evaluator Name]

Please rate the residency program overall in the following areas.

**Unsatisfactory** = Several behaviors performed inadequately or missed (ratings 1, 2, or 3)  
**Satisfactory** = Most behaviors performed acceptably (ratings 4, 5, or 6)  
**Superior** = All behaviors performed very well (ratings 7, 8, or 9)

1) Volume and variety of surgical cases.
   - **UNSATISFACTORY**  
   - **Satisfactory**  
   - **Superior**  
   - **N/A**

2) Quality and quantity of academic conferences.
   - **UNSATISFACTORY**  
   - **Satisfactory**  
   - **Superior**  
   - **N/A**

3) Exposure to research.
   - **UNSATISFACTORY**  
   - **Satisfactory**  
   - **Superior**  
   - **N/A**

4) Urology subspecialty exposure.
   - **UNSATISFACTORY**  
   - **Satisfactory**  
   - **Superior**  
   - **N/A**

5) Faculty supervision and teaching of residents.
   - **UNSATISFACTORY**  
   - **Satisfactory**  
   - **Superior**  
   - **N/A**

6) Accessibility of the faculty for consultation and/or questions.
   - **UNSATISFACTORY**  
   - **Satisfactory**  
   - **Superior**  
   - **N/A**

7) Financial and administrative resources and support.
   - **UNSATISFACTORY**  
   - **Satisfactory**  
   - **Superior**  
   - **N/A**

8) Contribution of participating institutions and outside rotations.
   - **UNSATISFACTORY**  
   - **Satisfactory**  
   - **Superior**  
   - **N/A**
9) Overall impression of the urology training program

UNSATISFACTORY \[\circ\] \[\circ\] \[\circ\] \[\circ\] \[\circ\] \[\circ\] \[\circ\] \[\circ\] \[\circ\]
SATISFACTORY \[\circ\] \[\circ\] \[\circ\] \[\circ\] \[\circ\] \[\circ\] \[\circ\] \[\circ\]
SUPERIOR \[\circ\] \[\circ\] \[\circ\] \[\circ\] \[\circ\] \[\circ\] \[\circ\]
N/A \[\circ\] \[\circ\]

10) Do you understand the Six Core Competencies and do you feel that they are being adequately incorporated into the program?

Yes \[\circ\] \[\circ\] No

Comments

Remaining Characters: 5,000

11) What are the major strengths of the training program?

COMMENT

Remaining Characters: 5,000

12) What are the major weaknesses of the training program?

COMMENT

Remaining Characters: 5,000

13) Overall comments not listed above

COMMENT

Remaining Characters: 5,000

Overall Comments:

Remaining Characters: 5,000

Return to Questionnaire List
Operative Performance Rating Form

Resident: ________________________ Staff: __________________________________

Date of Surgery: _____________ Procedure: ________________ CPT Code: ____________

Please circle the number corresponding to the resident’s performance in each area, irrespective of training level

### Knowledge of Operative Steps

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unfamiliar with the steps of the operation; Unable to recall or describe many operative steps</td>
<td>Knows and can explain most of the operative steps but unsure of some without hesitation</td>
<td>Obviously knowledge of all operative steps; Able to give details of steps</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Instrument Handling

<table>
<thead>
<tr>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Makes tentative or awkward moves by inappropriate use of instruments</td>
<td>Competent use of instruments but occasionally appears stiff or awkward</td>
<td>Fluid moves with instruments and no awkwardness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Knowledge of Instruments

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
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<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently asks for wrong instrument or uses inappropriate instrument</td>
<td>Knows names of most instruments and uses appropriate instruments</td>
<td>Obviously familiar with the instruments and their names</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Flow of the Operation

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
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<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently stopped operating and seemed unsure of next move</td>
<td>Demonstrated some forward planning with reasonable progression of procedure</td>
<td>Obviously planned course of operation with effortless flow from one move to next</td>
<td></td>
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</table>

### Respect For Tissue

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<th>2</th>
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<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>Frequently used unnecessary force on tissue or caused damage by inappropriate use of instruments</td>
<td>Careful handling of tissue, but occasionally caused inadvertent damage</td>
<td>Consistently handled tissues appropriately with minimal damage</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Resident has demonstrated sufficient competence to perform this procedure independently without supervision upon completion of his/her residency training.

