AUSTRALIAN COLLEGE FOR EMERGENCY MEDICINE
52nd FELLOWSHIP EXAMINATION
REPORT
August/ October 2013

This report is circulated to:
- candidates – successful and unsuccessful
- examiners involved in the examination – written, clinical and observers
- DEMTs across Australasia
- official observers (listed on Page 2)
- clinical site organisers
- Board of Education
- Fellowship Examination Committee

The report is not confidential and its wide dissemination is encouraged.

The questions alone (without examiner comments or answers) are published in Past Papers and can be accessed on the ACEM website. Recent previous examination reports are also available on the ACEM website.

1. INTRODUCTION

The 2013.2 examination was held on 16 August (written sections – all regions) and on 26 & 27 October (clinical sections – Perth). The clinical sections (Long Cases and Short Cases) were held at the Royal Perth Hospital, Fremantle Hospital and Rockingham Hospital. Royal Perth Hospital hosted all candidates for the SCEs.

163 candidates sat the written component of the examination. Of these candidates, 100 (61.3%) were invited to the clinical section. The overall pass rate for this examination was 82/163 (50.3%).

2. EXAMINERS

Examining in the Fellowship Exam is a substantial commitment in time. All of the examiners are thanked for their efforts. The examiners were:

**Writtens only**

Peter Aitken  Richard Harrod  Paul Pielage
Shahina Braganza  Wayne Hazell  Kate Porges
Adam Chan  Jennie Martin  Stephen Priestley
David Eddey  Sally McCarthy  Pam Rosengarten
Lou Finnel  Mark Miller  Ian Summers
Tonia Nicholson  James Taylor
3. OBSERVERS

The official observers were:

Dr Sean Arendse (The Alfred Hospital)
Dr Swee Cham (Lismore Base Hospital)
Dr Simon Chu (Lyell McEwin Health Service)
Dr Andis Graudins (Monash Medical Centre)
Dr Jennie Hutton (St Vincent’s Hospital)
Dr Victor Lee (Austin Health)
Professor Gyanendra Malla (BP Koirala Institute of Health Sciences)
Dr Shyaman Menon (The Northern Hospital)

4. MULTIPLE CHOICE QUESTIONS

131/163 (80.4%) candidates passed the MCQ section of the exam. To achieve this, a candidate must pass 33/60 questions (55%). The mean score obtained was 36.6 (SD ± 5.36). The grade frequencies were:

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5. SHORT ANSWER QUESTIONS

81/163 (49.7%) candidates passed the SAQ section of the exam. To achieve this, a candidate must pass 5 or more of the 8 questions with a total mark of at least 40/80. The grade frequencies were:

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SAQ 1

A 3 year old girl is referred to the Emergency Department by a GP with a rash. The GP had phoned the Emergency Department prior to the child arriving with concerns about the child's wellbeing.

Outline your assessment of the child in view of the GP's concerns. (100%)

The overall pass rate for this question was 100/163 (61.4%)

Features of successful answers

Essential points are in bold

Two issues:

a. The rash
b. GP's concerns on well-being.

Assessment needs to address both, which may or may not be related.

DDx: (for guidance only – focus on 'red flags')

- Associated with neglect/abuse
  - Insect or animal bites
  - Infestations, e.g. scabies
  - Skin infections – impetigo, fungal (ringworm)
  - Burns
  - Artefact
  - Trauma – abrasions, cuts, etc.
  - Nappy dermatitis
- Incidental to any neglect
  - Viral exanthem
- Meningococcal or pneumococcal sepsis
- Allergic – urticarial, erythema multiforme, drugs
- Bacterial infections – erythema nodosum

History:

- **GP** – collaborative history with GP - detail on nature of concerns – has GP complied with mandatory reporting?
- **General** – fever, respiratory symptoms, malaise, lassitude, conscious state, immunisation status
- **Rash** – onset, duration, location, pruritic or not, blanching or not, treatment to date
- **Neglect** – consistency of history, growth, prior suspicious or unusual presentations, prior contact with social or protective services – need to be sympathetic and non-accusatory
- **Family Hx** – single parent, step parents, siblings and their status
- **Social supports**

Examination:

- **General** – Temp, pulse, weight, SpO₂, conscious state
- **Interactions** – with carers, staff, “strangers”
- **Rash** – location, description, red flags (non-blanching, petechial, ecchymotic), pattern recognition
- **Neglect/abuse** – risk assessment for harm
  - height and weight marked against growth charts,
  - evidence of malnutrition
  - inconsistency with history
  - personal hygiene
  - skin lesions of different ages
  - evidence of previous trauma (including skeletal survey)
  - ophthalmology exam for retinal haemorrhages

Investigations

- swab rash if appropriate
- BSL
- UA
- Others based on PDx of rash

Involvement of other services in assessment:

- child protection (though ED assessment may not agree with GP’s concerns, and therefore not required)
- paediatrics – need for admission
- social work
- police
Features of unsuccessful answers

Candidates failed this question if they neglected to comment on these areas:

- Contacting the GP to explore their concerns
- Consideration of bacterial sepsis as a possible cause of the rash
- Consideration of child abuse and neglect as the basis of the GP’s concerns on the child’s wellbeing
- Assessment not looking for features in history and examination consistent with child abuse and neglect.

SAQ 2

A 28 year old woman (G1P1) presents to the Emergency Department with a 12 hour history of headache. She delivered a healthy baby one week ago.

Her pregnancy was unremarkable.

