

Portfolio:	Education	Ref. No.	ETA-IMG-038
Team:	Specialist International Medical Graduate Assessment		
Title:	Assessing a Specialist International Medical Graduate's Comparability to an Australian and Aotearoa New Zealand Trained Surgical Specialist		

1. PURPOSE AND SCOPE

- 1.1. The standards of practice of the Royal Australasian College of Surgeons (RACS) Surgical Education and Training (SET) program (including AOA 21 Program for orthopaedics) have been accepted by the Medical Board of Australia (MBA) and the Medical Council of New Zealand (MCNZ) as those required for registration to practice as a surgical specialist.
- 1.2. A Specialist International Medical Graduate (SIMG) is a doctor who has undertaken a specialist surgical training program outside Australia and Aotearoa New Zealand and is seeking to be assessed for comparability to an Australian and Aotearoa New Zealand trained surgeon.
- 1.3. When assessing a SIMG for comparability, RACS will consider the training program completed and subsequent to that any further training, assessment, experience, recent practice and continuing professional development (CPD) undertaken by the SIMG to determine whether all these components will enable the SIMG to practice at a level comparable to the standard expected of an Australian and Aotearoa New Zealand trained surgical specialist commencing in the same field of practice.
- 1.4. In accordance with the requirements of the MBA, and with respect to the Specialist Assessment of Specialist International Medical Graduates in Australia policy, the Board of Surgical Education and Training (BSET) or Executive BSET will determine if a SIMG's training and experience, in comparison to an Australian and Aotearoa New Zealand trained surgical specialist is:
 - a. Substantially Comparable
 - b. Partially Comparable, or
 - c. Not Comparable.
- 1.5. This policy defines the process for assessing the comparability of a SIMG to an Australian and Aotearoa New Zealand trained surgical specialist.

2. KEYWORDS

Specialist; International; Medical; Graduate;, Comparability, Assessment; Examination; Surgical; Specialist; Training; Education; Experience

3. RECENCY OF PRACTICE

3.1. Assessing Recency of Practice

- 3.1.1. A SIMG will be regarded as having recent clinical practice if they have documented evidence that demonstrates that in the last 2 years they have:
 - a. Evidence of medical and specialist registrations; and
 - b. A minimum of 12 months practice in the relevant surgical speciality; and
 - c. A minimum of 6 months of continuous practice in the relevant surgical speciality; and
 - d. A minimum of 100 major cases as primary operator; and

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- e. Evidence of involvement in the following areas of Continuing Professional Development:
- Peer reviewed audit
 - Maintenance of knowledge and skills

4. COMPARABLE SPECIALIST SURGICAL TRAINING

4.1. The Comparability Framework

- 4.1.1. In making the assessment of comparability, the assessors will identify the common features of the training program completed by the SIMG to the components of the SET program (including AOA 21). Reference to a comparable training program indicates that it has common features to the SET program but does not imply that it is identical.
- 4.1.2. Implicitly or explicitly, the training program being assessed will need to demonstrate that it incorporates teaching and assessment of the competencies of:
- a. Collaboration and teamwork
 - b. Communication
 - c. Cultural competence and cultural safety
 - d. Health advocacy
 - e. Judgement - clinical decision making
 - f. Leadership and management
 - g. Medical expertise
 - h. Professionalism
 - i. Scholarship and teaching
 - j. Technical expertise
- 4.1.3. In the assessment process RACS relies on documentation provided by the SIMG to demonstrate comparability of their education and training. RACS is not obliged to assume comparability where evidence is not provided, or to actively seek additional information to supplement that which has been provided.

4.2. Common Features required of a Comparable Education and Training Program

- 4.2.1. A comparable education and training program will have been accredited by an external accreditation agency whose role is similar to the Australian Medical Council (AMC) and the MCNZ in assessing minimum standards in specialist medical education.
- 4.2.2. A comparable education and training program will include experience in accredited training positions that:
- a. Provided individual rotations not less than three months in duration.