YES NO

Comments:

Resident Signature: ___________________________ Date: __________________

Staff Signature: ___________________________
Please circle the number corresponding to the resident's performance in each area, **irrespective of training level**.

**Unsatisfactory** = Several behaviors performed inadequately or missed (ratings 1, 2, or 3)

**Satisfactory** = Most behaviors performed acceptably (ratings 4, 5, or 6); satisfactory performance is described below

**Superior** = All behaviors performed very well (ratings 7, 8, or 9)

<table>
<thead>
<tr>
<th>Observed Patient Encounter Rating Form</th>
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<tbody>
<tr>
<td><strong>Medical Interview</strong></td>
</tr>
<tr>
<td>1. Initiating interview</td>
</tr>
<tr>
<td>1 2 3</td>
</tr>
<tr>
<td><strong>Unsatisfactory</strong> Satisfactory Superior</td>
</tr>
<tr>
<td>4 5 6</td>
</tr>
<tr>
<td>7 8 9</td>
</tr>
<tr>
<td>Greets patient; introduces self clearly; begins process of building rapport through appropriate eye contact, relaxed body language &amp; pleasant affect</td>
</tr>
<tr>
<td>2. Taking history - content</td>
</tr>
<tr>
<td>1 2 3</td>
</tr>
<tr>
<td>4 5 6</td>
</tr>
<tr>
<td>7 8 9</td>
</tr>
<tr>
<td>Elicits description of symptoms and sequence of events; obtains relevant background information such as past medical history, relevant social &amp; occupational information; elicits patient's concerns/ worries; identifies, confirms, &amp; characterizes patient problem</td>
</tr>
<tr>
<td>3. Taking history - process</td>
</tr>
<tr>
<td>1 2 3</td>
</tr>
<tr>
<td>4 5 6</td>
</tr>
<tr>
<td>7 8 9</td>
</tr>
<tr>
<td>Listens attentively; allows patient to complete statements without interruption; uses concise, easily understood questions &amp; comments; appropriately uses open &amp; closed questioning techniques; facilitates patient's responses verbally &amp; nonverbally; redirects patient as needed</td>
</tr>
<tr>
<td><strong>Physical Examination</strong></td>
</tr>
<tr>
<td>4. Preparing for exam</td>
</tr>
<tr>
<td>1 2 3</td>
</tr>
<tr>
<td>4 5 6</td>
</tr>
<tr>
<td>7 8 9</td>
</tr>
<tr>
<td>Explains exam before beginning it; has necessary equipment/material at hand</td>
</tr>
<tr>
<td>5. Conducting exam - content</td>
</tr>
<tr>
<td>1 2 3</td>
</tr>
<tr>
<td>4 5 6</td>
</tr>
<tr>
<td>7 8 9</td>
</tr>
<tr>
<td>Conducts an appropriate &amp; complete genitourinary exam; conducts an appropriate non-genitourinary exam</td>
</tr>
<tr>
<td>6. Conducting exam - process</td>
</tr>
<tr>
<td>1 2 3</td>
</tr>
<tr>
<td>4 5 6</td>
</tr>
<tr>
<td>7 8 9</td>
</tr>
<tr>
<td>Conducts exam in a logical and efficient sequence; is sensitive to patient comfort; is respectful of patient's privacy</td>
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<tr>
<td><strong>Clinical Judgment</strong></td>
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<tr>
<td>7. Assessing the information</td>
</tr>
<tr>
<td>1 2 3</td>
</tr>
<tr>
<td>4 5 6</td>
</tr>
<tr>
<td>7 8 9</td>
</tr>
<tr>
<td>Obtains sufficient information from interview &amp; exam to include or exclude likely, relevant, significant conditions; electively orders or performs appropriate diagnostic studies as needed</td>
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<tr>
<td>8. Identifying the problem</td>
</tr>
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<td>1 2 3</td>
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<tr>
<td>4 5 6</td>
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<tr>
<td>7 8 9</td>
</tr>
<tr>
<td>Synthesizes information to make a clinically appropriate working diagnosis</td>
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<tr>
<td>9. Addressing the problem</td>
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<tr>
<td>4 5 6</td>
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<tr>
<td>7 8 9</td>
</tr>
<tr>
<td>Develops a plan that is appropriate for the working diagnosis &amp; reflects a good understanding of current accepted practice; addresses patient's concerns &amp; preferences</td>
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<tr>
<td><strong>Explanation &amp; Planning</strong></td>
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<tr>
<td>10. Explaining the problem</td>
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<td>1 2 3</td>
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<tr>
<td>4 5 6</td>
</tr>
<tr>
<td>7 8 9</td>
</tr>
<tr>
<td>Explains assessment clearly &amp; uses non-technical language; provides the correct amount &amp; type of information; checks for patient understanding; responds to patient emotion &amp; reassures patient as appropriate</td>
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<td>11. Discussing the plan</td>
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<tr>
<td>4 5 6</td>
</tr>
<tr>
<td>7 8 9</td>
</tr>
<tr>
<td>Describes plan clearly &amp; uses non-technical language gives reasons for plan; discusses relevant benefits &amp; risks; checks for patient receptiveness to plan; explores possible compliance issues; negotiates, educates &amp; counsels as needed</td>
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<tr>
<td>12. Closing the session</td>
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<tr>
<td>1 2 3</td>
</tr>
<tr>
<td>4 5 6</td>
</tr>
<tr>
<td>7 8 9</td>
</tr>
<tr>
<td>Summarizes assessment &amp; plan; discusses next steps</td>
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</table>

