Welcome to the 4th edition of what we hope will be a useful guide for your journey to successfully complete the ACEM Fellowship Examination.

The preparation you are about to begin and the exam process you will undertake will make you a better doctor and if all goes to plan an emergency physician.

This manual is a collection of our thoughts on how to prepare for and undertake the Fellowship Exam. It aims to provide advice on:

- Establishing your study program
- Focusing your study
- Developing a sound technique for answering questions within all components of the exam
- Conducting yourself on exam day

Above all, the manual aims to advise you on how to reflect good clinical practice in written and verbal formats; because at the end of the day that is what the exam is asking of you.

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Addit: Please note that this manual will be void following the introduction of the new ACEM Curriculum and Training Program in 2015.
# Table of Contents

1. THE BEGINNING – GETTING ORGANISED ........................................... 4

2. THE CURRICULUM – AN OVERVIEW .................................................. 12

3. STRUCTURE OF THE EXAM. .............................................................. 15

   WRITTEN COMPONENT. ........................................................................ 15
   Multi-choice Questions: ....................................................................... 15
   Short Answer Questions: .................................................................... 16
   Visual Aid Questions: ......................................................................... 16
   CLINICAL COMPONENT ........................................................................ 17
   Long Case: .......................................................................................... 17
   Short Cases: ....................................................................................... 17
   Structured clinical examination: .......................................................... 18

4. WRITTEN EXAMINATION COMPONENTS – AN APPROACH TO PREPARATION AND TECHNIQUE ..................................................... 19

   MULTI-CHOICE QUESTIONS .................................................................. 19
   SHORT ANSWER QUESTIONS ............................................................. 20
   General Approach to SAQ Technique: ............................................... 22
   VISUAL AID QUESTIONS ..................................................................... 26

5. CLINICAL EXAMINATION COMPONENTS – AN APPROACH TO PREPARATION AND TECHNIQUE ..................................................... 28

   LONG CASE PREPARATION ................................................................. 28
   SHORT CASE PREPARATION ............................................................... 29
   STRUCTURED CLINICAL EXAMINATION PREPARATION .................. 32

6. EXAM DAY ............................................................................................. 35

   WRITTEN EXAM ................................................................................. 35
   CLINICAL EXAM ................................................................................ 36

7. CONCLUSION .......................................................................................... 39

8. APPENDICES .......................................................................................... 40

   APPENDIX I – ACEM RECOMMENDED REFERENCE BOOKS ........... 40
   APPENDIX II – RECOMMENDED JOURNALS ...................................... 41
   APPENDIX III – GLOSSARY OF TERMS ............................................. 42
   APPENDIX IV – EXAMPLE OF ANSWER BOOKLET. .......................... 43
   APPENDIX V – SAQ ANSWER TEMPLATES AND NOTES .................. 45
      (1) INTRODUCTORY STATEMENT for all SAQs: .............................. 45
      (2) ASSESSMENT SAQs: ................................................................. 46
      (3) MANAGEMENT SAQs: ............................................................ 47
      (4) TRAUMA ASSESSMENT and MANAGEMENT: .......................... 49
      (5) TOXICOLOGY: ......................................................................... 51
      (6) PAEDIATRICS: ........................................................................... 53
      (7) DISASTER PREPARATION: ...................................................... 54
      (8) ADMINISTRATION ................................................................... 55
1. THE BEGINNING – GETTING ORGANISED

When should you start your preparation? The correct answer is that you have been preparing continuously throughout the previous 4 years of your training (12 months provisional and 36 months advanced training)...if not your whole life; such that your preparation requires only a polishing of knowledge and a final honing of technique.

If this describes yourself – congratulations, you are in an enviable position.

If not, don’t worry...you are not alone. However, there is now a lot of work to be done. If you are similar to the majority then we would expect that your knowledge and skill base has undoubtedly improved throughout your training and has been sufficient for you to manage almost effortlessly on the floor in the ED. Unfortunately, the exam requires more than just ‘street smarts’ to pass. Put simply, you don’t know what you don’t know until you start preparing for the exam.