Portfolio:	Education	Ref. No.	ETA-IMG-038
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- b. Were located at more than one teaching institution, or, if at one institution, included rotations in 3 or more units.
- c. Included operative experience both assisting and as primary operator under supervision, with an increase in responsibility over the life of the program.
- d. Provided exposure to the teachings and practices of multiple surgeons.
- e. Formative and summative in-training assessment of technical and non-technical competencies which must have been undertaken by multiple surgeons. Such assessment examples include Direct Observation of Procedural Skills (DOPS) and mini Clinical Examination (Mini-CEX).
- f. Provided for the involvement in the full spectrum of care of patients pre and post operatively and in emergency, acute and elective settings and the opportunity for the trainee to develop independent decision making pre and postoperatively in the management of patients.
- g. Provided exposure to weekly consultant supervised outpatient clinics or other clinics where independent but supervised decision making in the preoperative and postoperative setting is possible.
- h. Provided experience covering a similar range of procedures, approaches and treatments to the SET program (including AOA 21).

4.2.3. Evidence of the training program completed must include:

- a. A copy of the training program curriculum that pertains to the period that the SIMG completed the training program; and
- b. A copy of the training program regulations and/or policies that pertains to the period that the SIMG completed the training program.

4.2.4. The training program will have included research through projects or courses that develop research skills.

4.2.5. Recognising that some skills are best developed by specific intensive courses, graduates of a comparable education and training program will have undertaken specific training courses such as surgical skills, the emergency management of severe trauma, care of the critically ill surgical patient and radiation safety.

4.2.6. Specific requirements for each specialty are listed in Appendix A.

4.3. Comparable Exit Examination

4.3.1. It is expected that an exit examination will assess the competencies of:

- a. Judgement - Clinical Decision Making
- b. Medical Expertise
- c. Communication

Portfolio:	Education	Ref. No.	ETA-IMG-038
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- 4.3.2. The exit examination should include:
- a. Examination of candidates by multiple external examiners using a predetermined scoring system; and
 - b. Multiple examination segments that include written and oral examination of a candidate's ability to demonstrate attainment of the required competencies.
- 4.3.3. Given the difficulties of comparing the standard of examinations from around the world, RACS does not recognize any particular examination as being comparable to the RACS Fellowship Examination (FEX). It will assess the examination process together with the training undertaken by the SIMG.

4.4. Post Graduate Training and Experience

- 4.4.1. Many overseas training programs have some deficiencies or differences as compared to Australian and Aotearoa New Zealand surgical education and training program. These deficiencies include the duration of training, the number of cases performed during training, the number of institutions involved in training, the number of surgeons involved in training and the breadth of training. Many surgeons go on to further, less structured positions, which may be described as Fellowships, Senior Registrar positions or similar. If a position is to be considered as part of the overall training package of the SIMG there should be evidence that the position has all of the following features:
- a. Addresses identified gaps in the training program
 - b. Enables acquisition of new and/or reinforcement of existing skills
 - c. Has exposure to multiple surgeons
 - d. Has a significant volume of primary operating
 - e. Allows independent clinical decision making
 - f. Involves responsibility for patient management
 - g. Include documented structured feedback or assessment which confirms a level of proficiency equivalent to Consultant level

Specific evidence is required. This must include logbooks summaries, position descriptions, and reports from supervisors which indicate the SIMGs performance across all RACS competencies.

4.5. Depth and Scope of Practice

- 4.5.1. If a SIMG has less than 5 years of consultant practice they will be judged at most, as partially comparable and if so, will be required to undertake the Fellowship Examination.
- 4.5.2. If a SIMG has 5 or more years of independent consultant level practice the depth and scope of that practice will be assessed.
- 4.5.3. Independent practice must include responsibility for, and decision making regarding pre-operative, intra-operative and post-operative care.