PLEASE RETURN FORM TO RESIDENCY COORDINATOR – Judy Pierson 3B163
Dear Patient:
To improve our services to you, we are requesting that you provide us feedback regarding your visit with us. This evaluation is for our resident physicians. Our residents are enrolled in a five year long training program in Urology. Your evaluation will help us monitor their progress.
Your responses are confidential.

Please check the appropriate box for each of the following services:

1. The doctor treated me with respect and courtesy.
   - [ ] Agree
   - [ ] Not Sure
   - [ ] Disagree

2. I was able to explain my problem to the doctor as fully as I needed to.
   - [ ] Agree
   - [ ] Not Sure
   - [ ] Disagree

3. The doctor explained things so now I know what might be the matter with me.
   - [ ] Agree
   - [ ] Not Sure
   - [ ] Disagree

4. The doctor explained what treatment, tests, or other follow-up is going to happen.
   - [ ] Agree
   - [ ] Not Sure
   - [ ] Disagree

5. The doctor gave me the opportunity to ask questions and express my opinion.
   - [ ] Agree
   - [ ] Not Sure
   - [ ] Disagree

6. The doctor used understandable and non-technical language
   - [ ] Agree
   - [ ] Not Sure
   - [ ] Disagree

7. I feel satisfied with the medical care that I received.
   - [ ] Agree
   - [ ] Not Sure
   - [ ] Disagree

Comments (describe good or bad experience)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please give this form to one of our office staff to be sent to office below. Please feel free to ask any questions you might have about our resident training program or your care.
(Return form to TTUHSC-Urology, Attn Residency Program Coordinator, MS 7260)

Thank you for your time
Urology Residency Program
SECURE 360° Rating Form

Rate this physician on the following performance statements. This form can be used by nursing staff, pharmacists, social workers or other ancillary personnel. Therefore, some items may not be relevant to you. Please mark and X in the appropriate box for each questions. If you are unable to assess a particular area, please mark “DK”.

<table>
<thead>
<tr>
<th>PROFESSIONALISM (1-10)</th>
<th>INTERPERSONAL &amp; COMMUNICATION SKILLS (11-20)</th>
<th>Agree</th>
<th>Disagree</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Responds to requests, including pages, in a helpful and prompt manner</td>
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<tr>
<td>2. Knows the limits of his/her abilities and asks for help when needed</td>
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<tr>
<td>3. Takes responsibility for actions, and is willing to respond appropriately to feedback, admits mistakes and does not blame others</td>
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<tr>
<td>4. Maintains respectful demeanor in demanding and stressful situations</td>
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<td>5. Is honest in interactions with others</td>
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<tr>
<td>6. Is respectful and considerate in interactions with patients</td>
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<tr>
<td>7. Is willing to answer questions and takes time to educate</td>
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<tr>
<td>8. Is courteous to and considerate of nurses and other staff</td>
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<tr>
<td>9. Listens to and considers what others have to say about relevant issues</td>
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</table>

