Australasian College for Emergency Medicine
ABN 76 009 090 715

AUSTRALASIAN COLLEGE FOR EMERGENCY MEDICINE
35th FELLOWSHIP EXAMINATION
February/May 2005

This report is circulated in its full form to:

- candidates – successful and unsuccessful
- examiners involved in the exam – written, clinical and observers
- members of the Fellowship Examination Committee
- DEMTs across Australasia
- Board of Censors (as part of their next meeting agenda)
- official observers (listed on Page 2)
- clinical site organisers for this exam

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

The questions alone (without examiner comments or answers) are published in Past Papers, which are available to all trainees from the College.

1. INTRODUCTION

The 2005.1 exam was the smallest exam seen for some time with 44 candidates sitting the written component and 35 subsequently being invited to the clinicals. The smaller number sitting is likely to be due to a number of factors. In general the first exam of the year is smaller. However, the (perceived) more distant location of the clinicals and in particular the impact of the requirement to satisfy regulation 4/10 prior to sitting are likely to be significant factors. The exam was held on February 23rd (written sections – all regions) and on May 7th and 8th (clinical sections – Christchurch). The smaller numbers meant that the clinicals could be held solely at Christchurch Hospital with a timetable that was far more manageable for both examiners and patients used in the short and long cases. Initial arrangements had been made to use Princess Margaret Hospital, which is also in Christchurch, as a second site but this proved unnecessary. The generous offer made by this hospital to host the exam given that it does not have an emergency department was much appreciated.

Overall, 27 candidates passed the examination from the 44 who sat the written sections (overall pass rate 61.4%). More detailed analysis of pass rates is included in subsequent sections of this report.

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

Craig Hore

Clinicals only

Jenny Brookes	Matthew Chu	Chris Curry	Mark Gillett
Wayne Hazell	Debbie Leach	Ian Rogers	Andrew Singer
Allen Yuen			

Writtens and Clinicals

Peter Aitken	Sylvia Andrew-Starkey	Phil Aplin	Richard Ashby
Michael Bastick	Shelia Bryan	Peter Cameron	Bill Croker
Bob Dunn	Bernard Foley	Gordian Fulde	Tim Gray

Richard Harrod	Anna Holdgate	Tony Joseph	Di King
David Lewis-Driver	Lewis Macken	John Maguire	Greg McDonald
Colin Myers	Paul Pielage	Stephen Priestly	Drew Richardson
Irene Rotenko	Mark Smith	James Taylor	Graeme Thomson
Bryan Walpole	Kim Yates	Simon Young	

3. OBSERVERS

The official observers were Doctors:

Don Liew	(DEMT Royal Melbourne Hospital)
Keith Joe	(DEMT Sandringham Hospital)
Neil Grant	(FACEM Middlemore Hospital)
Tonia Nicholson	(FACEM Waikato Hospital)
Andrew Munro	(FACEM Nelson Hospital) – invited NZ invigilator
Paul Quigley	(DEMT Wellington Hospital) – invited NZ invigilator

4. MULTIPLE CHOICE QUESTIONS

34 / 44 (77.3%) candidates passed the MCQ section of the exam. To achieve this a candidate has to pass 33 / 60 questions (55%). The mean score obtained was 35.8 / 60 (SD ± 4.7). The grade frequencies were:

Grade (/ 10)	Frequency (N)
10	0
9	0
8	2
7	6
6	10
5	16
4	9
3	0
2	1

5. SHORT ANSWER QUESTIONS

30 / 44 (68.2%) candidates passed the SAQ section of the exam. To achieve this a candidate has to pass 5 or more of the 8 questions with a total mark of at least 40 / 80. The grade frequencies were:

Grade (/ 10)	Frequency (N)
10	0
9	0
8	2
7	2
6	7
5	19
4	11
3	2
2	0
1	1

SAQ 1

A patient presents with neck pain following a motor vehicle crash.

Discuss what factors on history, examination and investigation you could use to clear the cervical spine.