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Portfolio:	Education	Ref. No.	ETA-IMG-038
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4.5.4. The standard of comparison is that of an ANZ trained surgeon with 5 or more years of independent practice. To meet this requirement the SIMG must demonstrate that they have the ability to:

- a. manage emergency presentations across the breadth of the specialty
- b. perform a suitable range of emergency procedures

4.5.5. It is recognised that the scope of many surgeon's practice becomes narrower over time but must include the ability to manage the relevant specialty specific presentations as listed in Appendix B. There is no expectation that the SIMG will perform the whole range of the specialty. A practical test would be to consider whether or not the SIMG could safely be on call at a medium sized hospital.

4.6. Non-Technical Skills

4.6.1. Non-technical competencies are extremely important to all surgeons. RACS requires all referee reports to address all RACS competencies (including AOA 21).

4.6.2. At interview a series of structured questions and scenarios will be utilized to assess the non-technical competencies of the SIMG. The results of this assessment will be highly influential in the final determination of comparability.

5. ASSOCIATED DOCUMENTS

Regulations

Specialist Assessment of Specialist International Medical Graduates in Australia
Aotearoa New Zealand Vocationally Registered Doctors Applying for Fellowship
SIMGs Assessed with a Defined Scope of Practice

Standards

Specialist medical college assessment of specialist international medical graduates (at Medical Board of Australia)

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Appendix A: Specialty Specific Training Requirements

This document defines the standards applied by each surgical specialty in assessing the comparability of a SIMG to an Australian and Aotearoa New Zealand trained surgeon within the same surgical specialty.

1. CARDIOTHORACIC SURGERY

- i) Competence in cardiac thoracic surgery with a minimum of 24 months supervised training in a Board approved institution. The training requirements are in line with SET 5 and SET 6 Cardiothoracic trainees.
- ii) Competence in paediatric surgery as assessed by the Board approved Paediatric unit.

2. GENERAL SURGERY

- i) Minimum of 48 months of training in general surgery and its subspecialties.
- ii) Minimum of 300 major cases as primary operator.
- iii) Competence in diagnosis and treatment in the following areas:
 - Abdominal wall
 - Bariatric
 - Breast
 - Colo-ano-rectal
 - Endocrine
 - Head and neck
 - Hepatobiliary and pancreatic
 - Lymphatic system and spleen
 - Oesophago-gastric
 - Skin and soft tissue
 - Small bowel
- iv) Competence in recognising and managing sepsis, trauma and other acute surgical conditions.
- v) Competence in gastroscopy and colonoscopy (diagnostic and therapeutic).

3. NEUROSURGERY

- i) Minimum of 60 months of training in neurosurgery, undertaken in more than one training institution over the life of the training program.
- ii) Involvement in 1200 major neurosurgical cases including both assisting and as the primary operator under supervision with an increase in responsibility over the life of the training program.
- iii) Experience in operative procedures covering the full range of neurosurgical procedures, approaches and treatments provided in the SET program.

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Team:	Specialist International Medical Graduate Assessment		
Title:	Assessing a Specialist International Medical Graduate's Comparability to an Australian and Aotearoa New Zealand Trained Surgical Specialist		

- iv) Participation in neurosurgical research and research outcomes comparable to that required in the SET program.

4. ORTHOPAEDIC SURGERY

- i) Minimum of 48 months of training in orthopaedic surgery.
- ii) Exposure and assessment as primary surgeon to the breadth of orthopaedic practice including:
- Elbow
 - Foot and ankle
 - Hand and wrist
 - Hip
 - Knee
 - Paediatrics
 - Shoulder
 - Spine
 - Systemic medical conditions
 - Tumour and tumour-like conditions
 - Trauma and injury
- iii) Exposure to, and assessment in, the non-technical (AOA 21 Foundation) competencies.