Her vital signs are:

- P 85 beats/min (regular)
- BP 145/95 mmHg
- RR 14 /min
- SaO₂ 99 % on air
- Temp 37 deg C

(a) List your differential diagnosis. (30%)
(b) Outline your assessment. (70%)

The overall pass rate for this question was 86/163 (52.8%)

Features of successful answers

Pass criteria are in BOLD

a) Differential diagnosis:

The clinical scenario indicated an acute headache in a woman in the early post-partum period with hypertension. Hence the DD was likely to be quite broad and include:

Pregnancy related

- Given the clinical information consideration of pre eclampsia (PET)/eclampsia was required to pass
- Other pregnancy related causes included venous sinus thrombosis, post epidural headache (less likely given time frame), Sheehan’s syndrome and post natal stress/depression/ non CNS infective focus e.g. mastitis, endometritis

Non Pregnancy related

- Common primary headache: Migraine/tension headache; one of these was essential. Others inc. cluster
- Acute vascular emergency: One vascular cause was essential e.g. SAH/stroke/dissection
- CNS infection: One CNS infective cause was essential e.g. Meningitis (bacterial/viral/listeria ) /encephalitis
- Other: sinusitis / other infective focus/ SOL less likely given time frame
b) Assessment
The candidate should focus on assessing for the important causes listed above.

History:
**History of headache:** Sudden (vascular) vs. gradual, location, radiation, assoc features etc.
**Obstetric history noted** inc. delivery and post-partum
**Past medical history:** Previous headache hx./co-morbidities
**Meds:** Analgesia/antibiotics/usual

Examination:
**BP** must be noted to be elevated in part a) or b).
A **neurological examination** looking for GCS and focal neurology was essential. Some indication that **signs of concern in PET** also were going to be assessed was also required, eye exam/reflexes, clonus/RUQ tenderness, oedema
**Signs of meningism.**

Investigations:
Must show what abnormalities are being looked for and be linked to differential. Investigations should focus on PET and serious CNS vascular and infective causes.

Bedside: **urine for protein**

Blood: Particularly focussing on pre eclampsia and possible HELLP: Electrolytes, renal function/LFTs, FBE, Coags. Should include expected abnormalities.

Other investigations as indicated by clinical state

Imaging:
**CT must be mentioned but perspective shown on use.**
**CT head:** if focal neurology, decreased GCS, possible SAH and concerns of raised ICP or seizures.

Other:
**LP** must be considered and indications: Possible meningitis with no CI and? SAH with –ve CT MRI/MRV or CT/CTV e.g. for venous sinus thrombosis

Overall comment: Many candidates passed part a) but omitted important information in part b) leading to an overall fail. It was acknowledged that given the multiple sub-sections of an assessment question that the omission of a single pass criterion should not necessarily lead to a fail for that section, but it should be taken in the context of the whole answer.

**Features of unsuccessful answers**
Failure to consider pre-eclampsia and other major DDx listed above.

Cursory history with no exploration of headache characteristics / associations, obstetric Hx.

Failure to perform neurological examination and correlate expected findings to DDx.
SAQ 3

A 55 year old man with cerebral palsy is brought to your Emergency Department from his supported accommodation by his carer. He has been unwell for 24 hours with fevers and a productive cough.

Chest x-ray reveals an extensive bronchopneumonia.

Vital signs on arrival are:

- **P** 130 beats/min (regular)
- **BP** 75/55 mmHg
- **RR** 30 /min
- **Sa O₂** 89 % on room air
- **Temp** 38.4 deg C
- **GCS** 15

Describe your management. (100%)

The overall pass rate for this question was 121/163 (74.2%)

**Features of successful answers**

**Minimum for Pass - candidates need to display understanding that this patient:**

- Has severe sepsis
- Needs early aggressive therapy
- Needs continued re-evaluation. Candidate must either nominate:
  - "Hard" end points OR
  - "Failure to improve" DICTATES
- Escalation (options to be specified but not doses)

**Specific Therapy (a minimum of:) NB - re-evaluation concept might be discussed in this context**

- Oxygen
- Graded response (if appropriate)
  - Haemodynamic Support
    - IVF THEN, if appropriate ...
    - CONSIDER Inotropes
- Antibiotics
  - Names OR STATE
  - Review Hospital Guidelines or CIAP OR
  - Rationale (broad spectrum because)
    - Rx CAP BUT consider
    - Institutionalized (possible complex co-morbidities
    - Aspiration

Demonstrate understanding of issues related to providing an appropriate level of care for this patient

- Requires more than a superficial mention of these consultant level concepts
- Important to emphasize establishing limitations of care

**Higher level candidates will discuss the following topics:**

Early Goal Directed Therapy, Surviving Sepsis Guidelines
• Specifics of time to administer antibiotics (< 60 minutes)
• Name drugs, doses AND specific organisms considering that patient is:
  o Institutionalised
  o possibly aspirating with
  o possible significant co-morbidities
Demonstrates understanding of these concepts in each therapeutic category
• Specific Haemodynamic & Respiratory End Points
• Specifics of type(s), amount and infusion rate of inotropes
Other therapies: bronchodilators, anti-pyretics, physiotherapy, etc.
Exclude complications; effusions, empyema
Pneumonia "Scoring" Systems (CURB, SMART-COP, PSI, etc.)
Disposition = Respiratory, ID, ICU, Palliative Care

More detailed discussion of the issues
• Capacity & Competence (clear sensorium able to comprehend, analyse & retain)
• Co-morbidities
• Advanced Care Directive
• Family, Guardians, Carers

Features of unsuccessful answers
The vast majority of candidates failed because of their failure to explore the limitation and appropriateness of care in a patient with Cerebral Palsy from a group home. A few candidates failed because they did not provide information on the end points or goals of the treatment and escalation strategies.

Failed candidates did not clearly explain / articulate the complex issues of potential limitation of care in a patient who perhaps had significant underlying disability.

Failed candidates largely ignored this important consultant level concept.

Many candidates who scored poorly did so because they did not explain how the concepts of advanced care directives / patient and relative opinions / ceiling of care impacted on management of this patient.

Poorly scoring candidates tended to separate the resuscitation from these issues and then write single word or phrase comments such as ; “discuss with next of kin”, “advanced care directives” and “ceiling of treatment “. In many cases, these isolated phrases, with no clear reference as to how they would be applied to modifying management, did not satisfy the examiner’s requirement for the candidates to show a clear understanding of how the patients pre-morbid function may influence management decisions.