The overall pass rate for this question was 32 / 44 (72.7%).

Examiners expected that a good answer to this question would include a discussion on the value or otherwise of important factors that would be considered on history, examination and investigation. These factors could be discussed by alluding to the content of the NEXUS and Canadian C Spine rules, and then going to discuss the merits of plain radiology and CT scanning in this setting. A common feature of failing answers was simply describing how the spine could be cleared without making any attempt to attach a relevance or weighting to each factor.

SAQ 2
A 76 year old female with a history of controlled atrial fibrillation presents to the emergency department with severe central abdominal pain of 2 hours duration.

Describe your assessment of this patient.

The overall pass rate for this question was 36 / 44 (81.8%).

It was expected that answers would make clear the broad differential diagnosis with a focus on the likelihood of serious illness (in particular ischaemic gut). To further focus the answer, giving reasons for doing things on history, examination and investigation rather than just a list of what would be done made for a much stronger response displaying a perspective on what were the important emergency medicine issues. Strong answers also considered co-morbidities and complications as part of the assessment. This was considered a straight forward scenario with a high level of knowledge required.

SAQ 3
You have just reviewed an 18 year old female who believes she is in premature labour. She is Gravida 1 and Parity 0. She is approximately 26 weeks pregnant by dates. She has received minimal antenatal care.
a. Describe your assessment of this patient. (50%)
b. Describe your management of this patient. (50%)

The overall pass rate for this question was 35 / 44 (79.5%).

Examiners considered this to be a challenging question as in many EDs such patients would simply be managed by transfer to the labour ward. The best answers acknowledged these issues. It was still expected that to pass candidates would know how to establish whether labour was in progress, seek important complicating maternal factors, prepare for delivery/neonatal resuscitation if this was imminent and consider in utero transfer to definitive care if this was possible.

SAQ 4
Describe a detailed protocol for the use of propofol in the emergency department.

The overall pass rate for this question was 22 / 44 (50%).

The expectation was that candidates would provide substantial detail in this answer on a topic in which they could reasonably be expected to have a high level of knowledge. Although technical issues such as pharmacology, dosing, indications were clearly required this in itself was not sufficient to pass. Since the question asked for a detailed protocol examiners expected that more managerial issues such as consent, credentialing of staff and audit would be addressed.

SAQ 5
A 72 year old patient presents to the emergency department with acute left hemiparesis.
a. List your differential diagnoses. (50%)
b. Discuss the use of thrombolysis in acute stroke. (50%)

The overall pass rate for this question was 30 / 44 (68.2%).

The first question was expected to be answered by considering not just cerebrovascular events but also the commonly encountered stroke mimics. It was hoped that the listed differentials would be given some order so that clinical perspective could be demonstrated. It was expected that the second question would be answered with some reference to the recent literature and important clinical trials and with an acknowledgement that thrombolysis in stroke in Australasia is controversial and currently has limited utility. Features of failing answers included differential diagnoses that were too limited or omitted significant conditions, failure to address both the pros and cons of thrombolysis and inadequate knowledge of the current state of research in this area.

SAQ 6

The mother of a child makes a complaint. She states that three days previously, her 5 year old son had presented to the emergency department with elbow pain after a fall onto his outstretched hand. Following X-rays, the treating doctor had "pulled on the elbow several times causing him to cry". The doctor stated that he had suffered a "sprained elbow" and to return if the pain did not settle. The mother is distressed that her son had received no analgesia for the sprain and that he continued to not move the elbow because of pain. She also complained that the doctor spoke in a rude and insulting manner, and was very rough in his examination. During your investigation, you find that the official report of the X-ray revealed a supracondylar fracture.

Describe your management of this situation.

The overall pass rate for this question was 28 / 44 (63.6%).

Examiners noted that this question was made more difficult by the method of complaint not being specified and so this also needed to be addressed in the answer. It was considered that the highest priority was the management of the presumably missed supracondylar fracture. In terms of the management of the complaint it was expected that it would be dealt with in a sensitive manner that did not serve to inflame the situation and did not unnecessarily escalate to legal and media issues straight away. It was expected that at least some quality improvement issues such as radiology reporting of missed fractures, analgesia protocols in the department and staff education would be considered as part of the complaints management process.