5. OTOLARYNGOLOGY HEAD AND NECK SURGERY

- i) Minimum of 60 months of training in otolaryngology head and neck surgery.
- ii) Minimum of 250 type A cases (as per RACS MALT logbook)
- iii) Minimum of 250 type B cases (as per RACS MALT logbook)
- iv) Minimum of 50 type A cases in each of Head and Neck, Otolaryngology and Rhinology
- v) Exposure to and competence in the following areas:
- Facial plastics
 - Head and neck
 - Laryngology
 - Otolaryngology
 - Paediatric otolaryngology
 - Rhinology

6. PAEDIATRIC SURGERY

- i) Minimum of 72 months of training.
- ii) Proficiency in basic sciences including anatomy and embryology applicable to the practice of paediatric surgery.
- iii) Competence in the following areas as expected by the end of RACS Senior SET, laid out in RACS Paediatric Surgery curriculum:
- Abdominal
 - Abdominal wall

Portfolio:	Education	Ref. No.	ETA-IMG-038
Team:	Specialist International Medical Graduate Assessment		
Title:	Assessing a Specialist International Medical Graduate's Comparability to an Australian and Aotearoa New Zealand Trained Surgical Specialist		

- Genito-urinary
- Head and neck
- Inguinoscrotal
- Neonatal
- Paediatric oncology
- Skin and appendages
- Thoracic (non cardiac)
- Trauma and burns

7. PLASTIC AND RECONSTRUCTIVE SURGERY

- i) Minimum of 60 months of training in plastic and reconstructive surgery.
- ii) Involvement in 2500 cases during training including 500 major cases (cases - not procedures).
- iii) Involvement in the full spectrum of plastic and reconstructive surgery provided in the SET program with associated logbook numbers, including 500 major cases in the following categories:
 - Aesthetic
 - Breast
 - Burns
 - CMF
 - General
 - Hand
 - Head and neck
 - Lower and upper limb
 - Paediatric
 - Skin cancer

8. UROLOGY

- i) Minimum of 60 months of training in urology.
- ii) Include involvement in the order of four operating lists per week for each separate 12 month period over the duration of the training program.
- iii) An operative logbook summary to be provided which includes:
- iv) the name of each procedure undertaken (and grouped by procedure type – as indicated below); and
- v) whether it was open, laparoscopic or endoscopic; and
- vi) the level of involvement. The level of involvement must note if the involvement in the procedure was either as primary surgeon, secondary surgeon or assistant surgeon.
- vii) Involvement in the following numbers of cases during training (indicative only):

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Version: 3

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Review Date: December 2023

Portfolio:	Education	Ref. No.	ETA-IMG-038
Team:	Specialist International Medical Graduate Assessment		
Title:	Assessing a Specialist International Medical Graduate's Comparability to an Australian and Aotearoa New Zealand Trained Surgical Specialist		

Procedure	Expected no's performed during urology training
TURBT – Resection or diathermy	250
Ureteroscopy (rigid) – biopsy, tumour resection, stone extraction or fragmentation	125
Ureteroscopy (flexible) – biopsy, tumour resection, stone extraction or fragmentation	150
PCNL – biopsy, tumour resection or fulguration, stone extraction or fragmentation	25
TURP / laser prostate, any energy source	150
Open nephrectomy or nephroureterectomy	25
Laparoscopic nephrectomy or nephroureterectomy	50
Pyeloplasty – Laparoscopic or open	10
Partial nephrectomy – Laparoscopic or open	15
Cystectomy or cystoprostatectomy – robotic, laparoscopic or open	25
Radical prostatectomy – robotic, laparoscopic or open	100
Scrotal surgery – exploration, torsion, hydrocele, epididymal cyst, orchidectomy	50
Urethral surgery – excision, urethroplasty, hypospadias, fistula	15

viii) Exposure to the breadth of urological practice including:

- Andrology
- Infection and inflammation
- Male and female urinary tract function
- Oncology
- Paediatric urology
- Trauma
- Upper urinary tract function
- Urinary stone diseases
- Uroradiology