SAQ 4

A morbidly obese (200kg) male was a front seat passenger involved in a high speed motor vehicle crash. The car was extensively damaged. He is complaining of severe chest pain and has abdominal seatbelt bruising.

Observations are:

P 130 beats/min (regular)
BP 103/64 mmHg
RR 32 /min
SaO2 91 % on non-rebreathing oxygen mask
GCS 14

Outline the problems you anticipate in his

(a) Investigation (50%)
(b) Management (50%)

The overall pass rate for this question was 63/163 (38.7%)

Features of successful answers

- Recognise the patient is critically unwell and morbidly obese
- Mention EFAST or U/S in the assessment
- Discuss problems with plain X rays
- Risks with moving an unstable patient from ED
- Logistics with CT (Wt /size of patient)
- IV access, mention I/O or U/S or central access
- Difficulties moving and transferring an obese patient
- Airway problems
- C spine protection must be considered
- Anticipate intubation and ventilation problems
- Mention O2 saturations or hypoxia or desaturation
- Discuss drugs/doses modifications required in the morbidly obese
- Must mention disposition

Superior answers included

- complications
- OHS considerations
- positioning the patient, e.g. ramping
- comorbidities
- WTU/BSL
- analgesia
- supportive issues
- transferring out or retrieval considerations
- problems acquiring and interpreting the ECG
Features of unsuccessful answers

Most failures were due to omissions in Part B. Candidates did not address the bariatric issues adequately or focused on “how to manage a trauma patient” rather than covering the anticipated problems in management.

Some candidates wasted time with excessively long lists of DDx. While a succinct opening statement highlighting the morbid obesity and shocked state was felt to be necessary, lengthy lists of DDx or straying into history / examination at the expense of adequately covering the topic was detrimental.

Not adhering to the Glossary of terms was an issue for some candidates – many failed to cover the problems anticipated in disposition of this patient.

Many failed due to inaccurate statements re fluids / drug dosages.

SAQ 5

A 9 year old boy presents to ED after stepping on a sharp object at the local beach. There is a small puncture wound on the plantar surface of his right foot. X-ray shows a 15x5 mm metal foreign body 5 mm beneath the skin surface.

You decide to remove the object in ED under ultrasound guidance.

a) Describe 3 analgesia/sedation techniques that you could use to facilitate removal. (70%)

b) The child is fully recovered and the foreign body removed. Outline your discharge plan. (30%)

The overall pass rate for this question was 92/163 (56.4%)

Features of successful answers

Part 1: 70%

1. Candidates must, to some extent, consider department status in how they would make a choice: factors could include staff available / skill mix / patient load and acuity.
2. Candidates must plan to discuss methods with parents & child in an informative and “paediatric” friendly manner to achieve selection and consent.
3. 3 “ED” analgesic and/or sedation methods described in a safe and competent manner. (A range of techniques would be acceptable except injected local anaesthetic on its own or prior to other methods).
4. At least 1 of the 3 methods must be procedural sedation (all drugs or drug combinations acceptable if described in a safe and competent manner including staffing, location and monitoring).

Part 2: 30%

1. Consider or give: antibiotics & immunisation.
2. Analgesics prescribed and/or advice.
3. Oral & written advice including all of the following as concepts: follow up plan, wound care, recognition of any problem requiring return to ED/or attendance to GP.

**Features of unsuccessful answers**

- Not addressing basic pass criteria including straight forward criteria such as immunisations & analgesia
- Paediatric unfriendly answers including using needle based local anaesthetics techniques without efforts to reduce the discomfort of these needles.
- Not answering the question in the way it was written. It was not a discuss question nor was it asking about discharge criteria.
- Erroneous drug doses and/or techniques.
- **Not completing parts of the question**

**SAQ 6**

A 27 year old previously well woman is brought to the Emergency Department by ambulance with a one hour history of massive oral bleeding. She had been discharged from the same hospital six days prior after a tonsillectomy.

Vital signs are:

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<th>Parameter</th>
<th>Value</th>
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<tbody>
<tr>
<td>P</td>
<td>150 beats/min (regular)</td>
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<tr>
<td>BP</td>
<td>80/30 mmHg</td>
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<tr>
<td>RR</td>
<td>25 /min</td>
</tr>
<tr>
<td>SaO₂</td>
<td>95 % on air</td>
</tr>
<tr>
<td>Temp</td>
<td>36.8 deg C</td>
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</table>

Describe your management. (100%)

The overall pass rate for this question was 113/163 (69.3%)

**Features of successful answers**

- **Management of life threatening haemorrhagic shock**
  Must include details of resuscitation including site, staff, equipment and appropriate use of crystalloid, blood and blood products. Higher level answers will include activation of Massive Transfusion Protocol or equivalent approach, resuscitation endpoints, and measures to avoid complications such as hypothermia, coagulopathy and hypocalcaemia.

- **Airway management**
  Expect at minimum a recognition of high risk to airway, and outline of measures taken to be ready to act if clinical deterioration. Higher level answers include detail on indications and methods for intubation and securing of airway in ED.
• **Control of oral bleeding**

  If not intubated, requires suction and positioning. If airway secured, consider local pressure, adrenaline soaked gauze, and oral packs.

• **Minimisation of time to definitive care/ theatre**

  Expected a high priority placed on early notification and involvement of ENT surgeon, anaesthetist, theatre, and blood bank. Others important include family and ICU

• **Supportive care**

  Must include large bore IV access, cardiorespiratory monitoring, prevention of hypothermia, and euglycaemia. Higher level answers include consideration of IA line, IDC, NGT, IV titrated analgesia, anti-emetics and IV antibiotics

• **Disposition**

  Theatre as soon as possible, with ICU or HDU post-operatively

**SAQ 7**

The hospital executive asks you to brief them on factors that impact adversely on flow of patients admitted through an ED.