SAQ 7

A 30 year old known schizophrenic is brought in to the emergency department by police. He is aggressive and has been handcuffed.

Describe how you would "medically clear" this patient.

The overall pass rate for this question was 42 / 44 (95.5%)

Better answers began with some sort of definition of what "medically clear" meant or at least a rationale for the actions being undertaken. It was also expected that an organized attempt would be made to differentiate organic delerium from an acute psychosis which includes elements of history, examination and investigation. The mini-mental state exam was the most obvious way to make this differentiation. The question was best answered in the context of the scenario presented with it being essential to consider drug intoxication and to gain extensive collateral history. Failing answers did not include the elements outlined above.

SAQ 8

Concerned parents present with their 5 day old baby. The neonate is feeding poorly, lethargic and jaundiced.

Describe your assessment of this patient.

The overall pass rate for this question was 33 / 44 (75%).

Examiners expected that candidates would approach this question with an understanding of the breadth of potential diagnoses, and specifically those in the stated scenario of a 5 day old baby. They then required a systematic approach that covered the key elements of history, physical examination and investigation that would ensure that the "sick" as opposed to "well" neonate was identified.

6. VISUAL AID QUESTIONS

34 / 44 (77.3%) candidates passed the VAQ section of the exam. To achieve this a candidate has to pass 5 or more of the 8 questions with a total mark of at least 40 / 80. The grade frequencies were:

Grade (/ 10)	Frequency (N)
9	0
8	3
7	6
6	13
5	12
4	9
3	1
2	0
1	0

VAQ 1

A 14 year old female presents to the emergency department via ambulance with agitation and drowsiness. An arterial blood gas is taken.

Describe and interpret the patient's results. (100%)

FIO_2	0.21	
pH	6.89	(7.35-7.45)
pCO_2	72 mmHg	(35-45)
pO_2	60 mmHg	(80-110)
HCO_3^-	10 mmol/L	(23-32)
Base Excess	- 20.5	(-2 / +2)
Sodium	136 mmol/L	(135-145)
Potassium	4.0 mmol/L	(3.5-5.5)
Chloride	90 mmol/L	(90-115)
Urea	16 mmol/L	(3.5-8.0)
Creatinine	0.14 mmol/L	(0.06-0.12)

The overall pass rate for this question was 39 / 44 (88.6%).

Examiners expected that candidates would provide a comprehensive description that included comment on the respiratory acidosis, metabolic acidosis, elevated anion gap and calculation of the A-a gradient. It was expected that clinically relevant (for a 14yo girl) unifying differential diagnoses would be provided rather than separate diagnoses for the respiratory acidosis or metabolic acidosis alone. A pass could be gained by a sound description and interpretation but better answers formulated a clinically relevant differential diagnosis which confirmed understanding of the concepts involved.

VAQ 2

A 12 year old boy presents with a 2 day history of sore throat and fever. The accompanying clinical photograph of the oropharynx shows an extensive unilateral peritonsillar swelling.

a. Describe and interpret the clinical image. (30%)

b. Describe your initial management. (70%)

The overall pass rate for this question was 37 / 44 (84.1%).

Examiners expected a description that recognized the extensive peritonsilar swelling and gave prominence to quinsy as a likely diagnosis. Better answers mentioned other plausible diagnoses such as infectious mononucleosis. Supportive care such as analgesics and antipyretics were considered vital parts of management as well as specific antibiotic therapy. Better answers considered other options including drainage, dexamethasone, possible airway compromise (although this was not the major point of the question) and the likely need for admission – at least to a short stay ward. Since the scenario was one of a child it was important that the parents were involved in management.