9. VASCULAR SURGERY

- i) Minimum of 60 months of training in vascular surgery.
- ii) Involvement in >600 major vascular cases during training (with >250 as primary operator).
- iii) Exposure to and competence in the following anatomical areas of vascular practice:
 - Amputations
 - Carotid and subclavian
 - Diagnostic vascular ultrasound (performance and interpretation)

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Version: 3

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Portfolio:	Education	Ref. No.	ETA-IMG-038
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- Dialysis access and vascular access
 - Endovenous and sclerotherapy
 - Iliofemoral, femoro-popliteal, and tibial/pedal
 - Management of the Complex Diabetic Foot
 - Mesenteric and renal arteries
 - Peri-operative medicine
 - Peripheral endovascular (diagnostic and therapeutic procedures)
 - Sympathectomy and rib resection
 - Thoracic and abdominal aorta
 - Thrombectomy/embolectomy
 - Trauma
 - Upper limb
 - Venous surgery
- iv) Competence in peri-operative management of the vascular patient.
- v) Vascular Ultrasound experience of >100 hours. No more than 20 hours of therapeutic ultrasound (EVLA, ultrasound-guided puncture etc.) will be accepted.
- vi) The expected standard is that the SIMG will have performed at least 100 Peripheral Endovascular Therapeutic procedures as primary surgeon and participated in at least 150 cases.
- vii) An operative logbook and logbook summary to be provided using the Australasian Vascular Audit (AVA) Operative Logbook Summary template.

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Appendix B: Specialty Specific Requirements for Depth and Scope of Practice

This document defines the standards applied by each surgical specialty in assessing the depth and scope of practice of a SIMG to an Australian and Aotearoa New Zealand trained surgeon within the same surgical specialty.

1. CARDIOTHORACIC SURGERY

The SIMG's scope of practice in cardiothoracic surgery should be in line with the SET training scope of practice.

The logbook should reach 75% either as assisted or as primary surgeon of the requirement as per regulation. The final logbook assessment is at the discretion of the Board.

2. GENERAL SURGERY

The scope of practice for general surgery is effectively the breadth of surgery included in the MALT logbook for general surgical trainees.

This is a document that has been mostly unchanged over several years but will get modified from time to time.

The SIMG should be competent in performing common general surgical emergencies and at least 50% of the elective procedures assessed in the trainee's logbook.

3. NEUROSURGERY

To be safely on-call in a neurosurgical department in Australia and demonstrate depth and scope of practices comparable to an Australian and Aotearoa New Zealand trained neurosurgeon, the SIMG must be able to demonstrate proficiency and experience within their period of recency of practice in the following procedures:

Trauma	<ul style="list-style-type: none"> • Head injury management including EVD/ICP monitoring and decompressive craniectomy • Extradural and acute subdural haematomas • Intracerebral haemorrhage - Evacuation
Cranial	<ul style="list-style-type: none"> • Craniotomy for glioma • Craniotomy for Meningioma • Craniotomy for posterior fossa pathology • Insertion / Revision of ventriculoperitoneal shunt • Subarachnoid haemorrhage - Management and primary operating experience
Spinal	<ul style="list-style-type: none"> • Spinal fusion: ACDF +/- Plate • Spinal fusion: Posterior – Instrumented • Spinal intervertebral disc: Discectomy - Lumbar • Spinal laminectomy/laminoplasty for canal stenosis - Lumbar and Cervical

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4. ORTHOPAEDIC SURGERY

Similar caseload, responsibility and delegated authority to an ANZ orthopaedic surgeon working in a non-metropolitan public hospital with an emergency department.

Sufficient training and experience to manage a general orthopaedic trauma scope of practice in a non-metropolitan public hospital with an emergency department.

