



## AUSTRALASIAN COLLEGE FOR EMERGENCY MEDICINE 36th FELLOWSHIP EXAMINATION August/October 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. Recent previous exam reports are available on the college website.

### 1. INTRODUCTION

The 2005.2 exam was held on August 10th (written sections – all regions) and on October 22<sup>nd</sup> and 23<sup>rd</sup> (clinical sections – Perth). The numbers of candidates meant that the clinicals were held at 2 sites (Royal Perth for the Long Cases, Short Cases and SCEs, and Fremantle Hospital for Long Cases and Short Cases).

Overall, 35 candidates passed the examination from the 56 who sat the written sections (overall pass rate 62.5%) with one candidate withdrawing between the writtens and clinicals due to illness. 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

Chris Gavaghan	Anne Maree Kelly	Lewis Macken
Bhavani Peddinti		

#### Clinicals only

Michael Bastick	Jenny Brookes	Matthew Chu	Chris Curry
Linda Dann	Steve Dunjey	Bob Dunn	Anna Holdgate
Debbie Leach	Graeme Thomson		

#### Writtens and Clinicals

Phil Aplin	Neil Banham	George Braitberg	Simon Brown
Tony Brown	Sheila Bryan	Tony Celenza	Bill Croker
David Eddey	Di Edgerton Warburton	Greg Emerson	Mark Gillett
David Green	Craig Hore	Trevor Jackson	David Lightfoot
Paul Mark	Jenny Martin	David Mountain	Lindsay Murray
Debra OBrien	Paul Preisz	John Roberts	Andrew Singer
Jeff Wasserthiel	Mark Webb	Gary Wilkes	

**3. OBSERVERS**

The official observers were Doctors:

Don Liew	(Royal Melbourne Hospital)
Tom Reade	(Western Hospital)
Simon Wood	(Joondalup Hospital)
Yuresh Naidoo	(Joondalup Hospital)
Bronwyn Pierce	(Bunbury Hospital)

**4. MULTIPLE CHOICE QUESTIONS**

54/56 (96.4%) 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 40/60 (SD  $\pm$  4.4 ). The grade frequencies were:

Grade ( / 10)	Frequency (N)
10	0
9	0
8	10
7	20
6	15
5	9
4	1
3	1
2	0

**5. SHORT ANSWER QUESTIONS**

36/56 (64.3%) 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	0
7	6
6	12
5	18
4	8
3	8
2	4
1	0

**SAQ 1**

You are the Director of the emergency department with the following problem. The hospital's access block is 47% and its bed occupancy is 92%.

Describe your strategies to reduce access block in this situation. (100%)

The overall pass rate for this question was 41/56 (73.2%).

Examiners expected that a good answer to this question would include a definition of the terms used, a recognition that this high level of access block will impair a whole range of departmental functions and a recognition that this is a whole of hospital problem. It was expected that strategies for dealing with the problem would include pre-hospital, ED and whole of hospital approaches. In particular a strong understanding of ED approaches such as senior staffing, allied health input and use of short stay/hospital in the home programs was expected. Failing answers did not describe

enough strategies, especially those centered in the ED. They also tended not to define the problem and show an appreciation that this is a whole of health issue.

**SAQ 2**

- a. How would you distinguish between neuroleptic malignant syndrome and serotonin syndrome?(50%)
- b. Outline your management of neuroleptic malignant syndrome. (25%)
- c. Outline your management of serotonin syndrome. (25%)

The overall pass rate for this question was 28/56 (50%).

It was expected that answers would make clear the causative agents, time course and classic clinical features of both syndromes. Better answers made clear both the useful differentiating points and the common features. The management questions were expected to include both general supportive measures such as IV fluids, cooling and prevention of muscle breakdown induced renal impairment, as well as syndrome specific drug treatments. Failing management answers drew little distinction between the two syndromes and were light on with respect to specific therapies such as bromocriptine, cyproheptadine and chlorpromazine.

**SAQ 3**

A 38 year old woman presents in a post-ictal state. A venous blood gas on arrival reveals a Sodium level of 110 mmol/L (Reference Range: 135-145 mmol/L).

- a. List the possible causes of hyponatraemia in this patient. (30%)
- b. Outline your management of this patient. (70%)

The overall pass rate for this question was 47/56 (83.9%).