At this point you also need to decide which Fellowship Exam you intend to sit. Whilst your DEMT should be of great assistance in this decision making process, there are a number of factors to consider:

- **Eligibility to sit** - Eligibility criteria to sit the exam are as follows:
  o You have to be a registered and financial trainee of the college.
  o You must hold a current registration to practice medicine in Australia or New Zealand.
  o You must have entered the final year of your training (i.e. have already completed 36 months of advanced training) by the date of the first clinical examination (as opposed to the written exam) of the examination you intend to sit.
  o You must have satisfied your trainee research requirements
  o You must have ‘at expected level’ ITA results from your preceding 12 months of training

  Please refer to the Training and Examination Handbook on the ACEM website with respect to more detail regarding Fellowship Exam candidature.

- **Preparation time** - Obviously everyone is different with respect to their study needs. **12 months is the bare minimum required to prepare.** Your personal studying
techniques, work demands and family commitments should also be considered in determining the preparation time you will need.

- **Where you are working** – Ideally you should be working in your ‘home’ ED during your preparation and at the time of sitting the exam (i.e. the ED in which you have either undertaken the majority of your training or feel most associated and comfortable with). Regardless of the ED you are based in, it should have sufficient infrastructure and resources to provide a well-organised fellowship preparation program.

The advantages of working in your ‘home’ ED at this time are:
- You are already familiar with the working environment, thus no added stressors of acclimatising to a new ED.
- It should be the most supportive workplace for you. Consultants know you and you know them. Allowances are more likely to be made for you with respect to rostering, attending fellowship preparation sessions etc. Overall, it is much easier to gain the assistance of others in your preparation when working in ‘your’ ED.
- You are preparing for an exam that requires you to reflect good clinical practice; working in an ED with FACEM supervision, as opposed to a non-ED term, is an ideal environment to ‘practice’ this.

The other common question asked is whether you should prepare and sit the exam from a large metropolitan ED or from a smaller urban or regional ED. There is no right or wrong answer to this question. Sitting from a larger centre doesn’t automatically mean you will pass; and sitting from a smaller centre doesn’t mean you will fail. Every accredited department in Australasia will either be capable of running a fellowship preparation program or will be able to access an area wide program for you. Regardless of the type of ED you are working in and whether you are accessing a local or an area wide program, what you need to optimise your chances is supportive senior staff who are familiar with the exam process and have the time and ability to assist you in your preparation.

- **First or second exam sitting of the year** – As mentioned, you are required to be in the final year of your advanced training (as of the date of the written exam) to be eligible to sit. With respect to which exam to sit in your final year, the points raised in this section should assist you in this decision.
Please avoid the mentality of ‘I’ll give it a go’ for the first sitting, and use the second sitting as a ‘back-up if I fail’.

- **Pick and Stick** – Once you have factored in all the issues and made your decision as to which exam you will sit...stick to it. Avoid the approach of being equivocal as to which exam you are going to sit and state that ‘I’ll start studying and see how I go’. There is no surer way of you not doing the work and having to postpone with this tactic. You need to take the attitude that you are going to prepare and sit the exam once - one good preparation and success, rather than multiple half-hearted preparations and failures. Do not be mistaken that exam failure does not come at a price for your confidence and as such can be counterproductive during future attempts. So, be decisive, set your target and prepare accordingly. Finally, whilst you will aim to create the utopian exam preparation, there will always be factors at play that will detract from this; be mindful of what these factors may be (personal, professional or otherwise) and identify them as they arise. As long as these factors are identified they generally can be managed.

**Whom should you tell that you are going to commence your Fellowship Exam preparation?** Inform your DEMT and other consultant staff early of your intention to sit. There will be either a local or area wide preparation program that the DEMT can advise you on to access. Hopefully, planning between yourself and the DEMT has already occurred to ensure the right term rotations for you leading up to the exam. Tell other registrars - it’s useful if there is a group of you sitting together (i.e. study groups). Inform your family and friends – it’s a hard slog over a considerable period of time for all concerned. The more that they know about what is involved the better prepared they will be to manage the situation. Finally, don’t lose your perspective, if it starts falling apart at home; remember that no exam is worth your marriage or family.