VAQ 3
A patient is being assessed in your emergency department following an overdose of paracetamol. You are told the paracetamol level is 100 micrograms/ml (630 micromol/L) and are given a paracetamol nomogram. The picture is of a paracetamol nomogram with 2 "treatment" lines.

What factors do you need to consider or determine in order to interpret this result? (100%)

The overall pass rate for this question was 31 / 44 (70.5%).

A high level of knowledge was expected in answers to this question on a topic that is frequently encountered in emergency practice. An awareness of the validity of the nomogram with its derivation from a study of single ingestions at a known time was expected as well as an understanding of the meaning of the 2 treatment lines. The result also needed interpretation in the context of patient factors such as age, co-morbidities, co-ingestants, paracetamol formulation, multidosing etc.. Failing answers did not consider enough variables in interpretation of the result and did not mention the nomogram validity.

VAQ 4
A 24 year old man presents to your emergency department following a fall. He is complaining of a painful right wrist. The X-ray shown is of a trans-scaphoid, perilunate dislocation of the wrist.

a. Describe and interpret his X-rays. (50%)
b. List your management priorities for this man. (50%)

Overall pass rate for this question was 38 / 44 (86.4%)

It was essential in the examiners view that an answer correctly identified both the scaphoid fracture and the dislocation. It was expected that management would include supportive treatment such as splinting and elevation, emergent reduction if neurovascular compromise was present and plans otherwise for urgent reduction. The examiners were prepared to accept initial reduction in the emergency department but only as part of a coordinated plan developed in consultation with orthopaedic service who would then take on definitive care.

VAQ 5
A 48 year old man presents to your emergency department via ambulance following a syncopal episode. He is confused with a GCS of 12 (M – 5, V - 4, E – 3). His observations, otherwise, are within normal limits. He has had a CT scan of his head performed. The CT image shows an apparently extra-axial, unilateral mass of mixed attenuation.
a. Describe and interpret his CT scan. (50%)
b. List what features you would seek on history in this man. (50%)

The overall pass rate for this question was 40 / 44 (90.9%).

The expectation was that candidates would comment on the mixed density extra–axial collection which had the typical appearances of an extradural haematoma. History would have been more difficult to obtain in this patient as he has a GCS of 12 but needed to be relevant to the stated scenario and so include consideration of issues such as trauma, bleeding diathesis, epilepsy and alcohol abuse as well as the usual key history questions.

VAQ 6

A 65 year old woman is brought to the emergency department following a collapse at home. She is pale with a BP of 75 mmHg (systolic), respiratory rate of 25/minute, a GCS of 13/15 and an SaO_2 of 92% on 6 litres/minute of oxygen. An ECG is performed. The ECG shows a bizarre broad complex rhythm at about 70 bpm with non capturing dual pacemaker spikes.

a. Describe and interpret her ECG. (50%)
b. Outline your initial management priorities for this woman. (50%)

Overall pass rate for this question was 37 / 44 (84.1%).

Examiners felt this VAQ tested fundamental emergency medicine knowledge and skills. It was essential that the description include hyperkalemia as a possible explanation for the broad complex rhythm. Stronger answers noted the presence of the pacing spikes though this was not considered essential to pass. It was expected that other possible explanations such as ischaemia and drug toxicity would be considered. Management needed to include full resuscitation area supportive care but had to focus on urgent management of the presumed hyperkalaemia as well as volume loading, maintenance of oxygenation and probable need for chronotropes/inotropes.

VAQ 7

A 24 year old man was involved in a high speed motor vehicle crash. A cystogram was performed. The cystogram shows extensive contrast extravasation.

a. Describe and interpret his X-ray. (50%)
b. What are the indications and contraindications to performing this procedure? (50%)

Overall pass rate for this question was 27 / 44 (61.4%).

Examiners expected that the cystogram interpretation would include identification of contrast extravasation and that the rupture was probably intraperitoneal. Better answers noted the absence of pelvic and lumber spine fractures fractures with the exception of a possible isolated iliac crest fracture. It was noted that many candidates answered the second question by talking about urethrograms. Although the two may be linked, and in particular an abnormal urethrogram would preclude proceeding to cystography they felt it was important that the question asked was answered. Better answers noted that higher priority injuries might preclude cystogram because of potential time delay and so showed that the role of a cystogram had been considered in the context of the patient scenario described.