Examiners expected that the list of possible causes would be structured such that it made clear both the most likely causes as well as some sort of classification that addressed volume status, urine sodium excretion and urine tonicity. The management needed to address routine aspects of post ictal care such as airway and treating hypoglycaemia as well as the specifics of sodium replacement. There needed to be recognition that active partial correction of sodium was required in the context of this scenario though subsequent management of acute versus chronic hyponatraemia may be different. Failing answers gave no structure to the list of possible causes and didn't recognize the serious nature of this presentation with the need for active treatment.

**SAQ 4**

A 17 month old boy is brought to your emergency department by ambulance. He has been previously identified to be a child at risk. He has been run over by a motor bike in the driveway of his home. He has multiple tyre marks over his lower limbs. He is alert and appropriately responding for his age. Following clinical examination, you determine that his injuries are restricted to his lower limbs.

Describe your management of this boy. (100%)

The overall pass rate for this question was 47/56 (83.9%).

The expectation was that candidates would address the management of the expected injuries (attending to volume status, analgesia, splinting and possible compartment syndromes) as well as communication with the family, protection of the child and the possible need to involve child protection services. Failures were largely due to assuming this was a question only about non accidental injury without treating this particular patients likely injuries.

**SAQ 5**

Discuss the different methods used to control epistaxis in the emergency department. (100%)

The overall pass rate for this question was 48/56 (85.7%).

The expectation of examiners with regard to this question was high given the frequency of epistaxis as an ED presentation. A comprehensive answer would include the pros and cons of first aid measures, general measures (such as managing blood pressure or coagulopathy), vasoconstrictors, cautery and nasal packing by various methods. The commonest reason for failing was describing the management rather than discussing as the question asked.

**SAQ 6**

A 62 year old man with known chronic renal failure presents with respiratory failure, secondary to pulmonary oedema. Oxygen saturation is 89% on 100% oxygen utilizing bi-level positive airway pressure (BiPAP). His observations are:

Glasgow Coma Score	14
Temperature	37.0°C
Respiratory Rate	32 /min
Systolic blood pressure	90 mmHg
Electrocardiograph	Rate of 105 /min with a regular broad complex rhythm.

An urgent Potassium level of 8.7 mmol/L (Reference Range: 3.5-4.9 mmol/L) has been recorded.

Discuss rapid sequence induction in this man. (100%)

The overall pass rate for this question was 23/56 (41.1%).

Examiners noted that this was a challenging question that required far more than a simple description of an RSI template. In particular as a discuss question it required consideration of whether RSI was appropriate at all, alternative approaches, the clinical context of a patient with life threatening hyperkalaemia and the pros and cons of elements of RSI such as drugs, posture, haemodynamics etc.

**SAQ 7**

A 26 year old woman on maintenance steroids for ulcerative colitis presents to the emergency department with a 12 hour history of abdominal pain.

Describe your assessment of this woman. (100%)

The overall pass rate for this question was 47/56 (83.9%)

Better answers opened with the specific issues related to the context of this patient (eg recognized complications of ulcerative colitis, immune modification by steroids) before describing assessment for causes of abdominal pain unrelated to ulcerative colitis. A description of what to seek on history, physical examination and investigation displayed a greater depth of knowledge if it was preceded by the rationale for each of these. Failing answers give limited detail on the reasons for different aspects of assessment and did not touch on alternate diagnoses such as pregnancy related problems.

**SAQ 8**

Describe a detailed protocol for the emergency department management of paediatric gastroenteritis. (100%)

The overall pass rate for this question was 35/56 (62.5%).

Examiners expected that candidates would approach this question by covering all of the important elements in assessment and management of paediatric gastroenteritis such that all major manifestations of the illness and conventional treatment strategies would be covered. Key issues were volume status, rehydration (by multiple different methods) and admission/discharge criteria. Failing answers focused narrowly on oral rehydration, did not provide accurate/detailed fluid replacement regimes or had the process of protocol design rather than its content as their focus.