**What resources will you need?** The college provides a significant amount of information to assist you in your preparation. The ACEM Training and Examination Handbook outlines detailed information concerning the structure of the examination – objectives of each component, aspects of the curriculum covered in each component, and the marking systems. A comprehensive Fellowship Exam curriculum is provided and it should form the base from which you study and prepare. Finally, a list of recommended references and journals to help trainees in their preparation is included (**see Chapter 8 - Appendices**).
With respect to the recommended texts and journals the college makes mention that the list is not exclusive, ‘but rather a guide to the books that should be of assistance’. On perusing the rather extensive list you may be thinking that it is not humanly possible to read all of these; and yet they are also suggesting there may be other texts not mentioned of similar worth to your preparation. So perhaps some qualification is necessary.

In the generating the questions for the exam, members of the respective examination committees are required to reference the topics they are formulating questions on. In general, they reference from the recommended texts, thus highlighting their importance as opposed to material not present on the list.

Given the size of the recommended text and journal list a more selective approach to what you acquire and subsequently study from may be helpful.

You will need to refer to one of the main emergency medicine texts (i.e. Tintinalli and / or Rosen) no matter how unfriendly they appear. Apart from their broad coverage, they are also used frequently as the reference for MCQ questions. Understandably, their drawbacks are the ‘North Americanisms’ that pervade aspects of the epidemiology and management of various conditions.

To complement one of the main US tomes, the Australian books ‘Textbook of Adult Emergency Medicine’ and ‘Textbook of Paediatric Emergency Medicine’ are essential. Numerous authors who are closely involved in the exam process have contributed to these books. They also provide a more useful Australasian clinical context.

Robert Dunn’s ‘The Emergency Medicine Manual’ is very useful. Although in point form, its coverage is broad, Australian based and directed at potential exam topics. Used as a guide, in association with the curriculum, to which more information can be added from the sources mentioned above, it will ensure you cover all the relevant topics for the exam. Importantly, its focus on lists makes quick review and organising information very easy.

Occasionally, you will find recourse to review a section in T.E. Oh ‘Intensive Care Manual’ or ‘Harrison’s’ for some core topics. ‘Clinical Procedures in Emergency Medicine’ is also a handy resource for reviewing your procedural theory and technique.

Sub-specialty areas will require additional resources. Toxicology is well served by the Australian based ‘Toxicology Handbook’ by
Murray et al. Trauma management will require knowledge of the ATLS/EMST principles, though these can also be found throughout most emergency texts as well as the ATLS manual. On a similar note the APLS manual serves the same purpose with respect to the management of the critically ill or injured child. Hopefully, most trainees will have undertaken both ATLS and APLS courses at some prior point in their training.

Depending on your level of knowledge and comfort with interpreting ECGs ‘ECG in Emergency Medicine and Acute Care’ is a useful resource to review during your preparation. Chou’s ‘Electrocardiography in Clinical Practice’ (this is not on the College list) is a very detailed text that you may find useful to supplement your reading.

With respect to the clinical exam, Talley and O’Connor’s ‘Examination Medicine – A Guide to Physician Training’ remains unrivalled.

The recommended journals can be a useful resource, especially major review articles that can tie in the recent advances / current management of certain conditions. You will not be expected to quote from journals (though done within the right context it is always impressive when you can); however you should be aware of major breakthrough research that impacts upon clinical practice in emergency medicine. Similarly, current “hot topics” within the college / journals / media could be fashioned into questions assuming they can be referenced.

- Then there are the resources not mentioned in the recommended references list: Those that have gone before you will often have hoarded numerous useful journal articles, practice questions and material from Fellowship Exam courses etc that they should be happy to share.

- The college web site also contains a vast array of useful resources, for members of the college to access. These include: Past SAQ, VAQ and SCE papers; Fellowship Exam Reports; general question guidelines (details on how exam questions are generated); Fellowship Exam sample answer book; and the code of conduct for the Fellowship Exam. The web site also has numerous policies and guidelines that concern administrative, medico-legal and clinical issues. It would be foolish to enter the exam without knowledge of these.
FOAM (Free Open Access Medical Education) is the new frontier and will continue to grow to be your companion throughout training. Leading the way is the Australian based “Life in the Fastlane’ (www.lifeinthefastlane.com). As well as its own content and providing a portal to many other useful blogs and websites (in particular ECG sites), its section on the Fellowship Exam is invaluable for easy access to past questions.

Finally, ensure you have a copy of the current ACEM ‘Glossary of Terms’ (Chapter 8 - Appendix 1 and found on the college website). This provides definitions of terms commonly utilised within exam questions. The importance of adhering to these definitions cannot be over emphasised.

