

FOR CaRMS AND THE AUA UROLOGY MATCH

The Urology Residency Interview Pack

Fifty interview stations with frameworks and worked answers, a method for building your own story bank, and a ninety-minute way to research any program.

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FIRST EDITION

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The Urology Residency Interview Pack. First Edition.

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This is an original, independently authored work. It is not affiliated with, endorsed by, or derived from CaRMS, the AUA, the Society of Academic Urologists, any residency program, or any interview preparation service. Every worked answer in this book is a composite written to show a structure; none describes a real applicant, a real patient, or a real program.

Read This First

What this book is. A preparation system for the urology residency interview, written by a urology resident who sat on the applicant side of the table and now sits on the other. It covers the two North American routes, the Canadian match through CaRMS and the American urology match run by the Society of Academic Urologists, because the interview itself is the same exercise in both: a program trying to find out, in twenty minutes, whether you will be safe, teachable, and good to work with for five years.

What this book is not. It is not a list of questions to memorize with answers to recite. Interviewers hear recited answers within one sentence and mark them down. Every station here comes with a framework and a worked answer so you can see the shape, then a prompt to build your own from your own life. The worked answers are composites. Use their structure, never their content.

Timelines change. The match calendars, application portals, and program requirements move every cycle. The dates in this book are given as typical windows and you must confirm them against the CaRMS and Society of Academic Urologists sites for your cycle.

Honesty. Nothing in an interview is worth a claim you cannot back. Interviewers call references, read your file, and talk to each other. Every framework in this book assumes you will tell the truth, including about the things that did not go well.

How to Use This Book

Six weeks before interviews: read Part 1 in one sitting, then do the story bank exercise in Part 3. That exercise is the single highest-yield hour in this book, because eight good stories answer about forty of the fifty stations.

Four weeks before: work through Part 2, two categories a week. For each station, read the question, say your answer out loud before reading the worked answer, then compare the shape. Record yourself for the motivation stations; the first recording is always worse than you think and better after three tries.

Two weeks before: run the program research method in Part 4 for every program on your list, in the spreadsheet it describes. This is also when your questions for them get written.

The week of: Part 5 only. The day-of checklist, the video setup, the questions to ask, and the thank-you rule.

PART 1

How the Urology Match Works

Chapter 1: The Two Routes

Urology is one of the smallest and most competitive surgical matches in North America, and the mechanics differ by country in ways that change how you should prepare.

Canada: CaRMS

Canadian urology positions are filled through the Canadian Resident Matching Service in the first iteration of the R-1 match. Applications open in the autumn of your final year, file review runs through late autumn, interviews cluster in January and February, rank order lists are due in late February or early March, and match day is in March. Confirm the dates for your cycle on the CaRMS site; they shift by a week or two each year.

What matters about the Canadian system:

- **Few spots, few programs.** Roughly a dozen programs and, in a typical year, somewhere between twenty and thirty positions across the country. Most applicants apply to every English program they are eligible for and the French programs if their French is real.
- **Electives are the interview before the interview.** Programs meet you on electives. A strong two-week elective at a program you want is worth more than any answer in this book, which is why the story bank in Part 3 draws so heavily on elective experiences.
- **The personal letter is program-specific.** Most programs ask for a letter addressed to them. A generic letter with the program name swapped is noticed.
- **Reference letters carry the file.** Three letters, ideally two from urologists who watched you work and one from another surgeon or a research supervisor who can speak to a different quality.
- **Interviews are mostly virtual now,** with a few programs returning to in-person days. Format varies: multiple mini-interview circuits, panel interviews, and one-on-one conversations with faculty and residents all exist. Ask the program administrator what format to expect; they will tell you.

United States: the AUA urology match

American urology programs match early, through a match administered by the Society of Academic Urologists rather than the National Resident Matching Program. Applications go through ERAS in the early autumn, interviews run from October into January, rank lists are due in January, and results are released in late January, months before the main match. Confirm the current calendar on the Society's site.

What matters about the American system:

- **More programs, more positions, and a signal system.** Applicants indicate preference to a limited number of programs at application time. Use your signals on programs where you have a genuine reason to be ranked, not on the most famous names.

- **Sub-internships are the equivalent of Canadian electives.** Four-week away rotations at programs you want, with the same rule: they are the interview before the interview.
- **Interview days are longer** and often include a resident social the evening before. The social is part of the interview. Residents report back.
- **Research volume is scrutinized** more than in Canada, but quality and your ability to talk about the work still beat a long list.

What every program is scoring, regardless of route

Interviewers use different forms, but the same four things are underneath almost every station:

1. **Safety.** Will you recognize when you are out of your depth, and say so?
2. **Teachability.** Do you take feedback without defending yourself, and does it change what you do?
3. **Fit.** Will the residents want you on their call schedule for five years?
4. **Motivation.** Do you know what urology is, the boring parts included, and want it anyway?

Every worked answer in Part 2 hits at least two of the four on purpose. When you build your own answers, check them against this list.

Chapter 2: The File Behind the Interview

By interview day the file has done its work: it got you the interview. But interviewers read it again the morning they meet you, and half the questions in any station come from it. Know your own file better than they do.

The curriculum vitae

Every line is a potential question. If a project is on your CV, you must be able to say in one minute what the question was, what you did, what was found, and what you would do differently. Remove anything you cannot defend at that depth. A shorter CV with nothing soft on it is stronger than a long one with a weak line the interviewer finds.