## 6. VISUAL AID QUESTIONS

39/56 (69.6%) 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	7
6	15
5	14
4	12
3	4
2	0
1	1

### VAQ 1

A 34 year old woman presents to your emergency department with a history of abdominal pain, vomiting and diarrhoea for two weeks. Examination reveals dehydration and generalised abdominal tenderness.

Her observations are:

HR 140 /min  
BP 130/70 mmHg (supine)  
Temperature 36.5°C  
SaO<sub>2</sub> 97% (room air)

Arterial blood gas and biochemical results are shown.

		Reference Range
FIO <sub>2</sub>	0.21	
pH	7.21	(7.35-7.41)
pCO <sub>2</sub>	31 mm/Hg	(33-47)
pO <sub>2</sub>	83 mm/Hg	(85-110)
Bicarb	12 mmol/L	(21-27)
Base excess	-14	(-3 - +3)
Na <sup>+</sup>	135 mmol/L	(134-146)
K <sup>+</sup>	2.8 mmol/L	(3.5-4.5)
Cl <sup>-</sup>	111 mmol/L	(95-105)
Creat	0.57 mmol/L	(0.04 – 0.10)
Urea	84 mmol/L	(3-8)
Gluc	7.2 mmol/L	(3.5-5.5)

Describe and interpret her results. (100%)

The overall pass rate for this question was 47/56 (83.9%).

Examiners expected that candidates would correctly interpret this as normal anion gap metabolic acidosis which could be due to GI or renal causes given the scenario presented. Reasons for failing

answers included omission of renal failure in the interpretation, stating that the hypokalaemia was due to acidosis and misinterpreting the anion gap.

### VAQ 2

A 70 year old man with past history of COAD presents with two days of rash and fever. His only medications are metered aerosol inhalers of salmeterol and fluticasone. His observations are all within normal limits. The accompanying picture shows generalized skin erythema and desquamation.

- a. Describe and interpret the photograph. (50%)
- b. List the potential complications in this case. (50%)

The overall pass rate for this question was 46/56 (82.1%).

Examiners expected a thorough description of the rash highlighting the erythema and desquamation. They noted that most candidates were able to do this. Although the syndrome was erythroderma it was expected that good answers would give causes relevant to the scenario such as drug reactions, TEN, Staph scalded skin, Stevens Johnson syndrome, psoriasis, generalised eczema and polymorphous light eruption. It was incorrect to over emphasise bullous conditions. Irrespective of the diagnosis it was expected that a number of complications would be mentioned such as heat loss, fluid/electrolyte loss, protein wasting, heart failure and secondary infection/sepsis.

### VAQ 3

A 26 year old man presents with a 24 hour history of a painful penis. There is no history of trauma. The clinical photograph shows a grossly oedematous foreskin suggesting a paraphimosis.

- a. Describe and interpret the photograph. (30%)
- b. Outline your management of this man. (70%)

The overall pass rate for this question was 42/56 (75%).

A high level of knowledge was expected in answers to this question as the diagnosis of paraphimosis should have been clear from the image. It was expected that candidates would be able to describe systematically how they would attempt reduction by manual compression preceded by appropriate analgesia or local anaesthesia. It was not adequate to simply refer for surgical management.

### VAQ 4

A 15 year old boy is injured in a high speed motor vehicle crash. He was resuscitated at a local hospital and has just arrived in your emergency department. He was intubated, ventilated and resuscitated at a local hospital. A chest X-ray was taken on arrival. The chest X-ray shows an intubated patient with bilateral chest tubes, multiple rib fractures, lung contusion and fractured clavicle.

Describe and interpret his chest X-ray. (100%)

Overall pass rate for this question was 31/56 (55.4%)

There were many abnormalities to detect on this xray but examiners felt this was emergency medicine “core business” and so expected a high standard. The fractures, lung opacification, various lines/tubes all needed to be noted. It was then also expected that this would be synthesized into important diagnoses that should not be missed (eg aortic injury) as well as the diagnoses that had been made (eg bony injuries) and the future problems that could be anticipated (eg impaired gas exchange). Some candidates failed by overreading the xray to report false positive findings.

**VAQ 5**

An 8 year old boy is brought to your emergency department after injuring his right arm in a fall from his bicycle. This is an isolated injury. The X-ray shows a displaced supracondylar fracture

- a. Describe and interpret his X-ray. (50%)
- b. Outline your management of this boy. (50%)

The overall pass rate for this question was 44/56 (78.6%).

