Findings from the inaugural national Canadian Resident Census

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Appendix available at *cuaj.ca*

ABSTRACT

INTRODUCTION: Despite the importance of residents and fellows to the national urologic workforce, comprehensive data describing Canadian urology trainees has been limited. This study reports findings from the inaugural Canadian Urological Association (CUA) Resident Census.

METHODS: A national, cross-sectional, anonymous, electronic survey of Canadian urology residents and fellows was conducted between May and August 2025. Survey development was led by the CUA Resident and Fellow Committee and the Postgraduate Training Committee. Descriptive statistics were used to characterize demographics, recruitment, training experiences, workload, career planning, and future priorities.

RESULTS: Of 271 eligible trainees, 143 responded (53%), including 116 residents (81%) and 27 fellows (19%); 33.7% of respondents were female and 2% were queer/non-binary. Urology trainees reported high satisfaction with the residency match process. Almost all residents (89%) indicated their intention to pursue fellowship training, most commonly in oncology and endourology. Insufficient exposure was greatest among andrology, urogynecology/reconstructive pelvic surgery, and gender-affirming care subspecialties. Trainees reported working an average of 75 clinical hours per week, with over half exceeding 80 hours. Over one-third (36%) reported experiencing mistreatment during training, most frequently from clinical supervisors.

CONCLUSIONS: This first national CUA Resident Census identified changing trends in demographics, while also highlighting potential issues such as high workload and variable subspecialty exposure. Limitations included a moderate response rate, regional overrepresentation of larger provinces, and reliance on self-reported data. These findings establish a baseline to inform advocacy, educational planning, and future longitudinal assessment.

INTRODUCTION

Urology training in Canada is undergoing a period of significant evolution, shaped by changes in trainee demographics, educational expectations, workforce planning, and increasing attention to trainee well-being, equity, and professional sustainability.[1-4] Despite the importance of learners within the Canadian urologic workforce pipeline, there has historically been a paucity of data describing the demographic characteristics, training experiences, working conditions, and priorities of Canadian urology trainees.

To date, the Canadian Urological Association (CUA) has not conducted a comprehensive national census of urology trainees. As the largest professional organization representing urology in Canada, the CUA's mandate includes *"Fostering excellence in urologic practice through advocacy, education, research, and practice support tools."* Conducting a national resident and fellow census aligns directly with this mission by providing data to inform advocacy efforts, guide educational initiatives, and support evidence-based decision-making related to urology training.

The primary objective of the first CUA Resident Census was to systematically characterize the current Canadian urology training workforce, including demographic features, training pathways, work and educational environments, and career-planning considerations. A secondary objective was to establish a baseline dataset that can be used for longitudinal comparison in future censuses, enabling the CUA to monitor trends and changes in training over time. An additional goal was to identify the most pressing priorities, challenges, and concerns

facing urology learners across Canada, thereby strengthening the CUA's ability to advocate on behalf of trainees at institutional, provincial, and national levels.

METHODS

Study design and oversight

The CUA Resident Census was a national, cross-sectional survey of urology trainees enrolled in Royal College-accredited Canadian urology residency and fellowship programs. The initiative was led by the CUA Resident and Fellow Committee (RFC) and Postgraduate Training Committee, with oversight and support from the CUA Board of Directors (BoD).

The initial proposal for the census was presented to the CUA BoD in the winter of 2024 by the RFC and was subsequently approved. Survey development and dissemination were conducted in collaboration with Léger, a Canadian market research firm that has previously worked with the CUA on member censuses.[5]

Survey development

Survey content was developed through a multistep, iterative process. Initial question domains and items were generated by the CUA Postgraduate Training Committee, informed by prior CUA censuses, emerging issues in postgraduate medical education, and known areas of concern within urology training. These questions were then reviewed and refined by the RFC to ensure relevance for urology residents across all stages of training. This allowed for direct input from urology residents across Canada to ensure the census addressed issues of importance to trainees and reflected resident experiences.