The personal letter

The letter is read for one thing: whether you understand what you are applying to. The strongest letters name a specific moment on a urology rotation, say what it showed you about the specialty, and connect it to what you will bring. The weakest letters describe urology in general terms that could have come from a website. Program-specific paragraphs should mention something you learned about the program from a resident or an elective, not from the program's own page.

Reference letters

You will not see them, but you should know who wrote them and what each one saw. If an interviewer says a referee praised your handling of a difficult patient, you need to know which patient they mean.

Research

Have one project you can talk about for five minutes and every other project you can summarize in thirty seconds. The five-minute project should be the one where you did the most and understood the most, not the one with the best journal.

The gaps

Every file has something an interviewer might ask about: a failed exam, a year off, a rotation with a lukewarm evaluation, a late switch into urology. Decide in advance what you will say. The rule is simple: one sentence of fact, one sentence of what you learned, one sentence of what changed. No defending, no over-explaining. Station 43 in Part 2 shows the shape.

Chapter 3: The Interview Day

Formats you will meet

Multiple mini-interview circuits. Six to ten stations of seven to ten minutes each, one or two interviewers per station, a prompt read before you enter. Scores are averaged, which means one bad station is survivable and one great station does not carry the day. Consistency wins.

Panel interviews. Three to six people, twenty to thirty minutes, a mix of standard and file-based questions. Direct your answer to the person who asked but make eye contact around the table on the way through.

One-on-one conversations. Usually with a program director, a chief resident, or a research lead. These feel informal and are scored like everything else.

Resident socials. Not scored formally, reported informally. Be the applicant who asked residents about their lives and listened.

What a station is actually measuring

Read every prompt for the underlying competency. A question about a conflict with a co-resident is measuring insight and communication, not who was right. A question about a mistake is measuring whether you can own one. A clinical scenario given to a medical student is measuring whether you know when to call for help, not whether you can manage the case.

The shape of a good answer

Most good answers to behavioural stations have four parts and take about ninety seconds: the situation in two sentences, what you specifically did, what happened, and what you took from it that changed later behaviour. The last part is the one applicants skip and the one interviewers score.

For clinical and ethical stations, the shape is different: state the concern, say what you would do first, say who you would involve, and say what you would do if the first step failed. Stations 21 to 30 and 11 to 20 show both shapes.

Video interviews

Camera at eye level, light in front of you, a plain background, a wired connection if you can, a phone hotspot ready if you cannot. Look at the lens when you speak, not at the faces. Pause for a beat after questions; the latency makes interruptions feel rude. Have water, your CV, and a one-page sheet of your story bank titles out of frame. Test everything with a friend the day before, on the platform the program uses.

What not to do

Do not name-drop faculty you have not worked with. Do not criticize other programs or your own school. Do not claim a subspecialty commitment you cannot back with something on your file. Do not fill silence; a five-second pause to think reads as composure. Do not ask questions the program's website answers.

PART 2

The Station Bank

Chapter 4: Motivation and Fit

Every worked answer in this Part is a composite written to show structure. Replace the content with your own life. Say your own answer aloud before you read the worked one.

Station 1: Why urology?

What it tests. Whether you know the specialty as it is practised, not as it is described.

Framework. A specific moment, what it showed you, why that matters to you, and one honest acknowledgement of the specialty's less glamorous side to prove you have seen it.

Worked answer. "The moment was a Tuesday clinic on my third-year elective. The morning was a seventy-year-old with a small renal mass, a young man with a varicocele and a fertility question, a woman with recurrent stones, and a man with retention who needed a catheter before anything else. By noon I had watched one surgeon counsel about cancer, fertility, pain, and a plumbing emergency, and treat each of them differently. That range is what I want: a specialty where the same person operates, scopes, counsels, and follows patients for decades. The part nobody advertises is the volume of catheter calls and the amount of clinic, and I liked those days too, because the problems are common and you can fix most of them."

Traps. Saying you like "the mix of medicine and surgery" without an example. Saying you love the OR and nothing about clinic.

Station 2: Why this program?

What it tests. Whether you did the work of learning what the program is.

Framework. Two specific facts you could only know from residents or an elective, one thing you would contribute, and no flattery.

Worked answer. "Two things. First, residents here told me the PGY-2 year carries the endourology service with graded independence, which is the year I think shapes whether you become confident with a scope, and I want that early. Second, the program has a formal quality-improvement stream with a faculty lead, and my own project on catheter-related infections would fit it. What I would bring is a habit of finishing projects; the two I have on my file were both taken to publication after the original student moved on."

Traps. Describing the city. Quoting the website. Saying it is your top choice unless it is and you have decided to say so.

Station 3: Where do you see yourself in ten years?

What it tests. Realism, and whether you have thought about the shape of a career rather than a title.

Framework. A plausible practice setting, one clinical focus you are honest about not yet knowing, one non-clinical thread, and openness to change.

Worked answer. "In a group practice at a teaching hospital, with a clinical focus I am not going to pretend to know yet; right now I lean toward reconstruction because I like problems with long follow-up, but residency will tell me. I want teaching in my week because I learn best when I have to explain. And I want to be the person in the group who runs the audit, because the projects I have enjoyed most were ones that changed a process."

Traps. Naming a fellowship as if it were decided. Saying "academic" without saying what you would do all day.

Station 4: Tell us about yourself.

What it tests. Whether you can prioritize, in ninety seconds, what matters about you.

Framework. Where you are from in one sentence, what led you here in two, what you do outside medicine in one, and what you are looking for in one.

