In this issue of *CUAI*, Preston and colleagues present a cohort of 2 years worth of graduating Canadian urology residents who were surveyed about perceptions of their training in minimally invasive surgery (MIS) and endourologic surgery.\(^1\) Most residents (about two-thirds) felt that their clinical laparoscopic experience was good or extensive. Moreover, most residents believe that laparoscopic renal and adrenal surgery are the gold standard, but they are less certain regarding the future value of laparoscopic/robotic prostatectomy.\(^4\) Overall, 33% of index cases are now recorded by residents as being taught in a MIS fashion. This raises a question regarding whether certain open surgeries should no longer be considered part of the core objectives of training in urology. These objectives are set and periodically revised by the urology specialty committee members. Briefly, procedural objectives are categorized into an “A”, “B”, or “C” list according to levels of complexity. Category “A” procedures are those defined as “...the fully trained resident must be competent to individually perform, in addition to being able to manage the patient prior to, during and after...”. Category “B” procedures “…are those that the resident will know how to do, including indications...the resident may not have actually done one of these procedures independently during the residency training period.” Category “C” procedures “…are those for which the resident will be able to describe the procedure, the indications, and the perioperative complications that might be encountered.”\(^5\) Should open renal and prostatic surgeries be reclassified from the “A” list of procedures to the “B” list?

In July 2009 the Accreditation Council for Graduate Medical Education (ACGME) mandated minimal numerical thresholds for procedures as part of the accreditation process for urology residency programs.\(^6\) It is not hard to imagine a similar edict from our own Royal College in the near future. The next challenge will then be the determination of how many open procedures trainees should be exposed to in order to be considered competent.

Will general urologists of the next generation be relegated to the triage of patients for interventional radiologists and a subset of urologists who are fellowship-trained in complex open procedures? Should we be reconsidering a switch to 2 or more streams of training so that there are competent open surgeons, laparoscopists and endourologists? There are no simple answers to these complex issues which have arisen due to advances in technology.
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