Do you need a study timetable? Unequivocally yes. Twelve months is a long time and without a timetable you will lose focus and direction. Depending on your personality, this timetable may plan for every minute of every day, or just provide a guide from week to week. Regular readjustment of the timetable is common as numerous factors can throw you off course from time to time (e.g. work / family commitments; getting “bogged down” in a topic for longer than planned; periods of unforeseen disinterest in studying etc). Initially, it can be difficult to plan a timetable because you are unsure how long you need to cover each of the syllabus topics. It is also dependent on your study technique and how much depth the topic requires. This manual aims to provide some guidance on this issue. Importantly, allow for regular ‘down-time’ to provide a release from study, otherwise you risk ‘staleness’ or at worst insanity. Be sure to include in your timetable the cut-off date to register and pay for the exam you intend to sit (it is usually about 2 months prior to the written exam).

How will you actually study? At this point there are many options. If the above steps are completed then you will have informed everyone interested; purchased or obtained all the relevant texts; accessed useful blogs and websites; borrowed relevant articles / handouts etc from those that have sat in the recent past; drawn up a study time-table; formed a study group; and essentially prepared yourself and others to have your life go on hold for the next 12 months. Make no mistake; it will consume you for the next year – if not, then you may not be working hard enough.

There are a number of general principles to follow within your approach to your study:
Focus: As mentioned, use the fellowship curriculum and Dunn’s ‘The Emergency Medicine Manual’ as a guide to navigate each topic. The designation of each curriculum topic with ‘categories of learning objectives’ and ‘levels of practice’ is essential to follow to ensure you focus your study in as little or as much detail as is indicated. You must also utilise one of the main texts to ensure you have enough depth of knowledge for most topics.

Organisation: Copious note taking generally occurs, however try to ensure your notes are organised in a way that allows for easy retention and review. For example, utilise headings / sub-headings etc to divide up information into smaller, easier to remember bundles. Use lists, where possible, to aid retention. Consider the use of mind maps if you are familiar with them, if not we would recommend exploring their utility to your study. Above all, you need to organise what you learn into a format that is readily accessible for you to recall and deliver amidst the pressures of the exam.

Context and checking: Do not study in isolation from practice questions. Do not think that you have to have studied the whole syllabus before beginning to practice MCQ, SAQ and VAQs – it will too late by then. As you study a topic, contextualise and check your knowledge (breadth and depth) by undertaking practice questions. This will help ensure you have focused on the right aspects of the topic and will assist you in further organisation of your knowledge. Keep in mind that while you may gain an impressive amount of knowledge on a topic through your study, unless you can organise all this information into a logical format tailored to the exam (i.e. reflecting good clinical practice), you will struggle answering questions in the time constraints that apply.

Options and Commit: Be aware that, as in clinical practice, the exam requires depth and breadth of knowledge across many topics. The exam process will test you on both. ‘Discuss’ questions usually cover breadth (i.e. what COULD you do) and ‘describe’ questions depth (i.e. what WOULD you do). Thus for certain topics, understand and be able to recite the varied options for assessment and management; but also ensure you can commit to one of these as your preferred option and be able to justify it.

Technique, technique and technique: Above all else, keep this phrase at the forefront of your mind as you progress through your preparation. It has been the authors’ experience
that most candidates do not fail the exam as a result of poor knowledge...poorly organised knowledge yes, but not knowledge itself. If you do the work, as most candidates do, you will gain the knowledge. Where most candidates come unstuck is in developing an effective technique to organise their knowledge and an answer technique that allows them to present this knowledge in an efficient manner. Unless you work on these facets you will not be able to translate the knowledge you have accrued into a mature, logical and well thought out answer. Within this manual we will provide what we (and many others) believe is the ‘approach’ of choice for each exam component. Depending on your thought processes adopting this approach may come very naturally or with great difficulty, but in the end you must develop it. Finally, before you start thinking the approach we are suggesting is simply a ‘trick’ to get you through the exam process, be assured that the techniques we are describing are those that are used by most emergency physicians to approach clinical problems they encounter in the practice of emergency medicine. To repeat, we are aiming to enable you to reflect good clinical practice, because that is what the exam sets out to do.