Worked answer. "I grew up in a small city and stayed close for medical school. A general surgery rotation showed me I wanted to operate, and a urology elective the following year showed me which kind of operating: procedures where the same surgeon owns the whole arc, from consult to follow-up. Outside the hospital I run, badly but consistently, and I cook for whoever is around. I am looking for a program where residents are trusted early and expected to teach."

Traps. Reciting the CV. Starting from childhood.

Station 5: What is your greatest strength?

What it tests. Self-knowledge and whether the strength is one a residency needs.

Framework. One strength, one piece of evidence, one way it will matter on service.

Worked answer. "Follow-through. On my surgery clerkship the resident asked me to chase a pathology result on a Friday; it was not back, so I left my number with the lab and called the resident from home on Saturday when it came in. It is not dramatic, but a service runs on people who close loops, and I close them."

Traps. Claiming three strengths. Claiming "hard-working," which every applicant claims.

Station 6: What is your greatest weakness?

What it tests. Insight, and whether you have already started working on it.

Framework. A real weakness that is not disqualifying, evidence that you know it, and the specific thing you do about it.

Worked answer. "I over-prepare. Before my first oral presentation on a rotation I wrote a script and read it, and the feedback was that it sounded read. Since then I prepare the structure and the numbers and leave the words alone, and I practise out loud once. It is still a pull; I catch myself wanting a script before hard conversations."

Traps. Perfectionism without an example. A weakness that is really a strength in disguise. A weakness that would worry a program, such as trouble with feedback.

Station 7: What would your co-workers say about you?

What it tests. Whether you have a realistic view of how you land on a team.

Framework. One quality, one specific piece of evidence from someone else's words if you have it, and one thing they might say you could do better.

Worked answer. "The nurse manager on my medicine rotation told me I was the student who asked what the nurses needed before rounds. I think they would say I am easy to work with and that I notice when someone is drowning. They might also say I take on too much and should hand things off sooner, which is fair."

Station 8: What do you do to relax, and how will you protect it in residency?

What it tests. Whether you have a life you intend to keep.

Framework. A real activity, evidence you do it, and a concrete plan for the residency version of it.

Worked answer. "I run, three or four times a week, usually early. On my surgery rotation I found the only way to keep it was to run before pre-rounds, so I moved the run to five in the morning and it survived. My plan for residency is the same: attach it to the earliest fixed point in the day so nothing later can eat it."

Station 9: Why should we rank you?

What it tests. Whether you can make a case without arrogance.

Framework. Two qualities with evidence, one honest limit, and a closing sentence about what you would bring to the residents specifically.

Worked answer. "Two reasons. I have shown I can finish: both projects on my file were completed after the original student left. And I have shown I can be trusted with feedback: the evaluation from my urology elective said I changed my presentation style within a day of being told. My limit is that I have less research than some applicants; what I have is finished and I can talk about all of it. What I would bring to the residents is someone who takes the call nobody wants and does not keep score."

Station 10: Is there anything you want to tell us that is not on your file?

What it tests. Whether you have prepared one thing that rounds out the picture.

Framework. One thing, short, that shows a quality the file cannot.

Worked answer. "One thing. I taught a first-year anatomy tutorial for two years, and the reason I kept doing it was that explaining the pelvis to people who had never seen it fixed my own understanding. I would want to keep teaching in residency."

Chapter 5: Ethics and Professionalism

Station 11: A senior resident asks you to write a note for a patient you have not seen.

What it tests. Whether you will refuse an unsafe instruction politely and offer an alternative.

Framework. Name the problem, decline the specific act, offer what you can do, escalate if pressed.

Worked answer. "I would say I cannot document an assessment I have not done, and offer to go and see the patient now so the note is real. If the resident is under pressure and needs the note for a discharge, I would ask what is holding them up and take something else off their plate. If they insisted I write it anyway, I would say I am not comfortable and that we should ask the staff how they want it handled."

Station 12: You see a co-resident post a patient's imaging on social media.

What it tests. Whether you act on a privacy breach and how you handle a peer.

Framework. Patient first, peer second, system third.

Worked answer. "First the patient: the image has to come down now, so I would message the resident directly and ask them to remove it, with the reason. Second the peer: most people who do this have not thought it through, so I would give them the chance to fix it themselves. Third, if there were identifiers or it was not removed, I would tell the chief resident or the program, because the institution has an obligation to the patient that does not depend on my friendship."

Station 13: A patient refuses a catheter you believe they need.

What it tests. Capacity, consent, and whether you can sit with a refusal.

Framework. Assess capacity, explore the refusal, explain the consequence, involve seniors, document, and respect an informed refusal.

Worked answer. "I would start by finding out why: pain last time, fear, a bad experience. Many refusals are about the how, not the what, and a different approach or analgesia solves it. If they still refuse, I would check they understand what retention does if untreated and that they can change their mind at any time. If they have capacity and still refuse, that is their right; I would tell my senior, document the conversation, and make sure the nursing staff know to watch for the signs that would make us revisit it."

Station 14: You made a medication error that did not harm the patient.

What it tests. Whether you disclose when nobody would have known.

Framework. Stop, correct, disclose to the team, disclose to the patient, report, learn.

Worked answer. "The error gets reported whether or not it caused harm, because the system only improves on reported errors. I would tell my senior immediately, correct the order, and we would tell the patient together: what happened, what it means for them, and what we have done. Then the incident report. The last step is the one for me: figuring out why it happened, whether it was a look-alike drug name or an interrupted order, and changing my own process."

Station 15: A staff surgeon is rude to a nurse in front of you.