Outline five (5) factors that you would focus on in your presentation and a potential solution for each. (100%)

The overall pass rate for this question was 102/163 (62.6%)

**Features of successful answers**

Better answers will reflect that the issues affecting flow are

• Due to effective use of inpatient beds, including consultant led service, discharge planning, timely investigation, rapid and effective use of para-medical services like physio, rapid drug dispensing, frequent rounds, medical decision units, access to community services like hospital in home, adopting a 'pull' approach to inpatients, etc.

• Due to adequate resourcing of ED, staffing numbers (doctors, nurses, ancillary staff), staffing seniority, cubicles, equipment, etc.

• Due to appropriate processes in ED, including rapid senior review, rapid decision making, early bed booking, right of admission, eased access to investigations, observation ward, fast track areas for low acuity patients, access to clinical care teams (physio, ot, psych, etc.)

• Due to appropriate interface with inpatient teams, with early inpatient team review, ease of communication, clinical decision units, etc. being prepared to accept patients that are not fully worked up, 'pull' from wards
Features of unsuccessful answers

- Not listing 5 factors.
- Not making it clear that is a 'whole of hospital' problem (i.e., an answer that focusses only on ED issues or alternately focuses only on inpatient issues will be judged a fail).
- Specifically, need to mention:
  - Efficient use of inpatient beds and ED processes (either ED/inpatient interface issues or ED issues [early decision, referral])
- Most failures were because candidates failed to provide adequate detail in addressing solutions to problems, and simply didn’t score enough points to pass. Some appeared to have no real understanding of what the issues were.

SAQ 8

A 14 year old female presents to your tertiary level Emergency Department two hours following self-reported overdose of one box (100x500mg) of sodium valproate. She is currently asymptomatic and is cooperative with your management.

Observations:

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<th>beats/min (regular)</th>
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<td>BP</td>
<td>110/65</td>
<td>mmHg</td>
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<td>RR</td>
<td>16</td>
<td>/min</td>
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<td>SaO2</td>
<td>99</td>
<td>% on air</td>
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<td>Afebrile</td>
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<td>GCS</td>
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Describe your management. (100%)

The overall pass rate for this question was 92/163 (56.4%)

Features of successful answers

- Recognise potentially fatal ingestion i.e. very high dose historically even though no current symptoms or signs
- Patient must stay for treatment and may need to be detained to do this (unless sequential levels show no evidence of significant ingestion)
- Recognise that serum levels help risk stratify toxicity. Examiners did not think knowledge of actual levels is pass/fail but good candidates gave us this.
- State specific signs of toxicity (i.e. principally a CNS toxin with coma, cerebral oedema associated with cardiovascular collapse, MOF & acidosis)
• Recognise need for active drug elimination and that dialysis is most effective treatment. (Whole bowel irrigation may have a role but I think less important? not pass/fail). If the candidates mention activated charcoal it is not a fail criterion.

• Once medical treatment is complete, needs mental health assessment. (Not essential as the patients clearly heading for a hospital admission)
• Recognise this child is at risk and inform the adolescent mental health team and social worker for early input.
• Disposition - admission to ICU/HDU or toxicology unit or monitored space in ED observation ward with ICU standby.

**Features of unsuccessful answers**
• Failure to recognise the lethality of the overdose.
• Failure to recognise the potential for delayed toxicity.
• Failure to consult a toxicologist.
• Discharging the patient after a short period of observation.

6. **VISUAL AID QUESTIONS**
81/163 (49.7%) candidates passed the VAQ section of the exam. To achieve this, a candidate must pass 5 or more of the 8 questions with a total mark of at least 40/80. The grade frequencies were:

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**VAQ 1**
A 6 month old girl is brought to your ED with a rash which has been present for a week but has become much worse in the last two days.

Observations:

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<tr>
<td>Pulse</td>
<td>100</td>
<td>/min</td>
</tr>
<tr>
<td>RR</td>
<td>20</td>
<td>/min</td>
</tr>
<tr>
<td>SaO2</td>
<td>98</td>
<td>% on room air</td>
</tr>
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Her photo is shown.

a) Describe and interpret the image (50%)
b) Outline the important considerations in determining her disposition (50%)

Photo of well nourished 6 month old in no obvious distress with facial rash

The overall pass rate for this question was 130/163 (79.8%)

**Features of successful answers**

(a) **D** and **I** the photo

Pass reasonable description of rash and child, with DDx

**Rash** all to **bold** pass

- **Crusty**
- **Erythema**
- **Involving face** (sparing of rest of body — assumed or comment)

**Child overall state** needs some statement to pass

- **E.g. robust/well nourished, comfortable, sitting, not unwell, etc.**

Greater detail regarding rash or child = higher marks

**DDx**

**Dermatitis/eczema plus one other** to pass (including secondary infection)

Secondary infection

Herpetic

SJS

(b) Outline the important considerations in determining her disposition

**To pass much mention toxicity and social factors**

**Clinical factors**

- **Toxic** vs. well
- Intake and output
- DDx requiring inpatient care
- Co morbidities
- Other concerns with examination and hx: neglect, other illness, etc.

**Parents**

- **Social**
- Geographical/transport issues for both acute Mx and planned R/V
- Time of day/night
- Coping: **e.g. not = admit, vs. highly motivated to Mx at home**/sensible + clinically ok = home
- **NAI** neglect of this issue, previous issues, etc.
Planned Mx and R/v
- DDx or DDx preferred Mx — e.g. IV antibiotics preferred vs. oral
- Access to dermatological or paeds review if simplified by admission
- Complex mx regime e.g. frequent creams/ointments, multiple medications, bandaging, frequent bathing — vs. simple

Features of unsuccessful answers
Significant omissions of important criteria as bolded above

VAQ 2
An 18 year old man presents with right eye pain. There is no history of trauma.