This was considered a straight forward question that most well prepared candidates would easily pass. The description/interpretation needed to include not only the grossly displaced fracture but also specifically mention that this is associated with the risk of neurovascular injury. Failing answers incorrectly described the film as a dislocation, did not emphasise the need for urgent reduction if there was vascular compromise and did not mention the paediatric specific issues of parental involvement (ie they only managed the fracture and not the child).

**VAQ 6**

An 80 year old woman presents to your emergency department with palpitations and breathlessness for three days. She had undergone coronary bypass grafting two weeks earlier. The ECG provided shows a narrow complex tachycardia with electrical alternans.

- a. Describe and interpret her ECG. (50%)
- b. List the possible causes of her breathlessness. (50%)

Overall pass rate for this question was 45/56 (80.4%).

Examiners noted that better answers correctly diagnosed the electrical alternans but it was still possible to pass by noting that this was a narrow complex rhythm of which possible causes included a pericardial effusion post surgery. It was incorrect to call the rhythm atrial fibrillation. It was expected that the list of possible causes for her breathlessness would be structured so as to highlight the important or likely causes in this particular patient.

**VAQ 7**

A 40 year old man presents to the emergency department with a history of chest pain two hours previously. He is now pain free. The ECG provided shows a change from broad to narrow complex rhythm across the ECG and ST/T changes suggesting a proximal LAD stenosis.

- a. Describe and interpret his ECG. (50%)
- b. What investigations does this man need and why? (50%)

Overall pass rate for this question was 36/56 (64.3%).

The key to this question was to recognize ECG changes strongly indicative of a proximal left coronary stenosis which was visible in the second half of the ECG when the broad complex rhythm was no longer present. Candidates who failed did not appreciate the clinical significance of the ECG changes and the presumed site of stenosis, and therefore did not make clear the need for early angiography.

**VAQ 8**

A 65 year old man presents with painless loss of vision in his left eye. His fundoscopic examination is shown. The image of the retina suggests retinal vein occlusion

- a. Describe and interpret his fundoscopic examination. (50%)
- b. What are the underlying causes of this condition? (50%)

Overall pass rate for this question was 48/56 (85.7%).

The examiners expected that candidates would highlight in their description the features of central retinal vein occlusion seen in the image such as venous tortuosity and retinal haemorrhages. The second part of the answer needed to make clear that this was an atherosclerotic/clotting process (and not an embolic one) and as such the causes were the systemic causes of these processes. Failing answers did not identify this as a central retinal vein occlusion or incorrectly described it as an embolic phenomenon.

## 7. CLINICAL EXAMINATIONS

These were held in Perth on Saturday October 22nd and Sunday October 23rd.

Clinical exam coordination at the Royal Perth site was by Justin Yeung and at the Fremantle site was by Rod Ellis. A total of 45 candidates were invited to the clinical section.

### 7.1. LONG CASES

41/45 (91.1%) passed the long cases. The pass mark is 5/10. The grade frequencies were:

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

### 7.2. SHORT CASES

35/45 (77.8%) 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	0
7	2
6	12
5	21
4	10
3	0

### 7.3. SCEs

39/45 (86.7%) 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	1
9	7
8	7
7	9
6	2
5	13
4	4
3	1
2	1

### SCE 1

You assess a 16 year old female in your emergency department. She presents with lower abdominal discomfort and per vaginal bleeding (volume less than normal menses) of 24 hours duration. She thinks she may be pregnant based on one missed period (LNMP 5-6 weeks), but has not previously sought medical care in relation to this. She is haemodynamically stable.

- (Question given outside the room) What is the role of urine pregnancy test in this patient?
- Her urine pregnancy test is positive. What is the role of vaginal examination in this patient?
- The patient's  $\beta$ HCG is 5000 IU which is consistent with her dates. How do you interpret this result in conjunction with ultrasound findings?
- A transvaginal ultrasound shows a normal 6 week intrauterine pregnancy. The patient states she does not wish to continue her pregnancy. Outline your management.
- Her parents arrive and demand to know what is wrong with her. How will you approach this?

Overall pass rate for this question was 35/45 (77.8%).