In addition, the CUA Equity, Diversity, Inclusion, and Accessibility Officer reviewed the survey to provide guidance on inclusive language, equity-oriented data collection, and appropriate framing of sensitive topics. Questions related to mistreatment during training were informed by the University of British Columbia Faculty of Medicine's definition of mistreatment, which was provided to respondents, specifically: "Learner mistreatment is disrespectful or unprofessional behavior directed at a learner or a group of learners that has a negative effect on the learner or the learning environment. Mistreatment is any conduct that is contrary to the principles that support a respectful environment and includes making demeaning, offensive, belittling, and disrespectful comments, using abusive language, engaging in bullying, harassment, and discrimination."[6]

Survey content and administration

The final census instrument included a combination of multiple-choice, Likert-scale, and open-ended questions (Appendix available at *cuaj.ca*).

Léger administered the survey electronically using a secure online platform, in both French and English. Invitations were sent to CUA urology residents and fellows via email and social media, with reminders issued between May 2 and August 17, 2025, to maximize participation. Participation was voluntary, and responses were collected anonymously. All members who completed the census were offered a $25 Amazon gift card as an incentive.

Data analysis

Léger performed data cleaning and descriptive statistical analyses. Results were reported using counts, proportions, and descriptive statistics, as appropriate. Standard deviations (SD) were reported, and results were reported when statistically significant with a 95% confidence interval.

RESULTS

Demographics

From a potential pool of 271 residents and fellows registered as CUA members, 143 trainees (53%) completed the census. Of these, 116 (81%) were residents and 27 (19%) were fellows.

Response rates varied by region, with the highest participation in Manitoba (64%) and the lowest participation in the Atlantic provinces (~30%). Most respondents trained in Ontario (45%), Quebec (27%), and British Columbia (10%) (Figure 1). This distribution largely mirrors CUA trainee membership, although Atlantic trainees were underrepresented.

The mean age of residents was 30 years (SD 3.0), while fellows had a mean age of 33 years (SD 3.2). The majority of respondents identified as male (61% of residents and 78% of fellows), mirroring trends seen in both CUA and American Urological Association (AUA) data on practicing urologists.[5,7] Notably, the proportion of female trainees (36% residents and 22% fellows) was higher than reported for Canadian urologists in practice (17%), reflecting an increase in female representation over time (Figure 2).[5] Of note, 2% of respondents identified as queer or non-binary.

Among both residents and fellows, the largest number of respondents identified as White (46%), followed by Middle Eastern/North African (16–17%). The most underrepresented ethnic groups were Latin American, Indigenous, Black, and Southeast Asian. The most com-

monly disclosed sexual orientation among trainees was heterosexual (86% overall), followed by bisexual (6% of residents, 0% of fellows) and gay (4% of residents, 2% of fellows). This demonstrates a higher percentage of non-heterosexual people than the general Canadian population aged 15 years or older (4.4%).[8]

With respect to educational background, most respondents completed medical school in Canada (87%), which closely aligns with findings showing that 90% of practicing urologists reported attending a Canadian medical school (Figure 3).[5]

Language use in clinical practice reflected Canada's multilingual context. English was the primary language of practice for 72% of respondents, while 19% primarily used French, and 9% reported routine use of both official languages. Over half of trainees (55%) reported speaking at least one additional language (Figure 4). This linguistic diversity highlights the growing multicultural capacity of the urology workforce in Canada, with potential implications for patient communication, equity, and access to care.[9]

CaRMS satisfaction, ranking preferences, and interview format

Most respondents (93%) reported high satisfaction with the Canadian Resident Matching Service (CaRMS) interview process, which was consistent across roles and provinces. Similarly, 93% of respondents matched to one of their top three ranked programs, which was greater than the CaRMS 2025 match rate for both surgical disciplines (85%) and all medical disciplines (84%).[10] This suggests that urology trainees may experience a comparatively better alignment between their program preferences and match outcomes.

Regarding the format of the residency interview, about two-thirds (64%) preferred in-person interviews over virtual platforms (36%). This preference was even stronger among fellows, with 85% indicating in-person interviews as their preferred format, compared to 60% of residents. This finding is discordant with the Association of Faculties of Medicine of Canada (AFMC) mandate to exclusively provide virtual interviews for medical residencies.