What it tests. Whether you have a sense of your own role in a hierarchy without being passive.

Framework. Do not escalate in the moment, support the person harmed, decide whether the pattern needs reporting, and know the route.

Worked answer. "In the moment I would not confront the surgeon; that helps nobody and makes the room worse. I would find the nurse afterward and acknowledge what happened. If it were a one-off on a bad day, that might be enough. If it were a pattern, or the nurse wanted to report it, I would support that and know that the program and the hospital both have routes for it. As a resident I would also watch my own behaviour on the days I am tired, because that is how this starts."

Station 16: A patient offers you a gift.

What it tests. Judgment about boundaries, without rigidity.

Framework. Small and shareable versus anything that creates obligation; policy; gratitude.

Worked answer. "A box of chocolates for the ward is a thank-you and I would accept it for the team. Anything of real value, money, or anything personal I would decline, warmly, and say that the best thank-you is to tell the hospital, because that feedback matters. Most hospitals have a gift policy and I would follow it; the principle is that nothing should make the next decision about their care feel owed."

Station 17: You suspect a colleague is impaired at work.

What it tests. Whether patient safety overrides loyalty.

Framework. Immediate safety, do not manage it alone, escalate to someone with authority, support the colleague afterward.

Worked answer. "The patient in front of them is the first concern, so if they were about to do something clinical, I would find a reason to step in or delay it. Then I would go to the chief resident or the staff on service, immediately and privately, because I am not equipped to assess impairment and it is not my job to. Afterward I would want to be the colleague who checks in, because most impairment is illness and people recover when someone acts."

Station 18: A family asks you not to tell the patient a diagnosis.

What it tests. Whose information it is, and cultural sensitivity.

Framework. The patient owns the information; find out what the patient wants to know; involve the staff; do not lie.

Worked answer. "I would ask the family why, because the reason matters, and I would explain that the information belongs to the patient. Then I would ask the patient, in a neutral way, how much they want to know and who they want in the room. Some patients genuinely want a family member to handle it, and that is their choice to make. What I would not do is lie to a patient who asks directly. And I would bring my staff in before the conversation, not after."

Station 19: You are asked to do a procedure you have never done, unsupervised.

What it tests. Whether you will say no to the wrong kind of opportunity.

Framework. Name your level, ask for supervision, offer to do it supervised now, and never proceed alone.

Worked answer. "I would say I have not done one and that I would like to, with someone watching. If the person asking is busy, I would ask who else could supervise or whether it can wait ten minutes. If it were an emergency and nobody was available, I would call the staff. The thing I would not do is try it because it seemed simple; the simple ones are the ones that go wrong when nobody is watching."

Station 20: A patient asks for your personal opinion about their surgeon.

What it tests. Professional loyalty and honesty at the same time.

Framework. Do not comment on colleagues; redirect to the patient's actual concern; help them ask the surgeon.

Worked answer. "I would ask what is worrying them, because the question usually has a real concern behind it, such as a complication they read about. I would not give an opinion about a colleague. I would help them write down what they want to ask, and if they wanted, I would tell the surgeon that the patient had questions so the next conversation happens."

Chapter 6: Clinical Judgment for the Applicant

These stations give you a scenario at a student's level. They are scored on safety and escalation, not on management detail. Say what you would do first, who you would call, and what you would watch for.

Station 21: You are called to see a post-operative patient with a heart rate of 130 on the ward at night.

Framework. See the patient now, treat what is in front of you, call for help early, look for the surgical causes.

Worked answer. "I would go now, not after finishing what I am doing. At the bedside: airway, breathing, circulation, a full set of vitals, and a look at the wound, the drains, and the abdomen. I would put in a large intravenous line, send bloods including a lactate and a group and screen, start fluid, and call my senior while doing it, because a tachycardic post-operative patient is bleeding, septic, or in pain until proven otherwise. I would not wait to see if the fluid works before calling."

Station 22: A seventeen-year-old presents with two hours of sudden testicular pain.

Framework. Time-critical diagnosis, do not delay for imaging, call the urologist.

Worked answer. "This is torsion until proven otherwise and the clock started two hours ago. I would examine him, keep him nil by mouth, give analgesia, and call the urology resident immediately rather than ordering an ultrasound first, because a delayed ultrasound can cost a testicle. If the resident wanted an ultrasound and it could be done in minutes, fine, but the call comes first."

Station 23: A patient in clinic tells you they have not been taking the medication the staff prescribed.

Framework. No judgment, find out why, bring it back to the staff, adjust the plan.

Worked answer. "I would thank them for telling me, because most people do not. Then why: side effects, cost, not understanding what it was for, or a decision that it was not worth it. Each of those has a different fix. I would bring it to the staff before they see the patient so the visit can be about what to do next rather than about what was not done."

Station 24: You are asked to consent a patient for a procedure you do not fully understand.

Framework. Consent requires understanding on both sides; decline, learn, or hand off.

Worked answer. "I would say I cannot consent someone for something I could not explain the risks of, and ask the resident either to do the consent with me watching or to walk me through the procedure first so I can do it properly. Consent is not a form; it is a conversation, and the patient can tell when the person in front of them does not know."

Station 25: An elderly man with a urinary catheter in the emergency department has a fever of 39 and low blood pressure.

Framework. Sepsis with a urinary source; the sepsis bundle; the catheter is part of the problem; call.