In closing, as you begin your exam preparation prepare yourself and others for an emotional roller coaster ride. It will generally be days of hard grind, interspersed with ‘high days’ where you feel that you know and can answer anything, to ‘low days’ where you’d be lucky to remember your own name...but in the end success awaits you.
2. THE CURRICULUM – AN OVERVIEW

We have not duplicated the curriculum within this manual and would refer you to the Training and Examination Handbook on the college website – members section.

The ‘Curriculum’ and the ‘Learning and Examination Processes’ sections are very detailed and as such should be scrutinised carefully, especially with respect to the categorisation and grading of topics regarding core competencies, learning objectives and level of practice required.

Whilst it remains a daunting list the use of ‘core competencies’, ‘categories of learning objectives’ and ‘levels of practice’ should assist you in focusing your time and effort in the right areas of the curriculum.

The ‘core competencies’ (closely aligned to Can MEDS) describe the competencies to be assessed in relation to all domains of the curriculum. Put simply, with any topic or issue in the examination (and for that matter with respect to any area of trainee assessment) the college is looking for you to display your ability as a medical expert, a communicator, collaborator, manager, health advocate, scholar and as a professional. As per the ACEM Training and Examination Handbook the core competencies are listed below:

- **Medical expert** with regard to the knowledge, skills and attitudes required in the specialty for the appropriate assessment (history, examination, investigation), diagnosis and management (supportive care, specific care and disposition) decisions involved in patient care
- **Medical expert** with regard to the procedural and technical skills required in the specialty
- **Communicator**
- **Collaborator**
- **Manager**
- **Health advocate**
- **Scholar**
- **Professional**
- **Medical expert** integrating the above competencies in clinical practice

The ‘categories of learning objectives’ are allocated within the curriculum to provide guidance as to the perspective from which each topic should be viewed. The categories are:

- **Diseases / Injuries / Symptoms**
• Physical examination
• Investigations
• Medical interventions
• Pharmacological and toxicological agents
• Procedures
• Equipment
• Theories
• Systems
• Non-clinical / clinical interface

Within each of these categories the curriculum outlines specific learning objectives to be achieved at the completion of training.

Finally each topic in the curriculum is allocated to one of three ‘levels of practice’:

• Expert
• High
• General

These designations are based on whether a topic and its learning objective can be undertaken and managed within the practice of emergency medicine either with or without consultation and the involvement of other specialties. This can refer to clinical or non-clinical topics. Essentially, the more we deal with the acute aspects of care of a condition without the involvement of other specialties the more ‘expert’ our knowledge and skills should be with respect to that condition.

Thus ‘expert’ level topics are ones that we would normally manage without the need for consultation and assistance. A greater knowledge and depth of detail will be required and as such a greater amount of time should be spent studying this topic in your preparation. ‘High’ level topics are ones where we may undertake immediate and stabilising care but require the input from other specialties to provide continuing and definitive care. ‘General’ topics are ones where we may only play a role in recognition, investigation and initial supportive care before consultation and involvement of another specialty.

It should be expected that topics assigned expert and high levels of practice will be assessed more frequently within the Fellowship Exam. The greater the level of practice the greater the depth of knowledge required and the greater the depth to which it will be examined. This does not mean ‘general’ level of practice topics will not be examined; but they will just not be examined as frequently and the level of knowledge required to pass will not be as great.
Of course, this all doesn’t change the fact that there are still a lot of topics; even if you just looked at the expert and high level topics it remains daunting. However, it is also worth mentioning that as big as the exam is, there are a finite number of questions for a very large curriculum. Thus, the committee setting the exam will be striving to provide you with discriminating questions on relevant and important emergency medicine topics. Remember, every question has a purpose and that purpose is dictated by the curriculum.

Knowing that it is easy for your imagination to run wild when viewing the curriculum with respect to the seemingly endless exam question possibilities, I suggest also perusing the recent exams and you will notice that it is in fact relevant and important emergency medicine topics that appear time and time again.

Finally though, no matter which way you look at it and no matter how much guidance the curriculum provides...there is a lot of work to be done to cover it all.
3. STRUCTURE OF THE EXAM

It is imperative early on in your preparation to have a good understanding of what the exam involves. As suggested previously, there are advantages to knowing how you will be tested to enable you to appropriately direct your study.