Geographic location was the most important factor influencing CaRMS rankings, with 61% of respondents including it in their top three considerations and 29% ranking it as the most important (Figure 5). Operative exposure followed, ranked in the top three by 47% of respondents and identified as the #1 factor by 15%. Program culture and work environment were also highly valued, appearing in the top three for 37% of respondents and the #1 factor for 18%. Other factors, such as program reputation, resident cohort, faculty, teaching opportunities, and future employment prospects, were valued less. Residents and fellows shared similar priorities, although fellows tended to prioritize operative exposures more than residents (54% vs. 46%, respectively).

Exposure to subspecialties and fellowship interest

Across Canada, urology residents reported the greatest exposure to oncology and endourology/minimally invasive surgery (MIS). In contrast, substantial proportions reported insufficient exposure to several subspecialties, including gender-affirming surgery (48%), urogynecology and reconstructive pelvic surgery (URPS) (36%), and andrology (36%) (Figure 6A). While this pattern is partly expected given that endourology/MIS and oncology are the most prevalent subspecialties nationwide (27–33%), it is notable that insufficient exposure was disproportionate in andrology and reconstructive surgery, despite these subspecialties being more common than pediatric urology and transplant surgery.[5]

In the U.S., residents report higher exposure to subspecialties with limited training in Canada, such as URPS and andrology, but lower exposure to transplant surgery, with the latter likely reflecting differences in service provision between the two countries.[11] Adequate exposure supports both clinical competence and confidence in caring for a wide spectrum of urologic disease, which is particularly important given the predominance of general urology practice in Canada (47%).[5]

Following residency, most Canadian urology residents planned to pursue fellowship training (89%), with rates ranging from 72% in Quebec to 96% in Ontario. This strong interest appears largely driven by perceived job market demands, as 76% of residents and fellows felt that fellowship training was necessary to secure a desired

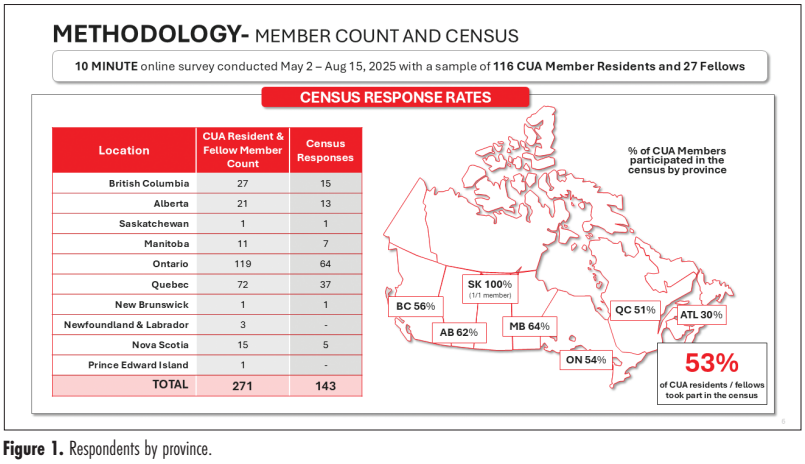

Figure 1. Respondents by province.

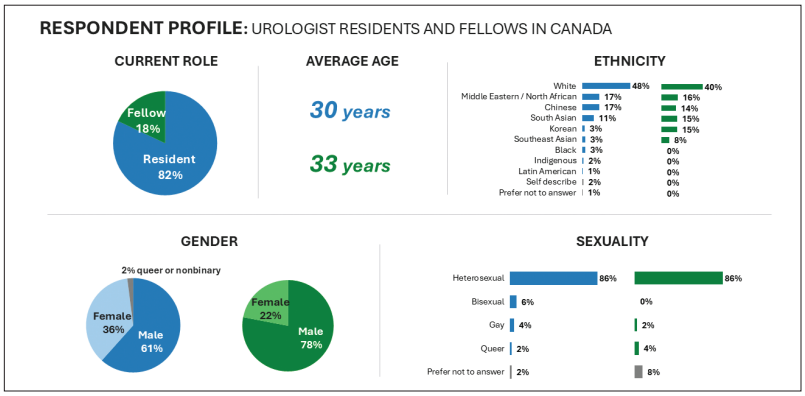

Figure 2. Demographic profile in 2025, including role, age, ethnicity, gender, and sexuality.