His vital signs are:

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<td>Pulse</td>
<td>110 bpm,</td>
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<td>BP</td>
<td>120/80 mmHg</td>
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<tr>
<td>SaO₂</td>
<td>98 % on room air</td>
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</tbody>
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A contrast enhanced CT scan is performed – 2 slices are shown.

a) Describe and interpret his CT scans (70%)
b) Outline the important features of the eye examination in this patient (30%)

[CT scans available on ACEM website]
The overall pass rate for this question was 87/163 (53.4%)

Features of successful answers
a) 1) Proptosis of right eye +/- retrobulbar oedema
   2) Periorbital oedema of right eye
   3) Right intra-orbital gas or air/fluid level
   4) Right orbital abscess or right orbital (post septal) cellulitis with gas formation
b) 1) Range of movement of eye +/- pain on movement
   2) Visual acuity

Features of unsuccessful answers
- The most common omission was failure to describe either gas or an air/fluid level (seen on the 2nd CT) +/- failure to interpret this as an abscess.
- Other omissions were failure to describe either the Proptosis or peri-orbital oedema.
- Infrequently, the CTs were incorrectly interpreted as showing evidence of retro-orbital haematoma (despite the history).
- Finally, testing either the ROM of the eyes or visual acuity was missed.
VAQ 3

A 68 year old woman presents to your ED with abdominal pain and vomiting. 2 months previously she had been admitted to hospital following a motor vehicle accident in which she suffered chest and abdominal injuries that were managed non-operatively.

Her observations are:

<table>
<thead>
<tr>
<th>Observation</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCS</td>
<td>15</td>
</tr>
<tr>
<td>Pulse</td>
<td>110 /min</td>
</tr>
<tr>
<td>RR</td>
<td>25 /min</td>
</tr>
<tr>
<td>Temp</td>
<td>37 °C</td>
</tr>
<tr>
<td>BP</td>
<td>120/70 mmHg</td>
</tr>
<tr>
<td>SaO₂</td>
<td>96 % on room air</td>
</tr>
</tbody>
</table>

2 Xrays are shown

Describe and interpret her Xrays (100%)

[Xrays available on ACEM website]

The overall pass rate for this question was 124/163 (76.1%)

Features of successful answers

Description:
- Must note abnormality in left lower thorax.
- Must note multiple loops of dilated small bowel with fluid levels.

Interpretation:
- Must state that appearance is that of small bowel obstruction.
- Must consider possibility of unrecognised diaphragmatic rupture complicated recent MVA

Note: Candidate must consider other causes of SBO unrelated to trauma and provide at least two likely causes in the differential diagnosis of SBO in a 68 yo woman in order to score more than a bare pass.

Features of unsuccessful answers

Inadequate description of the abnormal bowel gas pattern. A number of candidates did not pick up the potential diaphragmatic rupture or link the two together. A majority of the candidates did not give a reasonable list of differential diagnosis for the bowel obstruction.

VAQ 4

A previously well 2 year old boy is brought to your ED by his parents when he suddenly started to feel unwell and looked pale. His symptoms began an hour prior to presentation.

On examination he is anxious and alert with a normal capillary refill time.

Observations:

<table>
<thead>
<tr>
<th>Observation</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>85/40 mmHg</td>
</tr>
<tr>
<td>Temp</td>
<td>36 °C</td>
</tr>
<tr>
<td>SaO₂</td>
<td>97 % 2L/min O₂ via nasal prongs</td>
</tr>
</tbody>
</table>
An ECG is taken.

a) Describe and interpret his ECG (50%)

b) Give details of your two preferred treatment options (50%)

[ECG Scan available on ACEM website]

The overall pass rate for this question was 84/163 (51.5%)

**Features of successful answers**

a) • Rate > 200/min  
   • Rhythm – regular  
   • QRS duration <0.08 s (narrow)  
   • Supraventricular tachycardia (broad sense of the term) most likely due to AV nodal re-entry (SVT)  
   • Differential includes: Re-entry via an accessory pathway (e.g. WPW or LGL); Atrial flutter and/or fibrillation; Paroxysmal atrial tachycardia; If Sinus Tachycardia is listed must comment on why this is not likely.

A satisfactory statement on or adequate response to each of the above five main bulleted points is an automatic pass. If one is missed the candidate may still pass with an otherwise good answer after discussion between examiners.

b) • Haemodynamically stable patient  
   • Must involve and engage parents in treatment  
   • ECG monitor and recording of response to treatment  
   • Manoeuvre(s) to increase vagal tone: Diving reflex via application of cold to face/neck/torso; Hanging upside down; Carotid sinus massage; Valsalva (may be difficult given the patient’s age); Face dunking and/or inversion into cold water are unsatisfactory; Eyeball pressure and/or anal dilatation are unacceptable.
   • Administration of adenosine: Broselow tape or weight-based (10-15 kg range) calculation of dose; 50-150 µg/kg initial dose; May repeat after 5-10 minutes. Double previous dose up to 300 µg/kg; Intravenous bolus with flush

A satisfactory statement on or adequate response to each of the above five main bulleted points is an automatic pass. If one is missed the candidate may still pass with an otherwise good answer after discussion between examiners. Also note that:

• Other AV slowing drugs such as verapamil, beta blocker, digoxin, amiodarone are acceptable instead of adenosine if very well discussed and justified.
• DC cardioversion is not acceptable as one of the two preferred treatment options in this child.
Features of unsuccessful answers

Description and interpretation of the ECG caused few problems although some candidates miscalculated that rate and did not clarify their meaning of the term SVT. It was uncommon for a candidate to be unsuccessful solely due to an unsatisfactory answer to this section.

The most common errors in answering part b were:
- Overstating the severity of the patient’s condition or not making any statement and thereby not incorporating it into the patient’s treatment;
- Failure to engage the parents;
- Failure to monitor the patient;
- Insufficient detail in describing treatment options, particularly use and dosing of adenosine;
- Propensity to use electrical cardioversion as the first or second treatment option for a stable patient, when there were several more appropriate and demonstrably safer alternatives. Except for the use of electrical cardioversion, which was considered unacceptable the unsuccessful answers generally combined two or more of the above errors.