Worked answer. "This is sepsis until proven otherwise. Two large lines, cultures from blood and from the catheter after changing it, lactate, fluids, and antibiotics within the hour, following the hospital's protocol. I would call my senior early and ask about the catheter: whether it is draining, whether there is an obstruction behind it, because an obstructed infected system needs to be drained, not just treated with antibiotics."

Station 26: A patient's imaging shows an incidental finding unrelated to why they came.

Framework. The finding belongs to the patient; document, communicate, arrange follow-up, do not let it fall through.

Worked answer. "I would tell my staff first, then make sure the patient hears about it before they leave, in plain words, with a written note of what it is and what happens next. Then I would make sure the follow-up is actually arranged, with a named person, because incidental findings are lost in the gap between the person who saw them and the person who should act on them."

Station 27: You disagree with a management plan from your senior.

Framework. Ask, do not assert; make sure you have the same information; escalate only for safety.

Worked answer. "I would ask them to walk me through their reasoning, because most of the time they know something I do not. If I still disagreed, I would say what I was worried about, specifically. If it were a matter of style, their call. If I believed the patient was in danger and they were not hearing it, I would go to the staff, and I would tell the senior I was doing it."

Station 28: A patient with a known stone is in severe pain and the analgesia order is not working.

Framework. Reassess, treat pain properly, look for the reasons the pain is not controlled, escalate.

Worked answer. "First I would reassess: vitals, temperature, and whether anything has changed, because uncontrolled pain in a stone patient can mean infection or obstruction. Then I would treat the pain properly, with an anti-inflammatory if it is safe and an opioid if needed, and call my senior about whether this patient now needs drainage rather than more analgesia."

Station 29: A nurse tells you a patient looks different today but the numbers are normal.

Framework. Trust the observation, go and look, escalate on the gestalt.

Worked answer. "Nurses who say that are right often enough that I would go and see the patient immediately. Normal numbers do not exclude early deterioration. I would examine them, compare

with yesterday, and if I could not explain what the nurse saw, I would call my senior and say exactly that: the nurse thinks something has changed and I cannot explain it."

Station 30: You are at the end of a thirty-hour shift and asked to stay for one more case.

Framework. Fatigue is a safety issue; know the rules; offer an honest alternative.

Worked answer. "I would be honest that I am at the end of a long shift and would not be safe to assist. If the case needed a body in the room, I would say so, and let the staff decide with that information. Programs have duty-hour rules for this reason, and I would rather be the resident who said no than the one who dropped an instrument."

Chapter 7: Teamwork and Conflict

Station 31: Describe a conflict with a colleague and how you handled it.

Framework. Situation in two sentences, what you did that was specific, what happened, what you do differently now. The content of the disagreement matters less than how you handled the person.

Worked answer. "On a team project a colleague stopped responding for two weeks with a deadline coming. I was frustrated and my first draft of a message said so. I deleted it and asked instead if something was going on. It was: a family illness. We redistributed the work for the fortnight and finished on time. What I do differently now is ask before I assume, every time."

Station 32: Tell us about a time you received difficult feedback.

Framework. The feedback verbatim, your first reaction honestly, what you did, evidence it changed.

Worked answer. "A staff told me my presentations were too long and that the team stopped listening after the first minute. My first reaction was to defend it; I said nothing. That evening I timed myself: three minutes. I cut to a sentence of who, a sentence of overnight, the plan. Two days later the same staff said the presentations were fine. That was the day I learned to take the note and fix it before defending it."

Station 33: Tell us about a time you led a team.

Framework. Define the team and the goal, what you did as the leader specifically, one obstacle, the result.

Worked answer. "I ran the student tutoring program in my second year: twelve tutors, forty first-years. The problem in year one had been tutors not showing up. I paired every tutor with a backup and sent a reminder the day before each session. Attendance went from about seventy percent to nearly full. The thing I learned about leading is that the system matters more than the speech."

Station 34: How do you handle a team member who is not pulling their weight?

Framework. Assume a reason, talk privately, redistribute fairly, escalate only if it persists and affects patients.

Worked answer. "Privately first, and by asking, because the person who is not pulling their weight usually knows and is either drowning or dealing with something. If it were a bad week I would cover and say so. If it continued and patients were affected, I would tell the chief resident, and I would tell the colleague I was doing that. What I would not do is complain about them to the rest of the team."

Station 35: Describe a time you worked with someone very different from you.

Framework. The difference, what it made hard, what you did to bridge it, what you learned that you kept.

Worked answer. "My research supervisor worked in long silences and short emails, and I work by talking things through. Early on I read the silence as disapproval. I asked for a fifteen-minute check-in every two weeks, and that solved it; the silence was just how they worked. I learned to ask people how they like to communicate at the start rather than guessing."

Station 36: Tell us about a time you had to deliver bad news.

Framework. Preparation, setting, the words you used, what the person needed, what you would do again.

Worked answer. "On a medicine rotation I had to tell a patient that their planned discharge was cancelled because of a new lab result. Small news to us, big to them. I sat down, said it in one sentence, then waited. They were angry, and I let them be, and then explained what happened next. What I would do again is the sitting down and the waiting; what I would do better is bring the nurse who knew them."

Station 37: What role do you usually take in a team?

Framework. An honest answer with evidence, and awareness of when you take a different role.

Worked answer. "Usually the organizer: I am the one with the shared document and the timeline. On a team with a stronger organizer I have learned to be the one who does the unglamorous middle of the work instead, because two organizers is one too many."

Station 38: How would you handle a resident senior to you who gives you inconsistent instructions?

Framework. Clarify without accusation, write it down, close the loop.