Once you understand the structure of the exam and how various questions are asked you will be better able to focus your study. As you cover the various topics consider how that topic could be tested. Subsequently, attempt to organise your thoughts to formulate an answer.

In all your practice, aim to achieve a 7/10 answer which is a good pass dealing competently with the major issues.

Detailed information concerning the exam format and marking system is provided in the Training and Examination Handbook, Structure of Examination, on the ACEM web site

Some general points concerning the exam:
- There are two sittings of the Fellowship Exam each year.
- The exam is divided into six parts, with each section attempting to test different skills and abilities.
  - Written component:
    - Multi-choice questions (MCQs)
    - Short answer questions (SAQs)
    - Visual aid questions (VAQs)
  - Clinical component:
    - Long case
    - Short case
    - Structured clinical examination (SCE)
- There is a 10-12 week break between the written and clinical components.
- To be invited to the clinical component you are required to pass at least two of the three written sections.
- Paediatrics will make up approximately 25% of the exam.

WRITTEN COMPONENT

Multi-choice Questions:
- 60 questions in 100 minutes – 100 seconds per question.
- No perusal time.
- Use B or 2B pencils.
- Utilises a stem with 4 alternatives – A to D.
- One best response from the 4 alternatives.
- No negative marking – therefore do not leave any out.
• Pass mark is 33/60 (55%).
• Tests factual knowledge of the curriculum.
• Often requires quite detailed knowledge of a topic.
• One-third of the questions cover ‘Medicine’ topics from the curriculum; one-third cover ‘Surgery’, ‘Obstetrics and Gynaecology’; and the remaining third covers Sections 1-3 and 7-18 of the curriculum.
• Approximately 25% of the questions (i.e. 15 MCQs) will be paediatric.

Short Answer Questions:
• 8 questions in 130 minutes – 16min 15sec per question.
• **No perusal time.**
• Use ball point pen.
• Questions marked out of 10. Pass mark for each question is 5/10.
• Required to pass a minimum of 5 questions AND have a total score of 40 or greater.
• Therefore you can fail up to 3 questions but don’t leave any questions out as you need all the marks you can get to make it to 40/80 overall.
• Questions tend to focus on assessment of conditions; management issues; principles of clinical governance; skills in team / resource management and emergency medical administration; analysis, synthesis and prioritisation of diagnostic and management options; and discrimination between various assessment and management options based on evidence based principles.
• SAQs test your ability to communicate competently in the written medium and tests your time management skills.
• Questions generally have 1 or 2 parts (i.e. parts (a) and (b)). The percentage marks allocated to each is clearly stated.
• One question will be sourced from each of the following core curriculum domains: Administration, Medicine, Trauma, Paediatrics and Resuscitation / Anaesthetics.
• The remaining questions will be sourced from the following domains: Emergency Medical Systems, ENT / Eyes, Environmental, Obstetrics and Gynaecology, Psychiatry, Toxicology, Minor trauma (including orthopaedics) and Surgery.
• Individual questions may cover more than one domain.

Visual Aid Questions:
• 8 questions in 80 minutes – 10 minutes per question.
• **No perusal time.**
• Use ball point pen.
• Questions marked out of 10.
• Pass mark for each question is 5/10.
• Required to pass a minimum of 5 questions AND have a total score of 40 or greater.
• Therefore you can fail up to 3 questions but don’t leave any questions out as you need all the marks you can get to make it to 40/80 overall.
• Questions involve interpretation of laboratory data, radiological images and clinical photographs.
• Tests abilities of recognition, description, analysis and synthesis of data, and decision making.
• Questions consist of a ‘stem’ (background information) and a ‘prop’ (visual information source).
• Questions are related to the combined information provided by the stem and the prop.
• The questions are generally of one or two parts – the percentage marks allocated to each part will be clearly indicated.
• There are five core topic questions covering – ECGs, plain radiology, paediatrics, trauma, and pathology results.
• The remaining 3 questions can be on any topic relating to aspects in emergency medicine – including the 5 core topics.

CLINICAL COMPONENT

Long Case:
• Examined on the first day of the clinical exams.
• You are required to do 1 long case and it is marked out of 10.
• You are given 35 minutes with the patient. Then you have a 5 minute ‘break’ to organise your thoughts / notes. Then a 20-minute session with 2 examiners presenting your findings.
• You are assessed on history taking, physical examination findings, and then your ability to synthesise the information and discuss investigation and management issues.
• Writing paper is provided.
• Again, interpersonal and communication skills are assessed.
• Patients may be inpatients or outpatients, and will usually have a multisystem illness.