VAQ 5

A 77 year old man with a history of atrial fibrillation presents to your ED with extreme lethargy, nausea and vomiting.

His observations are:

<table>
<thead>
<tr>
<th>Observation</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCS</td>
<td>12(E3, V4, M5)</td>
</tr>
<tr>
<td>Temp</td>
<td>36 °C</td>
</tr>
<tr>
<td>Pulse rate</td>
<td>35 /min</td>
</tr>
<tr>
<td>BP</td>
<td>85/50 mmHg</td>
</tr>
<tr>
<td>Sa O₂</td>
<td>94 %2L/min O₂ via nasal specs</td>
</tr>
</tbody>
</table>

Biochemistry and Digoxin level are shown

(a) Describe and interpret his results (50%)

(b) List the features of your treatment in the first hour (50%)

[Biochemistry available on ACEM website]

The overall pass rate for this question was 89/163 (54.6%)

Features of successful answers

a) DESCRIBE: - raised anion gap metabolic acidosis, severe renal failure, significant hyperkalaemia and digoxin toxicity
   INTERPRET: demonstrate some causative link between vomiting, renal failure, hyperkalaemia and digoxin toxicity, leading to bradyarrhythmia, haemodynamic compromise, critically unwell with potential for deterioration and death

b) Demonstrate need for resuscitation interventions
   Treatment of hypotension - IV fluid bolus & treatment of bradyarrhythmia
   Treatment of bradyarrhythmia – (e.g. Atropine, pacing)
   Treat hyperkalaemia - must include agent to shift K into cells (e.g. Salbutamol, insulin & dextrose)
- Calcium use without qualification of reason can only achieve a maximum score of 4 overall
- Treat digoxin toxicity – digoxin FAB
- Treat underlying cause for renal failure - maintenance of adequate intravascular volume by IVT, avoid overload
- relieve any post renal obstruction
- Monitor – volume status / urine output

**Features of unsuccessful answers**

a) Lack of demonstration of causal link between clinical state and results
   - Generic lists of causes of individual results without linking / prioritising to scenario or clinical state
   - Lack of demonstration of patient instability and potential for deterioration / arrest
b) Lack of treatments to temporise haemodynamics (hypotension and bradycardia) and hyperkalaemia while waiting for digoxin FAB administration or effects
   - Calcium used in treatment of hyperkalaemia in presence of digoxin toxicity without qualification
   - No strategy for IV fluid therapy in context of renal failure
   - No consideration of IDC to relieve possible post renal obstruction cause of renal failure

**VAQ 6**

A junior doctor in your ED shows you the following ECG. It is of a 40 year old lady who is about to go to the Operating Theatre for treatment of a fracture of her wrist sustained after a fall. She has had no chest pain.

**Observations:**

<table>
<thead>
<tr>
<th>BP</th>
<th>110/60 mmHg</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCS</td>
<td>15</td>
</tr>
</tbody>
</table>

Describe and interpret her ECG (100%)

[ECG available on ACEM website]

The overall pass rate for this question was 118/163 (72.4%)

**Features of successful answers**

- Good description of the ECG; Sinus rhythm;
- Mention of Brugada Syndrome;
- Mention of risk of ventricular arrhythmias or sudden death or consideration of syncope as the cause of fall;
- Referral or notification of anaesthetist, cardiologist or orthopaedic surgeon.

**Features of unsuccessful answers**
No mention of Brugada Syndrome or mention of it as one of the differential diagnoses and then concentration on coronary artery disease (usually Wellen’s Syndrome) without consideration of the risk of arrhythmias.

**VAQ 7**

A previously well 38 yo man presents with a week of worsening vomiting, diarrhea and abdominal pain. On the day of presentation to the ED he has become drowsy and confused.

**Observations:**

- **Temp:** 37 °C
- **Pulse:** 110 /min
- **BP:** 120/80 mmHg
- **GCS:** 12 (E3, V4, M5)

His liver function tests (LFTs) and coagulation profile are shown

Describe and interpret his results (100%)

[Biochemistry available on ACEM website]

The overall pass rate for this question was 78/163 (47.9%)

**Features of successful answers**

Recognise impaired synthetic function of liver (low albumin, high INR). Likely hepatic encephalopathy with at least one other differential for confusion i.e.: low BSL, ICH. One viral hepatitis cause listed. One drug or toxin cause listed-Hepatitic liver failure rather than obstructive.

**Features of unsuccessful answers**

Calling picture an obstructive pattern. Did not recognise hepatic encephalopathy or consider other causes for altered GCS Interpretation was not related to information given in stem.

**VAQ 8**

A 63 year old man presents to your emergency department after falling 2 metres from a ladder and landing on his feet. He is only complaining of pain in his left ankle.

**Observations:**

- **GCS:** 15
- **BP:** 135/75 mmHg
- **Pulse:** 90 /min
- **RR:** 15 /min
2 ankle views are shown

a) Describe and interpret his Xrays (70%)

b) List the features of your management of his ankle injury (30%)

[Xrays available on ACEM website]

The overall pass rate for this question was 108/163 (66.3%)

Features of successful answers

Describe:
- Mortis irregularity (or narrowing or similar wording including Plafond #/Pilon #) laterally on AP film
- Minimally displaced fracture, anterior aspect, of distal tibia with intra-articular extension

Interpret:
- Mechanism highly suggestive of injuries elsewhere (either local or distant)
- Definite Orthopaedic referral (May mention as answer to management)

Management:
- Analgesia - titrated opiate
- Splintage/Immobilisation
- Disposition to mention Admission (or transfer if service not available)

Features of unsuccessful answers

- Omitted key pass criteria
- Failure to appreciate axial loading injury and consequences
- Failure to appropriately describe images and manage axial loading injury

7. CLINICAL EXAMINATIONS

These were held in Perth on Saturday 26 and Sunday 27 October 2013.