Worked answer. "I would ask, once, which instruction to follow, and repeat it back so we both heard the same thing. Then I would write it down. If it happened often I would start sending a short summary message after each conversation, which protects both of us and usually makes the inconsistency disappear."

Chapter 8: Research and Scholarship

Station 39: Tell us about your research.

Framework. The question, your role, the finding, the limitation, what you would do next. Five minutes for the main project, thirty seconds for the rest.

Worked answer. "The main project asked whether a simple change to the catheter removal protocol reduced retention on our ward. I designed the audit form, collected six months of data, ran the analysis with the statistician, and wrote the manuscript. Retention dropped from about eighteen percent to about nine, but it was a before-and-after study without a control, so the honest conclusion is that it is worth a proper trial, not that it works. If I stayed on it, that trial is what I would do next."

Station 40: What is a paper you read recently that changed how you think?

Framework. A real paper, one finding, what it changed, one criticism.

Worked answer. Name a paper you have actually read in full. Say the question, the design, the one number that matters, and the thing that changed in your thinking. Then one honest limitation. Interviewers can tell within seconds whether you read it or read about it.

Station 41: How would you design a study to answer a question that matters in urology?

Framework. A question you care about, the population, the comparison, the primary outcome, the biggest threat to validity.

Worked answer. "Does a structured phone call at forty-eight hours reduce emergency visits after ureteroscopy? Adults having elective ureteroscopy with a stent, randomized to a nurse phone call or usual care, primary outcome an emergency visit within thirty days. The threat is that the call itself sends people to the emergency department; I would count that as an event and look at whether the visits were appropriate."

Station 42: What do you think about research during residency?

Framework. An honest answer that shows you know the cost and have a plan.

Worked answer. "I think one good project a year is realistic and ten weak ones is not. My plan would be to attach myself to one supervisor early, pick a question that can be answered with data the department already has, and finish it. The projects I have finished were the ones with a narrow question and a supervisor who answered emails."

Chapter 9: Resilience, Wellness, and the Hard Questions

Station 43: Explain the gap or weak point on your file.

Framework. One sentence of fact, one of what you learned, one of what changed. Then stop.

Worked answer. "I failed the first sitting of my second-year exam. I had been studying by rereading, and it does not work for me. I switched to practice questions and spaced review, passed comfortably on the second sitting, and have used that method for every exam since."

Station 44: Tell us about your biggest failure.

Framework. A real failure with your part in it, what it cost, what changed.

Worked answer. "I ran a student conference in third year and sold half the tickets we needed, because I started advertising six weeks out and the people we wanted plan their calendars months ahead. It cost the society money. The next year I started in September for a March event and handed the marketing to someone who was better at it than I was."

Station 45: How do you handle stress?

Framework. How stress shows up in you, what you do about it, evidence it works, and the point at which you would ask for help.

Worked answer. "It shows up as sleep first: I sleep less and then I get short with people. What works is exercise in the morning and a hard stop on screens at night, and I know it works because the weeks I skip it are the weeks I am worse. The point where I would ask for help is when it lasted more than a couple of weeks, and I know the program has people for that."

Station 46: What would you do if you realized you were burning out in PGY-2?

Framework. Name it early, tell someone, use the program's structures, protect the fixed points.

Worked answer. "Say it out loud to someone before it is a crisis, probably my chief resident or the program director, because they have seen it before and I have not. Then look at what is negotiable: a lighter elective block, a conversation about call distribution. And protect the things that keep me upright, which for me are sleep and running. The mistake would be to wait until I could not hide it."

Station 47: How do you respond when a patient dies?

Framework. The immediate practical duties, the emotional response honestly, what you do with it.

Worked answer. "First the practical things: the family, the documentation, the team. Then, honestly, it sits with me for a few days. What I do with it is talk to someone who was there. I think

residents who say it does not affect them are either not being honest or should be worried."

Station 48: What do you think is the biggest challenge facing urology?

Framework. A real issue, why it matters, what a resident could do about it.

Worked answer. "Access. Wait times for benign conditions like stones and prostate symptoms are long in most Canadian centres, and a lot of that is workflow rather than surgeon supply. The thing a resident can do is quality-improvement work on the pathway: the nurse-led stone clinic, the direct-to-scope pathway for hematuria. Those projects are unglamorous and they move the number."

Chapter 10: Curveballs and Questions for Them

Station 49: The curveball.

Some programs use a deliberately odd question: which instrument would you be, teach us something in two minutes, what would you do with a free year. These test composure and whether you can be interesting without a script.

Framework. Pause, smile, pick the first honest answer, give one reason, stop. Do not perform.

Worked answer. "Teach you something: how to make a proper cup of coffee with a French press. Coarse grind, water just off the boil, four minutes, press slowly. Most people press too early. It is the one thing I am confident I do better than most of the people in this room."

Station 50: Do you have any questions for us?

What it tests. Whether you are choosing them too.

Framework. Two or three questions the website cannot answer, one of which is about residents' lives. Part 5 has thirty.

Worked answer. "Two. What does a PGY-1 here do in the first month that they were not expecting? And when residents here have left the program early or late, what was the reason?"

Traps. Asking about vacation first. Asking nothing. Asking a question you already asked a resident at the social.

PART 3

Your Own Story Bank

Chapter 11: Eight Stories Answer Forty Stations

Interviewers do not want fifty different answers. They want to meet one person, and a person has a small number of formative experiences that show up again and again. Build eight stories, know each one cold, and you can answer nearly every behavioural station in Part 2 by choosing the right story and shaping it to the question.