Examiners noted that the most challenging questions on this SCE was question 3 in which candidates had to display an understanding of how test results are applied in clinical practice and needed more than just book knowledge. Some candidates also struggled with the counseling aspects and dealing with both the patient and her parents.

### SCE 2

You are called to the resuscitation area of your emergency department to attend a 20 year old man who has just been brought to the emergency department by his friends, who have left immediately. The only information they gave was that he has taken some drugs at a party. He is obtunded with the following observations; GCS of 6/15, HR 45 (SR), BP 105/70 mmHg, RR 8 per min, SpO<sub>2</sub> 90% (room air), Temp 37.0°C.

- (Question given outside of the room) Which drug toxicities might explain this presentation?
- The patient's brother arrives and states the patient has taken a large amount of alcohol and Gamma- Hydroxybutyric acid. Describe your management of this patient.
- You are commencing initial management and have not yet obtained IV access when the patient becomes extremely combative. Describe your management of this situation.
- What medicolegal issues are relevant to the physical restraint of patients in the ED?
- What are the potential problems of physical restraint devices ?

Overall pass rate for this question was 40/45 (88.9%).

Examiners noted that the most challenging aspects were addressing the drug specific issues of this particular intoxication (which a few had little knowledge of) and dealing with the medicolegal issues which were felt to be consultant level core ED concepts.

### SCE 3

A 4 yr old boy presents to the emergency department with his concerned parents. He has a 24 hour history of severe abdominal pain and vomiting. He has become increasingly lethargic over the past 2 days. He has no significant past history. He appears unwell, with observations: T=37.8°C, HR=150/min, BP=85/50 mmHg, CR=5secs, RR=40/min, He opens his eyes to verbal stimuli but is very drowsy. These are his initial investigation results. Arterial blood gas (Results on oxygen 15 LPM via non-rebreathing mask) pH 7.18 (7.35 – 7.45), pCO<sub>2</sub> 20 mmHg (35 - 45), pO<sub>2</sub> 96 mmHg, (90 - 100), O<sub>2</sub> Sat 96% (94-100), HCO<sub>3</sub><sup>-</sup> 8 mmol/L (24 - 32), Na<sup>+</sup> 140 mmol/L (135 - 145), Cl<sup>-</sup> 98 mmol/L, (95 - 110), K<sup>+</sup> 3.5 mmol/L (3.5 – 5.0)

- (Question given outside of the room) Please interpret these results?
- His glucose is 39 mmol/L. How do you manage fluid and electrolytes in this child?
- Describe your management of his serum glucose.
- What are the life threatening complications of diabetic ketoacidosis?
- What are the indications for using bicarbonate therapy in paediatric diabetic ketoacidosis?

Overall pass rate for this question was 41/45 (91.1%).

Examiners felt that this SCE tested core concepts and principles which all ED consultants should be familiar. The best prepared candidates were most able to display their knowledge in the fluid management question and how this might relate to the serum glucose.

#### SCE 4

You have just commenced your morning shift in the emergency department. A nurse asks you to come and see a 50 year old male patient at the request of the night registrar who is just finishing his shift. He has requested assistance as he is having difficulty inserting a central venous line. He was placing the central line because he had failed to obtain peripheral venous access. The patient requires IV antibiotics for severe cellulitis. You attend the patient and determine that there have been multiple attempts at insertion of a right sided internal jugular line. A right sided internal jugular central venous catheter appears to be partly inserted. Blood can be aspirated easily.

- (Question given outside of the room) How do you assess this situation?
- This is his CXR (shows a partly inserted IJ catheter with a guidewire in the right atrium) – please describe and interpret.
- What is your management from now?
- How would you determine that a registrar is safe to perform CVL insertion unsupervised?
- What is your preferred route for central venous access during CPR and why?
- What are your indications and contraindications for central line insertion in the ED?

Overall pass rate for this question was 36/45 (80%).

The examiners felt that this SCE tested well clinical, administrative and credentialing issues at a consultant level. Many of the principles and key concepts could be equally applied to other common ED procedures. The best candidates were able to show that their assessment in question 1 would consider all aspects of both patient welfare and the welfare of the staff member concerned.