The Clinical examination site organisers were Heidi Wade and Jessamine Soderstrom at Royal Perth Hospital, Rod Ellis and Helga Weaving at Fremantle Hospital and Hiten Patel and Ashiela Narang at Rockingham Hospital.

7.1. LONG CASES

87/100 (87%) passed the long cases. The pass mark is 5/10. The grade frequencies were:

<table>
<thead>
<tr>
<th>Grade ( / 10)</th>
<th>Frequency (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>7</td>
<td>26</td>
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<tr>
<td>6</td>
<td>19</td>
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<tr>
<td>5</td>
<td>16</td>
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<tr>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

7.2. SHORT CASES
83/100 (83%) passed the short cases. The pass mark is a mark of 5/10, which can be obtained by passing 3 cases with an aggregate of 15-18/40 inclusive or at least 2 of 4 cases with an aggregate of 19/40 or more. The grade frequencies were:

<table>
<thead>
<tr>
<th>Grade ( / 10)</th>
<th>Frequency (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>6</td>
<td>28</td>
</tr>
<tr>
<td>5</td>
<td>41</td>
</tr>
<tr>
<td>4</td>
<td>17</td>
</tr>
</tbody>
</table>

7.3. SCEs
91/100 (91%) passed the SCEs. To pass, a candidate needs to score 30/60 and pass at least 4 stations. The grade frequencies were:

<table>
<thead>
<tr>
<th>Grade ( / 10)</th>
<th>Frequency (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>7</td>
<td>30</td>
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<tr>
<td>6</td>
<td>14</td>
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<tr>
<td>5</td>
<td>11</td>
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<tr>
<td>4</td>
<td>6</td>
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<tr>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

SCE 1:
A 22 year-old man who was using intravenous amphetamines has been brought to the ED by police. He is handcuffed and in an agitated state. Vital signs: HR 140 bpm, BP 200/110 mmHg, RR 22, temperature 38.1 °C, SpO2 98% on room air. GCS 14- confused

Initial investigations include an arterial blood gas on room air:

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
<th>Reference Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>pH</td>
<td>7.25 mmHg</td>
<td>(7.35-7.45)</td>
</tr>
<tr>
<td>CO₂</td>
<td>23 mmHg</td>
<td>(35-45)</td>
</tr>
<tr>
<td>pO₂</td>
<td>99 mmHg</td>
<td>(75-100)</td>
</tr>
<tr>
<td>HCO₃⁻</td>
<td>10 mmol/l</td>
<td>(22.0-33.0)</td>
</tr>
<tr>
<td>Lactate</td>
<td>5 mmol/l</td>
<td>(0.7-2.5)</td>
</tr>
<tr>
<td>Glucose</td>
<td>10 mmol/l</td>
<td>(3.0-7.8)</td>
</tr>
<tr>
<td>Base Excess</td>
<td>-16 mmol/l</td>
<td>(-3+3)</td>
</tr>
</tbody>
</table>

- Describe and interpret the arterial blood gases.
- Outline your approach to this patient's agitation.
- The patient is now sedated. His serum CK is 80,000 IU/L. He develops a broad complex bradycardia with a HR of 30bpm. His BP is 70 systolic. Describe your management.
- During the restraint, a security guard sustained a needlestick injury. Describe the management of the security guard.
Overall pass rate for this question was 90/100 (90%)

This SCE tested the candidate’s ability to manage an agitated unwell patient. Unsuccessful candidates failed to recognise the life threatening hyperkalaemia but apart from that the SCE was done quite well.

SCE 2:

A 45 year-old man presents to your tertiary ED with persistent shortness of breath and severe epigastric pain after a long run. Other than mild asthma, he has no other medical problems. The attending RMO has tried pulsed salbutamol via metered dose inhaler (MDI) over 30 minutes, with no effect. He then tried 2 sprays of sublingual GTN. Vital signs were P 55/min, BP 110/70 on arrival but now BP 70/50, SaO2 97% RA, RR 30/min. The patient is pale and sweaty. The nurse looking after the patient is concerned about the patient, and requests your assistance.

- Outline your response to this situation.
- An ECG is performed. Describe and interpret the ECG. (ECG showed an inferior STEMI with posterior involvement, suggesting RV AMI given the hypotension).
- Cardiology services are mobilising for urgent angioplasty. The cath lab will be ready in 30 minutes. The patient complains of dizziness. BP remains 70/50. A cardiac rhythm strip is available. (Rhythm strip showed CHB with ventricular escape rate 30 /min.)
- Outline your immediate treatment.
- The Cardiology consultant comes to see you after the patient has been treated in the cath lab, to raise concerns about the initial management of the patient in the ED. Outline your response.

Overall pass rate for this question was 89/100 (89%)

The SCE tested core knowledge. Interpretation of the ECG and management of the admin component discriminated between pass and higher level responses.

SCE 3:

A 43 year old man presents to your metropolitan ED via ambulance, with haematemesis.

Vital signs are: GCS 15; pulse 125, BP 100/65, RR 20, O2 sats 97% on air, temp 37.3 degrees C

- Outline your assessment.
- Your assessment confirms long history of excessive alcohol consumption and signs of chronic liver disease. His skin is cool and clammy. Vital signs are unchanged. Outline your initial management.
- The patient has a further large haematemesis and becomes drowsy. His BP is now 60 systolic. You activate the hospital’s massive transfusion protocol. Describe the principles of massive transfusion in haemorrhagic shock.
- The patient is improves with your resuscitation, but there is ongoing blood loss requiring urgent intervention. The gastroenterology registrar states the patient is “too unstable” to transfer to the endoscopy unit and requests he be kept in ED until he more becomes stable. Outline your response to this request.

Overall pass rate for this question was 94/100 (94%)

Candidates were required to demonstrate understanding of massive transfusion and most did well.
SCE 4:

The triage Nurse calls you about a paediatric patient who has just arrived in your regional ED. A Mother has arrived at triage carrying her 6 week old son who looks mottled and lethargic. He has a 2 week history of recurrent vomiting post feeds.