VAQ 8

A 9 month old baby presents with an isolated burn to its lower leg. The clinical photograph shows partial thickness burns on the inner aspect of the thigh and lower leg.

a. Describe and interpret the clinical image. (50%)
b. Describe your management of this child. (50%)

Overall pass rate for this question was 33 / 44 (75%).

The examiners expected that the description and interpretation would include a judgment of depth, surface area and pattern raising suspicion of non accidental injury. Management was expected to include analgesia, dressings, tetanus prophylaxis and appropriate measures taken to ensure the

child's safety. The burn area was at the upper limit where in some systems specialist referral might be considered and so the better answers acknowledged this as an option without mandating it. Failing answers were usually due to a poor description and/or not considering NAI as a mechanism. Disappointingly some candidates took an EMST formulaic resuscitation approach to this case which suggested the clinical context had not been considered.

7. CLINICAL EXAMINATIONS

These were held in Christchurch on Saturday May 7th and Sunday May 8th.

Clinical exam coordination was by Scott Pearson assisted by David Richards but was notable for the involvement of a large number of FACEMs and trainees from Christchurch and the South Island. A total of 35 candidates were invited to the clinical section.

7.1. LONG CASES

29 / 35 (82.9%) passed the long cases. The pass mark is 5/10. The grade frequencies were:

Grade (/ 10)	Frequency (N)
9	3
8	4
7	9
6	9
5	4
4	6
3	0

7.2. SHORT CASES

31 / 35 (88.6%) 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:

Grade (/ 10)	Frequency (N)
8	1
7	6
6	9
5	15
4	3
3	1

7.3. SCEs

29 / 35 (82.9%) passed the SCEs. To pass, a candidate needs to score 30/60 and pass at least 4 stations. The grade frequencies were:

Grade (/ 10)	Frequency (N)
10	2
9	2
8	4
7	9
6	6
5	6
4	5
3	1

SCE 1

Your Emergency Department provides retrieval services for the surrounding rural region. Ambulance control has requested retrieval of a 12 year old girl, who has had fevers for 24 hours and is now delirious.

The patient and her mother are currently being transported by ambulance. The ambulance is staffed by 2 volunteer ambulance officers, and they are two hours away from your Emergency Department.

The ambulance crew reports that the patient is deteriorating, with temperature 38°C, pulse 120 bpm, systolic BP 100 mmHg, respiratory rate 30 /min and GCS 14.

They have IV access and she has been given 1L of crystalloid fluid. They have noticed a rash developing on her trunk.

The ambulance crew requests advice on management of this patient and that you meet them en route, as per regional protocol.

- (Question given outside the room) What is your response to them?
- You delegate senior registrar to retrieve the child – what should he or she take with them?
- What is the role of lumbar puncture in this patient?
- The patient is now in the ICU and under their care. What further issues do you need to address?
- (Supplementary question) 5 days later a friend of the patient presents with symptoms of mild fever and sore throat. What are the key issues in her management?

Overall pass rate for this question was 31 / 35 (88.6%).

Examiners noted that the commonest reason for failing was lack of knowledge at a consultant level. The more challenging part of the SCE in this regard was the questions relating to contact prophylaxis and the systems for appropriate follow up.

SCE 2
It is 2400 hours on a weekday in your urban district Emergency Department. A 26 year old man is brought in by ambulance following a collapse at work. He is a machine operator at a nearby 24-hour factory. Ambulance officers report that his colleagues saw him collapse to the ground while working. No electrical equipment was involved. He was unresponsive and jerking all limbs for a brief period. His conscious state has improved *en route* to hospital. His Triage observations are: Alert and orientated man, GCS 15, HR 90, BP 120/80, Temp 37.5, SpO_2 100% (O_2 6 LPM).