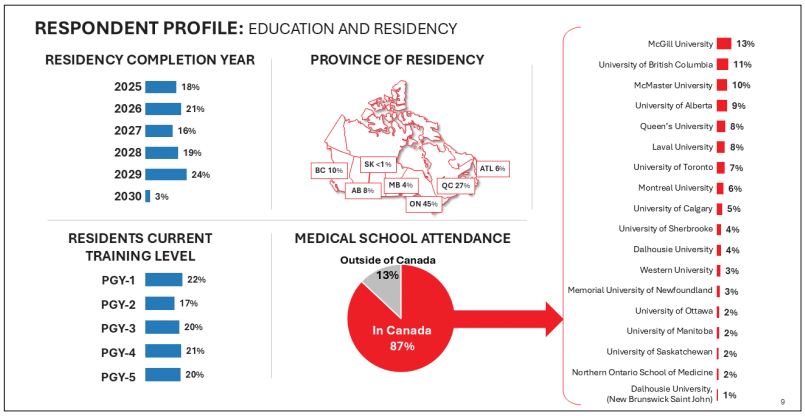

Figure 3. Data on trainee level, province of residency, and medical school attendance.

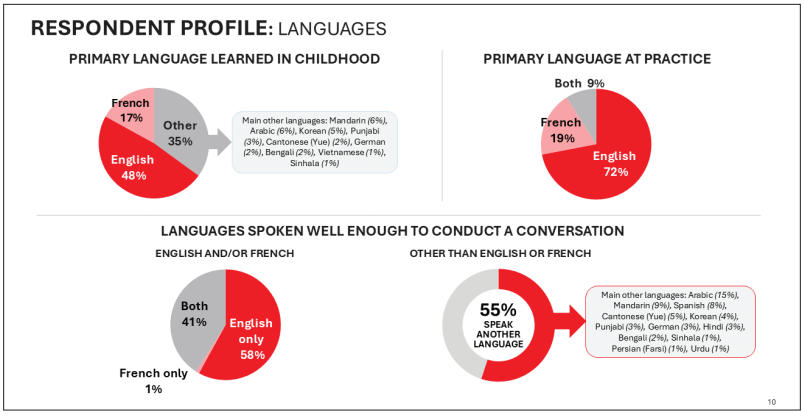

Figure 4. Languages learned in childhood and spoken in practice and outside of work.

job. Residents and fellows also cited academic interests (48%) and residency exposure/strong mentorship (33%) as key factors influencing fellowship decisions. In Canada, the most common fellowship subspecialties are endourology/MIS (35%) and oncology (35%) (Figure 6B).

Although a smaller proportion of urologists in the U.S. ultimately complete fellowship training (just under half), subspecialty patterns were similar to Canada, with training concentrated in oncology, robotic surgery, and endourology/stone disease.[7] While the decision to pursue fellowship is ultimately individualized, limited residency exposure to subspecialties such as andrology and URPS may contribute to lower fellowship interest in these areas. Variation in urologic disease burden across conditions underscores the need to align residency exposure, fellowship availability, and workforce planning with population-level needs.

In-program educational experiences

Protected time before the Royal College examination was consistent nationally, with 90% of residents and fellows reporting dedicated time off clinical duties; however, the number of weeks off before the Royal College examination differed significantly across provinces. For example, Ontario and Quebec were among the provinces with the fewest number of weeks off (Ontario: 2.6 weeks, Quebec: 4.3 weeks), with the remainder of Canada reporting six weeks off. To prepare for examinations, more than 60% of residents performed at least 1–2 mock objective structured clinical examinations (OSCEs) a year, with an average of four mock OSCEs per year. The average time spent studying per week was six hours for residents and four hours for fellows.

With regard to scholarly activity, 43% reported they did not have sufficient time, with this being more common for trainees working over 80 hours per week. Approximately 68% of trainees described having access to research years or a clinician-investigator program. Finally, the responsibility of academic half-day teaching was generally delegated to faculty, with the most common type of academic half-day style being faculty-led (39%), followed by resident-led (27%).