He was born at term, BW 2500g, well until 2 weeks ago when he started vomiting

Vitals: Wt 2650g, HR 160/min, RR 80/min, cool and cyanosed peripheries

- Outline your initial treatment.
- What features would you look for on history and examination?
- Please interpret the infant’s venous blood gases taken prior to resuscitation

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>pH</td>
<td>7.55 (7.35-7.45)</td>
</tr>
<tr>
<td>pCO₂</td>
<td>30 (35-45 mmHg)</td>
</tr>
<tr>
<td>pO₂</td>
<td>45 (75-100 mm Hg)</td>
</tr>
<tr>
<td>HCO₃</td>
<td>40 (22-30 mmol/l)</td>
</tr>
<tr>
<td>BE</td>
<td>+15 (-3+3)</td>
</tr>
<tr>
<td>Cl⁻</td>
<td>70 (95-115 mmol/l)</td>
</tr>
<tr>
<td>Na⁺</td>
<td>155 (135-145 mmol/l)</td>
</tr>
<tr>
<td>K⁺</td>
<td>2.5 (3.5-5.5 mmol/l)</td>
</tr>
<tr>
<td>Glucose</td>
<td>2.5 (3.0-7.6 mmol/l)</td>
</tr>
<tr>
<td>Lactate</td>
<td>5 (&lt; 2 mmol/l)</td>
</tr>
</tbody>
</table>

The diagnosis of pyloric stenosis is suspected. The child requires transfer to a paediatric hospital. Outline the preparations for transfer.

Overall pass rate for this question was 87/100 (87%).

This SCE tested the candidate’s ability to manage a sick infant.

SCE 5:

You are on the dayshift in your ED when it is shaken by a severe earthquake. Everyone is thrown off their feet. There is severe damage to the ED waiting room. Early reports indicate:

- That significant structural damage has occurred throughout the city
- A number of victims are dead and unknown numbers of people are trapped and injured.

There is no other ED in the city.

- Describe the triage system that you would use in the event of a mass casualty situation.
- What are your immediate actions to prepare for the expected influx of patients?
- It’s now a few hours later. The incident response will be prolonged and a large number of patients are likely to continue to arrive. What further steps will be required to manage the situation?
- It is now 3 days later. No further live patients have been located. Thousands of people are homeless and many areas are without power and water.
- What are the main issues facing your department over the next period?

Overall pass rate for this question was 87/100 (87%)
This SCE assessed the candidate’s ability to manage a major disaster, both in the initial phase and also as time went on.

This SCE was very discriminating. Candidates who were organised and demonstrated forward planning in their answer did very well, whereas those who were poorly organised did not.

SCE 6:
A 26 year-old man is brought to your major regional ED after a high-speed motorcycle accident. There is no external haemorrhage or apparent long bone fracture. He has a cervical collar in place and is complaining of pain in his back. The ambulance crew note that he has not been seen to move his legs. His initial observations are GCS 15; Pulse Rate 65/min; Blood Pressure 80/40 mmHg; Respiratory Rate 18/min; SaO2 100% on high-flow oxygen.

• Outline your initial approach.
• Examination reveals a sensory level above the patient’s nipples. X rays of his chest and pelvis are non diagnostic. After 1L of intravenous Normal Saline his observations remain unchanged. What actions will you take whilst waiting for a CT scan in 15 minutes time?
• A CT is performed. Interpret this single CT abdomen slice. (The CT showed a large peri-nephric retroperitoneal haemorrhage).
• The CT scan shows no apparent active bleeding. There is an unstable T4 fracture with signs of a cord injury. The patient has unchanged observations (PR 65, BP 80/40). What further actions would you take?

Overall pass rate for this question was 81/100 (81%).

This SCE aimed to test the initial assessment and treatment of a trauma patient and then the management of ongoing hypotension in a spinal injury patient.

Unsuccessful candidates failed to recognise the abnormality on the CT slice or failed to deal with transfer issues from the regional ED.

8. SUMMARY PASS RATES

<table>
<thead>
<tr>
<th>Format</th>
<th>Passes/Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCQ</td>
<td>131/163</td>
<td>80.4%</td>
</tr>
<tr>
<td>SAQ</td>
<td>81/163</td>
<td>49.7%</td>
</tr>
<tr>
<td>VAQ</td>
<td>81/163</td>
<td>49.7%</td>
</tr>
</tbody>
</table>

100/163 passed 2 or more sections and were invited to the clinicals

<table>
<thead>
<tr>
<th>Format</th>
<th>Passes/Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>LC</td>
<td>87/100</td>
<td>87%</td>
</tr>
<tr>
<td>SC</td>
<td>83/100</td>
<td>83%</td>
</tr>
<tr>
<td>SCE</td>
<td>91/100</td>
<td>91%</td>
</tr>
</tbody>
</table>

82 of the 100 candidates (82%) passed the clinical section of the examination.

The overall pass rate for this examination was 82/163 (50.3%)
9. ACKNOWLEDGEMENTS

The Fellowship examination is a huge logistical undertaking, and I would like to acknowledge and express my gratitude to the many people involved. Specifically I would like to thank my colleagues on FEC and its subcommittees for the development of the written exam and the SCEs. I would also like to thank the multiple site organisers of the written examination and to all written and clinical examiners.

I would particularly like to thank Heidi Wade, Jessamine Soderstrom, Rod Ellis, Helga Weaving, Ashiela Narang and Hiten Patel, the site coordinators of the clinical sections. They capably headed teams of their colleagues, nurses, clerical staff and orderlies with the resulting examination proving to be an efficient and successful event.

Finally I wish to highlight the meticulous work throughout with regards to conduct of the examination at the College secretariat level. I wish to especially thank the Fellowship Assessment Team comprising Philippa Henderson, Sarah Aldridge and Pam Donaghy for their logistical support and efficient administration enabling this examination to reach a successful conclusion.

Dr Bernard Foley
Chair, Fellowship Examination Committee