The eight slots

Write one story for each slot. Real, specific, yours. Each should be something that happened over hours or days, not a summary of a year.

1. **The moment you chose urology.** A specific clinic, case, or conversation. Station 1 lives here.
2. **A mistake you owned.** Something you got wrong, said so, and fixed. Stations 14, 32, 44.
3. **Feedback that changed you.** The words someone said, what you did with them. Stations 6, 32.
4. **A conflict handled well.** With a peer, a senior, or a nurse. Stations 31, 34, 38.
5. **A time you led.** Any team, any size, with a result you can name. Stations 33, 37.
6. **A patient who taught you something.** Not a case report; a human moment. Stations 36, 47.
7. **A time you said no, or should have.** Safety, boundaries, fatigue. Stations 11, 19, 30.
8. **Something outside medicine.** The thing you do that is not work, with evidence you keep doing it. Stations 8, 45, 49.

The worksheet

For each story, write these six lines. Keep the whole thing under 120 words so it fits in ninety seconds spoken.

- **Setting.** Where, when, who, in one sentence.
- **The problem.** What was wrong or hard, in one sentence.
- **What I did.** Two or three specific actions, in the first person, with verbs.
- **What happened.** The result, honestly, including if it was mixed.
- **What I took from it.** One sentence, concrete, and it must describe a change in behaviour rather than a feeling.
- **Where it shows up now.** One later example of the changed behaviour. This is the line that separates a story from a lesson.

Rules that keep stories honest

- If a story makes you look purely heroic, it is not finished. Add the part you got wrong or would do differently.

- Never use a patient detail that could identify them. Change the age, the sex, and the ward. Interviewers will not check the facts; they will notice if you seem careless with privacy.
- Do not use a story about a co-resident that blames them. The interviewer may know them.
- If a story is on your file, the numbers in your story must match the file.

The one-page sheet

Once the eight are written, reduce each to a title of four or five words and put the eight titles on one page. That page sits beside your screen on interview day. When a station starts, you look down, pick the title, and look up. The story is already in you.

A composite example of one slot

This is a worked example of slot 2, a mistake owned. It is a composite, not the author's own history. Notice the length and the last line.

Setting. Third-year medicine ward, a Friday afternoon, a patient going home. *The problem.* I wrote the discharge prescription with the pre-admission dose of an anticoagulant instead of the new reduced dose. *What I did.* The pharmacist caught it and called me; I thanked her, corrected it, and told my resident before she heard it elsewhere. Then I told the patient, with the resident, what had been wrong and what was now right. *What happened.* The patient went home on the correct dose; the resident said the disclosure was the part that mattered. *What I took from it.* I read every discharge prescription against the most recent medication reconciliation, line by line, before signing. *Where it shows up now.* On my surgery rotation I found two of my own errors that way before anyone else did.

PART 4

Researching a Program in Ninety Minutes

Chapter 12: The Method

You will interview at programs you know well and programs you have never visited. The method below gets any program to the same baseline in ninety minutes and produces three things: your answer to "why this program," your questions for them, and a row in the spreadsheet you will rank from.

Minute 0 to 20: the public record

Read, in this order, and take notes in the spreadsheet as you go:

- **The program's own page**, once, for structure: number of residents per year, rotation map, research time, the named subspecialty services. Note what is missing; a program that does not mention a service usually does not have it.
- **The accreditation status**. In Canada, programs post their most recent accreditation outcome; in the United States, the accreditation body lists any program with a warning. A recent adverse finding is a question to ask, gently.
- **Faculty list against publications**. Pick three faculty, search their names in a database, and see whether they publish and with residents. Resident co-authorship is the tell for a program that actually supports research.
- **Where graduates went**. Programs list fellowships and practice locations for recent graduates or will give them on request. A program whose graduates all leave the province or all stay is telling you something either way.

Minute 20 to 50: the residents

This is the part that matters, and the part most applicants skip.

- **Find two residents**, ideally one junior and one senior, through your school's alumni, an elective, a conference, or a polite message. Ask for fifteen minutes.
- **Ask these five questions and no more**: 1. What does a PGY-2 here do on a typical week? 2. When did you first do a case as the primary surgeon with the staff scrubbed but not touching, and what was the case? 3. What is the call schedule really like in the junior years, and does it change? 4. What is the one thing you would change about the program? 5. Who in the program would you go to if you were struggling, and would you?
- **Write down their answers verbatim** as far as you can. The exact phrases are what you will use in the interview when you say "residents told me."

Minute 50 to 70: the operative reality

The website says the program trains you in everything. Find out what it actually operates on.

- Ask the residents for the rough annual volume on the services that matter to you and where the big cases go.

- Note the number of hospitals residents rotate through and the distance between them; a program spread across three sites an hour apart is a different life from one on a single campus.
- Note whether there is a dedicated robotic block, an endourology block, and a paediatric rotation, and whether paediatrics is in-house or away.

Minute 70 to 90: write the two paragraphs and the three questions

- **Paragraph one, for the personal letter and for Station 2:** two specific things you learned from residents or the record, one thing you would bring.
- **Paragraph two, for yourself only:** what worries you about the program, honestly. This paragraph is what you will reread the night before you rank.
- **Three questions** for interview day, derived from what the residents said or from a gap in the public record. Part 5 has thirty to choose from if you are stuck.

Chapter 13: The Spreadsheet You Will Rank From

Make one sheet, one row per program, with these columns. Fill it as you go, not the week before rank lists are due.