Work hours and call burden

Nationally, residents and fellows reported a mean 75-hour clinical workweek (Figure 7), plus six hours of study and five hours of research. More than half of Canadian residents reported working more than 80 hours solely on clinical activity. This was comparable to results from American resident cohorts, where more than 51% of residents reporting more than 80 hours of clinical duty per week.[11,12] These clinical hours are significantly higher than those reported in the 2024 CUA Member Census, which reported an average of 46 hours/week spent on clinical activity across all CUA practicing urologists.[5] Burnout among urologists has been previously associated with high work hours (>80 hours per week), raising important concerns for urology trainees in our current system.[13]

Gender differences were noted across reported clinical work hours. Female residents reported, on average, seven more hours spent on clinical activities than male residents, with female residents reporting 79 hours (SD 16.5) of clinical activity per week and male residents reporting 72 hours (SD 16.2) (Figure 7). This was a statistically significant difference. This difference also translated to the number of on-call hours. The average total hours of on-call duties was 23 hours for trainees, but female trainees reported more on-call hours (29 hours, SD 20.6) than male trainees (20 hours, SD 15.1), and this was statistically significant.

Sex differences in work hours between Canada and the U.S. remain equivocal among practicing urologists.[5] Male attendings in the AUA workforce report from 2021 had slightly less work hours than female staff (female: 45.7 hours/week vs. male: 43.7 hours/week) but there was no significant difference in a 2014 AUA Census.[14,15] Possible explanations for this finding could be that a larger proportion of female residents are more junior and thus have a higher call burden, or possibly that there happens to be more female residents in urology programs with higher call burden.

Workload was highlighted as a primary issue for urology residents, with 58% citing workload, long hours, and lack of sleep as the largest stressors in training. The average number of call days was seven days per block for residents/fellows in the current study, which is the same amount as those reported by Canadian staff urologists.[5] Of those on-call days, one-quarter of residents received post-call days, with post-call days being more frequently used in postgraduate years 1 and 2 (37%) compared with senior residents (19%). Similar call burdens and low uptake of post-call days have been reported in surveys of Canadian plastic surgery residents.[12] Overall, while duty hours are subject to recall bias in surveys, the data are consistent across Canada and the U.S., with residents reporting high work hours and relatively significant call burdens.

Mistreatment

A total of 50 (36%) respondents felt they had been mistreated during their residency. Female residents (49%) were more likely to respond that they had been mistreated compared to male residents (31%). Furthermore, 47% of those who self-reported working 80 hours or more also reported experiencing mistreatment, as opposed to 23% of those who worked less than 80 hours. For those who did report mistreatment, clinical supervisors/staff were cited as the most common source at 85%. Other sources of mistreatment, from most to least common, were patients (59%), allied health professionals (53%), co-residents (44%), administration (24%), and other (7%).

This adds to the growing body of literature showing that female surgical trainees experience increased rates of mistreatment compared to their male counterparts,

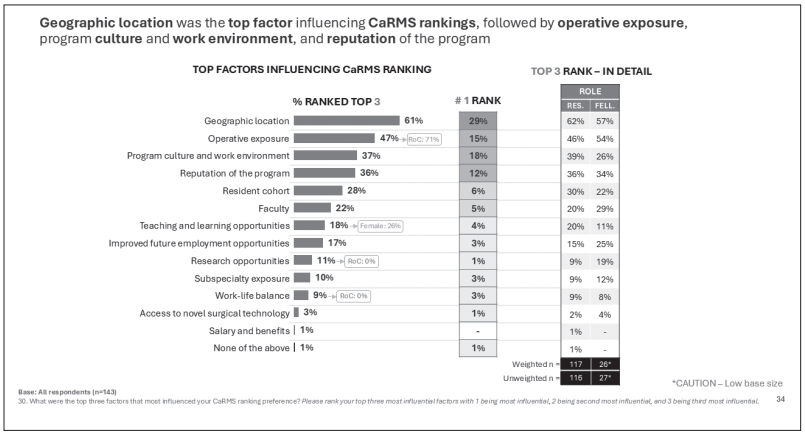

Figure 5. Factors affecting residency program ranking for current urology trainees.