#### SCE 5

You are attending a 77 year old man who has just arrived by ambulance to your tertiary level emergency department. He had a fall two days earlier. He has been confused since the fall. He is a hostel resident and is normally alert. His usual medications include warfarin. His General Practitioner arranged a CT scan brain earlier today and referred him to the emergency department. You note his observations are: GCS 14, BP 150/80 mmHg, HR 95, RR 18, SpO2 99% (Room air).

- Please describe and interpret his CT scan (which shows bilateral, acute on chronic subdurals).
- The patient's INR is 4.0. What issues do you consider in managing his anticoagulation?
- You decide to reverse his anticoagulation. Discuss your options for achieving this.
- Soon after your initial management the patient's GCS falls to 5 and his right pupil dilates. Describe your management.

Overall pass rate for this question was 33/45 (73.3%).

The examiners noted that candidates who were unable to clearly describe the subdurals seen in the CT scan then struggled with the rest of the SCE. They also noted that candidates frequently did not listen to the question in question 3 which was a “discuss” question and so was specifically seeking the pros and cons of various strategies rather just what the candidates would do.

#### SCE 6

A 59 year old man presents to your tertiary hospital emergency department with severe chest pain. His past history includes vascular grafting the previous year for a thoracic aortic aneurysm, and post-operative ventricular tachycardia for which he had an implantable defibrillator inserted. He has been given 10mg of IV Morphine by ambulance staff and sublingual GTN. On examination he is distressed and complaining of chest pain. His vital signs are; HR 120, BP 160/100, RR 20, SpO2 96% (oxygen via Hudson mask 6 LPM), Temp 37.0°C. A CXR is taken on arrival.

- Please describe and interpret his CXR (shows a very wide mediastinum, previous graft and an implantable defib/pacemaker).
- Your assessment suggests an aortic dissection. The patient awaits an urgent CT angiogram. Discuss treatment options for his blood pressure.
- Prior to treatment for blood pressure, a change occurs in his rhythm strip. He is asymptomatic. Describe and interpret the rhythm strip (shows runs of self limited VT).
- Discuss treatments for his arrhythmia.
- CTA confirms a recurrent thoracic aortic dissection. You inform the patient of the need for urgent surgical treatment, but he refuses, stating that he wishes to be allowed to die. Outline your approach to his request.

Overall pass rate for this question was 42/45 (93.3%).

As in many other SCEs the examiners noted that it was the “discuss” questions on the treatment of VT and BP that were the most challenging. These questions allowed strong candidates to display a depth of knowledge not shown by those who failed.

## 8. SUMMARY PASS RATES

MCQ	54 / 56	(96.4%)
SAQ	36 / 56	(64.3%)
VAQ	39 / 56	(69.6%)

46 / 56 passed 2 or more sections and were invited to the clinicals but one subsequently did not sit the clinicals

LC	41 / 45	(91.1%)
SC	35 / 45	(77.8%)
SCE	39 / 45	(86.7%)

At the examiners meeting, of the 45 candidates at the clinicals

- 35 candidates passed automatically
- none were discussed
- meaning 35 / 45 (77.1%) of those attending the clinicals passed.

So the overall pass rate was 35 / 56 (62.5%)

## 9. RECOMMENDATIONS/ISSUES FROM THIS EXAM

- Increasingly hospitals are using digital radiology systems. In most of the outpatient clinics that we use for the exam the computer monitors do not support high quality images. In recognition of this, and also with the issues of computer log on/log off, site co-ordinators will often need to organize hard copies of those radiographs it is considered examiners are most likely to use.
- The use of a tiered lecture theatre worked well for the examiners meeting. In particular it resolved the issue of trying to seat a large number of examiners around a single table. Use of a lecture theatre is strongly recommended for future exams.

## 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 Justin Yeung and Rod Ellis for their work as the site coordinators.

Gabrielle Whiting retired from the college half way through the preparation for this exam. One last time I wish to acknowledge her long service and meticulous work with the logistics of the exam at the College secretariat level. I also wish to thank our new Fellowship Exam Officer, Virginia Cunsolo and our college Chief Executive Jenny Freeman for their support at and prior to the exam itself.

**A Prof Ian Rogers FACEM**  
**Chair, Fellowship Examination Committee**