Column	What goes in it
Program and city	Name, city, number of sites
Positions	Spots per year in this cycle
Residents I spoke to	Names and dates, so you can thank them
PGY-2 reality	One line from the residents
First primary case	The answer to question 2 above
Call in junior years	Frequency and whether it is in-house
Operative strengths	The services with real volume
Gaps	What they do not have or do away
Research support	Evidence of resident co-authorship, protected time
Graduates	Where the last five went
Red flags	Accreditation findings, turnover, anything the residents flinched at
My honest worry	Paragraph two, in one line
Gut after the interview	Filled in the evening of the interview, before anything else
Rank	Left blank until every interview is done

How to use it on rank day

Sort by the gut column first, then read the honest worry column for the top five, then read the red flags. If the order changes after reading the worries, trust the change. Then sleep on it once and submit. The spreadsheet exists so that the rank list is a decision you can explain to yourself in a year, whichever way it goes.

Two rules about the rank list

Rank in the order you want, not in the order you think you can get. Both match systems are designed so that ranking a long shot first costs you nothing.

Tell a program it is your first choice only if it is, and only once. Programs remember, and the specialty is small.

Chapter 14: After the Interview

The same evening

Fill in the gut column. Write three sentences about what you noticed that the record could not have told you. Send a short thank-you if the program has not asked you not to; most Canadian programs accept a short note to the program director, and many American programs say explicitly that notes are not needed. Follow the program's stated preference over any general advice, including this book's.

The waiting weeks

Do not contact programs to ask where you stand; they cannot tell you and it reads as anxiety. Do contact a resident who helped you, to thank them, because that is simply the right thing to do and because you may work with them.

If you do not match

Both systems have a second round. In Canada the second iteration opens within days of match day and unfilled positions are listed; in the United States, unfilled urology positions are announced by the Society and filled quickly. Have a plan written before match day for what you would do in the first forty-eight hours, who you would call, and which alternative specialties or research years you would consider. Writing the plan does not make it more likely to be needed; it makes the two days survivable if it is.

PART 5

Quick Reference

Chapter 15: Thirty Questions to Ask Them

Pick two or three per interview. Prefer the ones that produce a story rather than a fact.

About the training

1. What does a PGY-1 do in the first month that they were not expecting?
2. When do residents here first do a case as primary surgeon, and which case is it usually?
3. How is the operative experience divided when two residents want the same case?
4. Which service do residents say they learn the most on, and why?
5. What does the endourology block look like in the junior years?
6. Where does paediatric urology happen, and for how long?
7. How much robotic console time does a senior resident get in a typical week?
8. What changed in the curriculum in the last two years, and why?

About the residents' lives

9. What is call like in PGY-2, and is it in-house?
10. How do residents here handle a week when one of them is away?
11. When residents have struggled, who noticed first?
12. What do residents do together outside the hospital, if anything?
13. How many residents have taken parental leave, and how did the program handle it?
14. What is the one thing residents would change?

About research and teaching

15. Which faculty publish with residents most often?
16. Is there protected research time, and is it actually protected?
17. How are residents supported to present at national meetings?
18. What teaching do residents give, and to whom?

About the program's direction

19. What was the most recent accreditation feedback, and what changed because of it?
20. Where did the last five graduates go?
21. Which fellowships have graduates matched to in the last five years?
22. Is the program growing, shrinking, or stable, and why?
23. Which faculty have joined in the last three years?

About the people

24. How would a resident describe the program director?
25. How do residents and nurses get along on the wards?
26. What happens here when a resident makes a serious mistake?

27. How is feedback given, formally and informally?

To a resident, at the social

28. What did you not know about this program before you started that you wish you had?

29. If you were applying again, would you rank it the same way?

30. What is the best day you have had here?

Chapter 16: Checklists

Two weeks before

- Story bank written, eight titles on one page.
- Program spreadsheet complete for every program on your list.
- Two or three questions chosen per program, written on the same page as the story titles.
- Your file reread, every CV line defensible in one minute.
- Practice interview done with someone who will be honest, recorded, watched once.

The day before

- Outfit chosen and checked on camera; plain colours read better on video than patterns.
- Platform tested with a friend on the actual link, camera at eye level, light in front.
- Wired connection or a hotspot ready; a phone number for the program administrator saved.
- The one-page sheet, water, and your CV within reach but out of frame.
- Sleep. Nothing you learn tonight will show tomorrow; tiredness will.

The morning of

- Log in fifteen minutes early. Sit in silence for five of them.
- Reread the program's row in your spreadsheet, once.
- Say your Station 1 answer out loud once, to warm up your voice.
- Close every other window and silence every device.

In the station

- Listen to the whole question. Pause for a beat. Pick the story or the framework.
- Situation, what you did, what happened, what changed.
- Stop when you are done. Do not fill the silence.
- If you do not understand the question, say so and ask; it is not scored against you.
- If you lose your thread, name it: "let me start that again." Interviewers respect it.

The same evening

- Gut column filled in.
- Three sentences on what the record could not have told you.
- Thank-you note if the program accepts them, three lines, no flattery.

Before you close this

The interview is not a performance of the person you think they want.

It is a conversation with people who will be your colleagues for five years, and they are trying to find out whether that will be good for both of you. Prepare so you can be yourself under pressure, then be yourself.

If a station in this book was wrong for your cycle, or if a program did something this book did not prepare you for, tell me. The next edition is written from what applicants report back.

Educational use only. Match rules, dates, and program requirements change each cycle; confirm every date against the official CaRMS and Society of Academic Urologists calendars.