Comments:

Please return completed evaluation to Judy Pierson, TTUHSC-Dept. of Urology, MS 7260
# Urology Service Evaluation

Students and Residents - please rate the following services:

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Probably Agree</th>
<th>Not Sure</th>
<th>Probably Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My urology rotation was a good use of my time.</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2. I was treated with respect and consideration.</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3. The attending(s) were good teachers.</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>4. The resident(s) were good teachers.</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>5. I would recommend this rotation to other students or PGY I residents.</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>6. The conferences were useful.</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>7. There was good balance of clinic and operating room experience.</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

As a result of this rotation, would you consider urology as a career? Explain ____________________________

__________________________

__________________________

__________________________

__________________________

__________________________

_________________________

72
Please complete this self-assessment for the preceding six-month time period. It is designed to help you identify your strengths and weaknesses and subsequently establish goals on how to improve your learning and patient care. The self-assessment will be discussed with the Program Director at your upcoming semi-annual review. Negative self-assessments will not reflect poorly upon your formal evaluation and for this reason, your honest answers are expected.

Name:______________________________________

Year in Training:__________________________

Date:_____________________________________

For each of the following ACGME core competencies, please rate yourself using the following scale:

1 = Area where I know that I need improvement
2 = Area where I think that I need improvement
3 = Area where I think that I perform adequately
4 = Area where I think that I am above average
5 = Area where I think that I am very skilled
PATIENT CARE – Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

“I always…..”

- Obtain a complete medical database via history and physical examination
- Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences
- Make informed decisions about diagnostic and therapeutic interventions based on up to date scientific evidence
- Work with other health care professionals, including those from other disciplines, to provide patient-focused care
- Involve the patient and patient’s family in decisions regarding care
- Communicate clearly with the patient and the patient’s family
- Teach the patient and their family about their diagnosis, treatment, and discharge plans
- Demonstrate empathetic and caring behavior to the patient and patient's family
- Triage patient effectively and efficiently
- Respond responsibly and appropriately to emergencies
- Reassess and evaluate ongoing treatment

MEDICAL KNOWLEDGE – Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

“I am comfortable with…”

- My knowledge about relevant medical illnesses
- My ability to generate a complete differential diagnosis
- My understanding of basic epidemiologic principles and their application to clinical medicine

“I recognize…”

- My own limitations in medical knowledge and seek consultation when appropriate
- My own limitations in procedural skills and seek consultation when appropriate
Are these specific disease states or syndromes (Breast Cancer, CHF, Asthma, etc…) where you are less comfortable with diagnosis and treatment?

**PRACTICE-BASED LEARNING AND IMPROVEMENT** – Residents must be able to investigate and evaluate their patient care practices and appraise and assimilate scientific evidence to improve their patient care practices.

*“I am able to, and frequently do…”*

- Analyze feedback and my patient care experiences to make improvements in patient care
- Use evidence-based medicine as it relates to my patients condition and diagnosis
- Consult the medical literature (web-based resources and reference materials) to support my education and improve patient care
- Assist in the education of medical students
- Assist in the education of my physician colleagues
- Assist in the education of other health care professionals (nursing, ancillary staff, etc…)
- Apply knowledge of study designs and statistical methods when reviewing scientific studies

**INTERPERSONAL AND COMMUNICATION SKILLS** – Residents must be able to demonstrate interpersonal and communication skills that result in the effective exchange of information between patients, their families, and professional associates.

*“I make a concerted effort to…”*

- Create a personal relationship with every patient
- Communicate the diagnosis, treatment outcomes, and expected course at each patient encounter
- Use effective non-verbal and listening skills in every patient encounter
- Communicate with patients and their families in a timely manner
- Communicate in a respectful manner to all professional colleagues, ancillary staff, and hospital/clinic personnel
- Complete written and electronic communication that is comprehensive, timely, legible, and easy to follow
PROFESSIONALISM – Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population while maintaining a professional relationship with all members of the patient care team.