- (Question given outside of the room) What differential diagnoses do you consider for his seizure?
- What features would suggest this was a seizure rather than another cause of collapse?
- Why would you order an urgent brain CT now?
- Why would you wait until the following morning to do a CT?
- What factors do you consider in determining whether this man may be discharged?
- It is now morning and you determine the patient is stable for discharge. He expresses the wish to return to work and continue driving against your advice. How do you manage this situation?

Overall pass rate for this question was 31 /35 (88.6%).

Examiners noted that the most challenging question were those around rationales for early or delayed CT and those around discharge planning which some candidates struggled to answer at a consultant level.

SCE 3
An elderly lady is brought into your ED at 0800 hours by ambulance. She was found by her neighbour on her backyard lawn. On arrival, her observations are: GCS of 9 (E3, V3, M3), BP 90/50, RR 20, SpO_2 90% (6L/min O_2.). Her ECG performed on arrival (which shows slow AF, shivering artifact and Osborne waves) is given to candidates outside the room.

- (Question given outside of the room) Please describe her ECG.
- Her core temperature is 29 degrees Celsius. What complications of hypothermia will you consider in this lady?
- The patients initial GCS remains at 9 despite initial treatment, and you decide to order a brain CT scan. Discuss the role of endotracheal intubation for CT scanning in this patient.
- As you are preparing for intubation the patient goes into ventricular fibrillation. How would you modify your standard ACLS procedures in this situation?
- After 10 minutes the patient remains in VF. What factors do you consider when deciding how long to continue resuscitation in this lady?

Overall pass rate for this question was 26 / 35 (74.3%).

Examiners expected a high level of ECG interpretation with the noting of J waves considered mandatory. The most challenging questions were those regarding the role of intubation and modification to ACLS protocols. Both these questions allowed those with consultant level judgment and specific knowledge to stand out.

SCE 4
It is 1800 hours on a Friday evening. You are the consultant in charge of the ED. The charge nurse informs you about a 4 year old boy with a laceration on his forehead, who has been waiting 45 minutes to be seen. He hit his head about 2 hours ago with no loss of consciousness or other concerning history. Her mother has complained about the wait as her child is distressed and hungry. The child has been assigned an ATS category 3. There are 2 cases due to be seen before him. The Triage nurse has just repeated his observations and he has a GCS of 15 and normal vital signs. She asks your advice on how to manage this situation.

- (Question given outside of the room) Outline your approach to this situation.
- A photograph showing a gaping forehead laceration is shown to the candidates. What are the options for wound closure in this case?
- Discuss the pros and cons of repairing this wound in the emergency department vs in the operating theatre.
- You decide to opt for sedation. Please describe your preferred method for procedural sedation in this child.
- What are the options for local anaesthesia in this child's wound?

Overall pass rate for this question was 29 / 34 (82.9%).

The examiners felt that the first question immediately introduced consultant level issues as it required an administrative approach that needed to balance the needs of the patient against those of the whole department. This challenged some candidates. There was surprise that some candidates could not give a detailed description that demonstrated their expertise and safety with regards to their preferred technique of sedation.

SCE 5
You are the Team Leader of a Trauma Team managing a 35 year old patient who has recently arrived by ambulance. The patient was the driver of a car involved in a high speed motor vehicle accident. The doctor in charge of the patient's airway is having some difficulty ventilating the patient, who is intubated. Two 16G IV cannulae have been inserted, blood has been sent for pathology, and IV crystalloid is being administered. His X-rays have just arrived for viewing. The patients vital signs are: BP 80/50; pulse 120; O_2 sats 86% (FiO2 100%).

- Please identify the major abnormalities in these X-rays. (The X-ray abnormalities are bilateral pneumothoraces, right sided subcutaneous emphysema, multiple pelvic fractures and a disrupted sacroiliac joint)
- As the team leader what are your management priorities?