5. OTOLARYNGOLOGY HEAD AND NECK SURGERY

The scope of practice for otolaryngology head and neck surgery is effectively the breadth of surgery included in the MALT logbook for otolaryngology head and neck surgery trainees.

The SIMG should be competent in performing common otolaryngology head and neck surgery surgical emergencies and at least 50% of the elective procedures assessed in the trainee's logbook.

6. PAEDIATRIC SURGERY

The scope of practice for paediatric surgery is effectively the breadth of surgery included in the MALT logbook for paediatric surgical trainees.

The SIMG should be competent in performing all common paediatric surgical emergencies and at least 75% of the elective procedures assessed in the trainees' logbook.

7. PLASTIC AND RECONSTRUCTIVE SURGERY

Scope of Practice

4 out of 10 categories required as defined below:

Examples of Major Cases		
1.	Aesthetic	Meloplasty, Rhinoplasty, Body contouring, Massive weight loss
2.	Breast	BRM, BAM, Post mastectomy breast reconstruction
3.	Burns	More than 5% BSA (body surface area)
4.	CMF	Craniofacial, Complex facial fractures
5.	General	Reconstruction of >100 cm ² defect- including pressure sore, abdominal wall, thoracic reconstruction; Major debridement (5% BSA); Completion lymphadenectomy
6.	Hand	Multiple tendon/nerve repair/reconstruction, Fasciotomy, Arthroplasty, complex fractures, carpal stabilisation, tendon/joint reconstruction
7.	Head & Neck	Major Head/neck reconstruction, Parotidectomy, Neck dissection
8.	Lower & Upper Limb (major)	Limb reconstruction excluding just debridement
9.	Paediatric	Cleft lip/palate, cranial vault remodeling, pollicisation
10.	Skin Cancer	Excision requiring major skin grafts/flap reconstruction >100 cm ²

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Depth of Practice

- i) Minimum of 500 cases per year (cases - not procedures).
- ii) 100 of 500 cases have to be in the 'major' category as defined by the Board of Plastic and Reconstructive Surgery and SIMG Committee. The complex cases have to be fairly evenly spread among a minimum of four of the above categories.
- iii) Cases may be considered major or minor at the discretion of the SIMG Committee and supporting documentation must be available upon request.

8. UROLOGY

- i) Experience in managing the following range of emergency presentations:
 - acute lower urinary obstruction with and without obstructive uropathy
 - acute scrotal presentations
 - bladder rupture
 - renal trauma and renal bleeding
 - upper urinary tract obstruction both with and without sepsis
 - ureteric injury
 - urethral trauma
 - urinary tract sepsis
- ii) Experience in managing a majority of the following elective presentations:
 - adrenal masses
 - benign prostatic disease and treatment of outlet obstruction
 - bladder dysfunction
 - cutaneous conditions of the penis
 - erectile dysfunction
 - infertility
 - management of abnormal PSA
 - management of haematuria
 - management of reflux
 - management of urological infection
 - PU J obstruction
 - urethral stricture disease
 - urinary incontinence
 - urinary tract calculi (renal, ureteric, bladder)
 - urological malignancy (bladder, kidney, penis, prostate, testis, ureter)
- iii) Operative experience to include:
 - minor/intermediate cases - TURBT, ureteroscopy (flexible or rigid), TURP (or equivalent), PCNL, urethral surgery, scrotal surgery;

and

 - major cases - nephrectomy or nephroureterectomy, partial nephrectomy, pyeloplasty, cystectomy and prostatectomy

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9. VASCULAR SURGERY

The scope of practice for vascular surgery is effectively the breadth of surgery included in the AVA logbook for vascular surgical trainees.

The SIMG should be competent in performing common vascular surgical emergencies and at least 50% of the elective procedures assessed in the trainee's logbook.

Evidence of this experience during surgical practice is to be provided with an operative logbook and logbook summary using the Australasian Vascular Audit (AVA) Operative Logbook Summary template.

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