“At all times I demonstrate…”

_____ Respect, compassion, and integrity for my patients
_____ Commitment to ethical principles
_____ Responsiveness to the needs of my patients and their families
_____ Commitment to maintaining confidentiality and obtaining informed consent
_____ Sensitivity and responsiveness to patients’ culture, age, gender, and disabilities
_____ Accountability to the needs of society
_____ Accountability to the needs of the profession
_____ Commitment to excellence

“At all times I…”

_____ Identify myself to patients and their families
_____ Am well-groomed and wear professional attire (including name badge)
_____ Respond to pages and inquiries in a timely manner
_____ Complete duties necessary to my training and patient care (evaluations, time sheets, dictations, signatures, medical records, etc) in an honest and timely manner

SYSTEMS-BASED PRACTICE – Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

“At every opportunity, I…”

_____ Consider how my practices affect other health care professionals and the hospital system
_____ Consider how my practices affect the society as a whole
_____ Practice cost-effective care and resource allocation (including my own time) that does not compromise quality of care
_____ Assist patients in managing the complexities of the health care system
_____ Look for ways to improve our system of health care
IDENTIFICATION OF STRENGTHS
After having completed the self-assessment, what would you identify as your strengths?
1.
2.
3.

IDENTIFICATION OF AREAS FOR IMPROVEMENT
What would you identify as your areas for improvement?
1.
2.
3.

IDENTIFICATION OF LEARNING OBJECTIVES
Please list three specific learning objectives and goals to work over the next six months:
1.
2.
3.

Comments:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signature:____________________________
TEXAS TECH UNIVERSITY HSC
DEPARTMENT OF UROLOGY

EVALUATION FOR RESIDENT CONFERENCES

Conference Name ____________________________________________

Conference Date ____________________________________________

Resident Presenter ____________________________________________

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<th>Reasonably Well</th>
<th>Extremely Well</th>
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<tbody>
<tr>
<td>A. Recent sources from current evidence</td>
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<tr>
<td>B. Used well formulated statistical concepts and/or relevant study design/methodology for this presentation</td>
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<td>C. Well referenced</td>
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<td>A. Effective use of slides/video/handouts</td>
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<td>B. Effective</td>
<td>1 2 3 4 5</td>
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<tr>
<td>C. Diction/audibility of presentation</td>
<td>1 2 3 4 5</td>
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<td>D. Effective use of time</td>
<td>1 2 3 4 5</td>
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<td>E. Major points summarized</td>
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<td>F. At appropriate level</td>
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<td>B. Successful in ability to answer</td>
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<tr>
<td>A. Met Expectations</td>
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Comments: ________________________________________________________________

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TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER
SCHOOL OF MEDICINE
DEPARTMENT OF UROLOGY
FACULTY / RESIDENT LEAVE REQUEST

A. Faculty/Resident requesting Leave: __________________ Signature: __________________
   (Print)

B. Date: __________________ Prepared by: __________________
   Coordinator

C. Period of Leave:

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<th>Out</th>
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<tbody>
<tr>
<td>Return</td>
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<td>p.m.</td>
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D. Purpose of Leave: □ Educational □ Vacation □ Other ________________
   Meeting/conference info. _______________________________________________________________________
   Internal COMP Days used __________ # days used

E. Cancel Clinic? □ Yes □ No
   Cancel Surgery Day? □ Yes □ No

F. Chairman Approval: ____________________________
   Signature

   Program Director Approval: ____________________________
   (For Residents only) Signature

G. ADD TO DEPT. CALENDARS ▪ SEND TO CLINIC ▪ SECURE COVERAGE
   (if needed)

H. Coverage during leave: (if applicable)

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Office Procedure

Office Use Only:
Coordinator – Andrea Patterson - Judy Pierson
Leave recorded to Outlook/Dept. Calendars: ______ Date copy to PSS: ______
Date copy to Nurse supervisor: ______ Date copy to Dr. Haynes(Call Schedule purposes): ______
Final – Date copy to Adm.: ______

PSS – Supervisor__________
Clinic Bumped: ____________ By: ____________ # Pts. cancelled: ____________
Copy to Coordinators (after pts. cancelled): ______