- Following placement of bilateral chest tubes patient ventilation is easier and oxygenation is satisfactory. He remains hypotensive with a BP of 85 systolic and HR 110 after 3 litres of crystalloid. What will you do about his hypotension?
- The patient's blood pressure has improved. The surgical registrar wants to take the patient to the CT scanner. What are the pros and cons of FAST scan versus CT scan in this patient?
- (Supplementary question) What injuries might be associated with pelvic fractures?

Overall pass rate for this question was 24 / 35 (68.6%).

The 2 X-rays used were grossly abnormal. The time pressure of the SCE exposed those candidates who were unable to quickly interpret these films in a prioritized, real life manner. Some proved unable to detect the important abnormalities which would reasonably be expected in such a situation.

SCE 6

A 14 year old boy presents to your Emergency Department at 1400 hours accompanied by his parents.

He is complaining of a painful right testis that has been present for 24 hours. He attended his General Practitioner yesterday, who organised an ultrasound that afternoon. The General Practitioner prescribed antibiotics which the patient commenced yesterday evening.

The Ultrasound report from yesterday reads:

"Colour Doppler ultrasound of the scrotum demonstrates normal blood flow to both testes. There is a right small hydrocoele and there is slight enlargement and increased blood flow to the right epididymis, consistent with epididymitis".

The patient states that his pain is now worse and is also present in the right lower abdomen. He reports that he has vomited once.

- What are the differential diagnoses?
- What clinical features may distinguish torsion from epididymitis in this boy?
- Discuss the role of repeat ultrasound in this patient.
- Urgent ultrasound confirms torsion of the right testis with no blood flow. What do you now communicate to the patient and his parents?
- The patient is taken urgently to theatre. His testis is not salvageable. His parents ask to speak to you and they express concerns about the GP's failure to diagnose torsion. What do you do?
- (Supplementary question) If the urologist had been in theatre and requested that you obtain consent from the patient, what are the key issues about valid consent in this case?

Overall pass rate for this question was 33 / 35 (94.3%).

Examiners noted that a degree of clinical maturity was required to answer the question about dealing with the parents' concerns about the GP. The correct response was not a damning opinion of the GP but rather careful listening and an awareness that not all the facts are known in what could be a dynamic situation. The other challenging question was the discussion of the role of ultrasound in this setting with better answers able to demonstrate knowledge in this area.

8. SUMMARY PASS RATES

MCQ	34 / 44	(77.3%)
SAQ	30 / 44	(68.2%)
VAQ	34 / 44	(77.3%)

35 / 44 passed 2 or more sections and were invited to the clinicals

LC	29 / 35	(82.9%)

SC	31 / 35	(88.6%)
SCE	29 / 35	(82.9%)

At the examiners meeting, of the 35 candidates at the clinicals

- 27 candidates passed automatically
- none were discussed
- meaning 27 / 35 (77.1%) of those invited to the clinicals passed.

So the overall pass rate was 27 / 44 (61.4%)

9. RECOMMENDATIONS/ISSUES FROM THIS EXAM

- Using sufficient examiner pairs to allow some examiners a "spare" morning or afternoon and to limit the number of SCEs for each examiner to 12, noticeably reduced examiner fatigue and allowed valuable opportunities for examiners to observe other examiners during the clinical cases. This will not always be possible depending on the size of the clinical exam but is desirable.

- The revised SCE design with some first questions given outside the room was well received by most examiners and will be continued for SCEs where it is deemed appropriate (but this will not necessarily be all).

10. ACKNOWLEDGMENTS

As always the Fellowship exam is a huge logistical undertaking and the effort required in running it should not be underestimated. Acknowledging the help provided by all of the many doctors, nurses, clerical staff and orderlies in running the exam is best done in this exam by noting that this was a real team effort. I would like in particular to thank Drs Scott Pearson and David Richards for their work as the site coordinators.

I would also like to thank Gabrielle Whiting for her meticulous work with the logistics of the exam at the College secretariat level and Jenny Freeman for her support at the clinical exam itself.

Ian Rogers FACEM
Chair, Fellowship Examination Committee