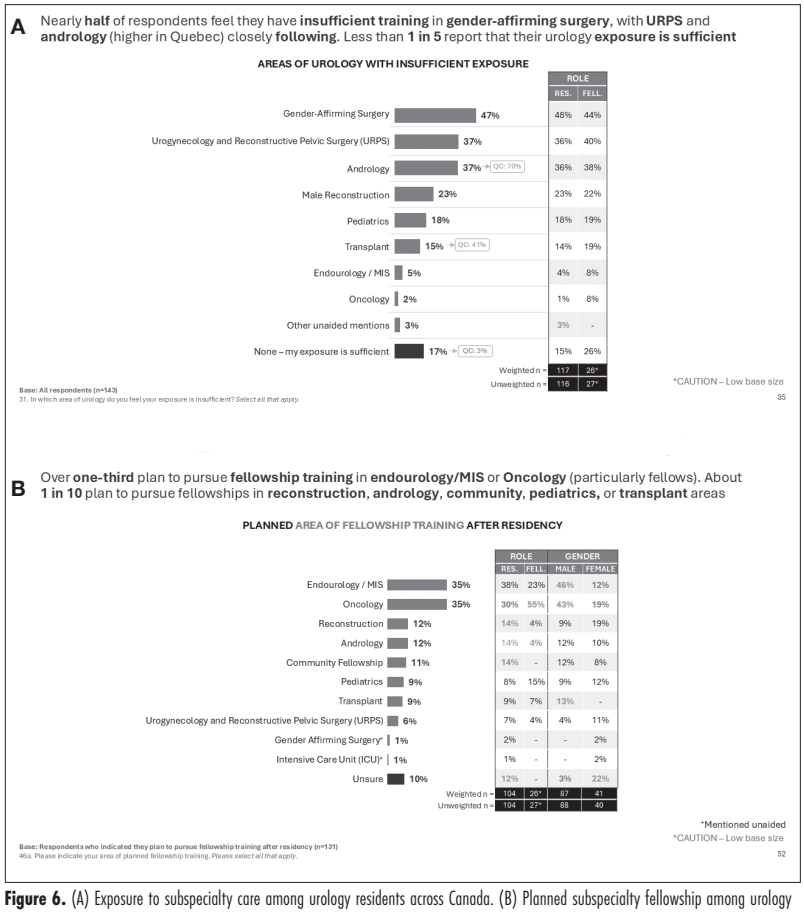

Figure 6. (A) Exposure to subspecialty care among urology residents across Canada. (B) Planned subspecialty fellowship among urology residents in Canada. MIS: minimally invasive surgery; URPS: urogynecology and reconstructive pelvic surgery.

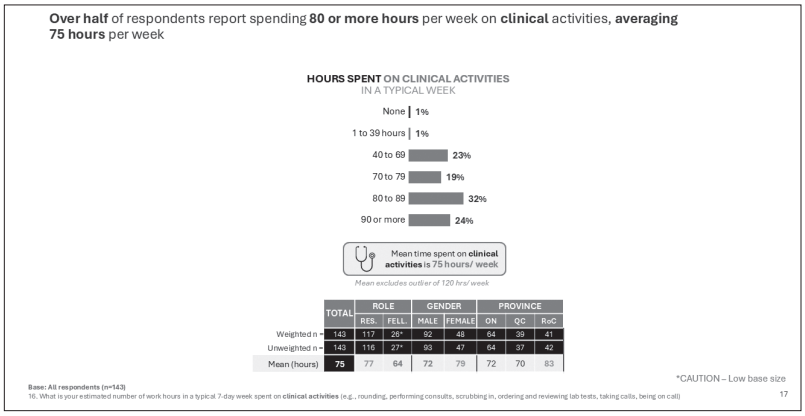

Figure 7. Average hours spent on clinical activities by Canadian urology trainees.

with many reporting specific instances of gender discrimination.[16,17] Our finding of a self-reported mistreatment rate of 36% was similar to the 29–63% rates of bullying, discrimination, and harassment described by surgical trainees in the literature.[16-18] Mistreatment can affect trainee wellness and lead to burnout. Although burnout was not a focus of this census, burnout has been shown to be a significant issue among urology trainees, affecting 48% of American residents.[4]

Artificial intelligence and clinical practice

Urologic care in Canada is largely digitized, with 89% of residents reporting routine use of electronic medical records in clinical practice. Despite this high level of digital infrastructure, integration of artificial intelligence (AI) into clinical workflows remains limited. Only 8% of Canadian urology residents and fellows reported using AI in their clinical work, a proportion similar to that reported by practicing urologists nationwide (7%).[5] This finding may be undermeasured, as the survey did not include specific prompts regarding potential AI applications. This low uptake contrasts with generally favorable attitudes toward AI among younger urologists.[7] At the same time, caution is warranted for trainees adopting large language models such as ChatGPT, as these tools have not yet been shown to reliably pass high-yield assessments, including the AUA's Self-Assessment Study Program and the simulated Canadian board examination.[19,20]

One in 10 trainees reported satisfaction with current CUA efforts to enhance urology training, highlighting opportunities for further development and refinement. When asked about priorities for future CUA investment, trainees most commonly identified educational development (24%) and the provision of additional resources (19%). AI-enabled initiatives represent a promising and timely area for exploration as the CUA continues to modernize training and support resident well-being. Qualitative responses identified AI-assisted scribing and note-generation as the most frequently cited use of AI in urology practice, mirroring previously published findings from practicing urologists.[5] AI scribes have the potential to reduce administrative burden and mitigate clinician burnout, although large-scale trial data are still emerging.[21,22]

Supporting this interest, a small Canadian study by Maryousef et al found that 90% of urology trainees and staff expressed a desire to use AI scribes to streamline documentation.[23] This represents a concrete opportunity for the CUA to support residents through targeted, urology-specific guidance on AI implementation. Practical implementation strategies have already been described and could inform such efforts.[24]

Limitations

The purpose of this census was to understand the demographic characteristics, educational experiences, and career goals of the urology trainees across Canada; however, the overall response rate was 53%, meaning that nearly half of eligible participants did not complete the survey. While comparable to response rates seen in the general CUA Census data, it nonetheless raises the possibility that the sample may not fully represent the overall trainee population.[5]

Although the survey successfully engaged trainees from across the country, provinces with larger trainee populations predictably contributed disproportionately more respondents. Approximately 71% of survey participants were training in either Ontario or Quebec. As a result, the experiences captured may not fully reflect those of trainees in less populated regions and may overemphasize the perspectives of those in larger academic centers.

As with any survey-based design, there were also inherent limitations related to self-reported data. Responses may reflect personal perceptions or recall bias, particularly for questions related to workload, well-being, and satisfaction. Respondents may underreport negative experiences, such as burnout or harassment, or overreport positive experiences due to confidentiality concerns within a small specialty.

Finally, the survey captured a cross-sectional snapshot over a single time period, not accounting for temporal variations. Future annual censuses will enable beter assessment of trends.

Future directions

Future iterations of the CUA Resident Census may benefit from strategies aimed at improving participa-

tion, representativeness, and data depth. Increasing response rates may be achieved through endorsement from program directors, extended survey windows, and peer encouragement.[25] Focused outreach to trainees in underrepresented regions, such as the Atlantic provinces, may help ensure more balanced national representation.

To obtain more granular data, the use of validated instruments to assess wellness, burnout, and educational satisfaction may strengthen findings.[26] While this represents the first census of its kind conducted by the CUA, there is an opportunity for repeated censuses or cohort followup, which would allow for assessment of trends over time and the impact of changes in training structure and policy. Future survey directions may include dedicated questions on experiences related to socioeconomic background, international medical graduates, further probes into burnout and mistreatment, and changes in subspecialty exposure over time.

CONCLUSIONS

The inaugural CUA Resident Census provides the first comprehensive, national snapshot of the Canadian urology trainee workforce, capturing evolving demographics, training experiences, workload, and career aspirations. The findings highlight a cohort that is increasingly diverse and highly motivated, yet challenged by substantial clinical workload, variable subspecialty exposure, and perceived experiences of mistreatment. The strong intent to pursue fellowship training underscores workforce pressures and gaps in residency preparation, while emerging interest in educational innovation and AI reflects changing expectations of modern training environments. Collectively, these data establish a critical baseline to inform CUA advocacy, workforce planning, educational reform, and improve the training experience for future generations of Canadian urologists.

COMPETING INTERESTS: The authors have no competing personal or financial interests to disclose.

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