Short Cases:
• Examined on the first day of the clinical exams.
• Consists of 2 twenty-minute sessions with a small changeover period.
• You will see 2 patients with 2 examiners in each 20-minute session (i.e. different set of examiners in each session, and overall you see 4 patients).
• You can expect one of the cases to be a paediatric patient.
• Tests ability to elucidate clinical signs and then synthesise and interpret the findings.
• Interpersonal skills are also assessed.
• Each case is marked out of 10.
• You must pass at least 2 of the 4 cases and gain an overall mark greater than 19/40. However you will also pass if you pass 3 of the cases and have an overall score of 15 and greater.

**Structured clinical examination:**
• Examined on the second day of the clinical exams.
• 6 SCEs in 60 minutes.
• You have 3 minutes outside the station to read the scenario; and then 7 minutes with 2 examiners. One examiner will be taking you through the scenario and asking questions, whilst the other examiner is marking your efforts and taking notes of what you say.
• Each station is marked out of 10. A pass mark for each station is 5/10.
• You are required to pass a minimum of 4 SCEs AND achieve an overall mark of at least 30/60.
• SCEs involve scenarios on patient management; administration issues; interpretation of investigations; problem solving; clinical judgement; communication; describing or demonstrating practical procedures etc.
4. WRITTEN EXAMINATION COMPONENTS – AN APPROACH TO PREPARATION and TECHNIQUE

Your first goal is to navigate your way through the written section. Accordingly, your study should be weighted towards the written section initially. To concentrate on the knowledge and skill requirements for the clinical exam, at the expense of the written exam, would seem a little foolish if you fail the written section. As long as you have laid the foundations prior to the written exam, the study and practice for the clinical exam can be geared up afterwards.

MULTI-CHOICE QUESTIONS

Whilst sitting the exam, this is often though to be the most difficult section in which to gauge your performance. In general terms, of the 60 questions, there will be 20 you were reasonably confident of having answered correctly; there will be 20 that you will have been less confident about; and there will have been 20 that you had very little idea about (perhaps narrowing it down to 2 alternatives if you are lucky). Thus every question is a challenge and at the end you may feel somewhat perplexed about the whole ordeal. With this in mind, it becomes clear why most people only pass or fail this section by a few questions.

With respect to preparation, practice makes perfect. The more MCQs you do prior to the exam the better. There are two aspects to preparing for the MCQ component – knowledge and technique. The MCQs test for a sound knowledge base. The ‘finer details’ or ‘specifics’ of a topic are often required to answer the questions. Being broadly read and having covered one of the bigger texts (Tintinalli or Rosen) places you in a good position. As mentioned previously, a lot of the information you will initially gather on a topic (prior to concentrating it down for notes / organising in your own mind etc) is where the ‘details’ for the MCQs come from. As a result, you are relying to some degree on visual recognition with these questions (i.e. you may not necessarily remember a certain detail about a topic spontaneously, but upon sighting it as an option in the MCQs your memory is triggered).

It is this point of visual recognition that brings us to the concept of MCQ technique and practice. A comprehensive preparation will generally provide you with the knowledge, but you will also require a well-honed technique to be successful. This is obtained by simply doing a lot of MCQs.
The MCQs associated with Tintinalli and Rosen are a good resource, as are the MCQs on iMeducate. An Australian Emergency Medicine MCQ book, titled 'Emergency Medicine MCQs' by De Alwis et al has also been compiled with the Fellowship Exam in mind.

In the exam, it is unusual for 'time' to play a major factor in completing this component of the exam. Some of the questions have quite long stems – be patient and read them carefully. As with all the questions in any part of the exam, each word is there for a purpose. Importantly, there is no negative marking. Thus, ensure you attempt every question. Although you are given ample time to complete the MCQs, do optimise the time available with a sound approach. Don’t be caught hastily answering question numbers 50 to 60 in the last 5 minutes, after having slowly and methodically worked your way through questions 1-49. As mentioned, a lot of people pass or fail by only a few questions; so don’t give away easy marks through a poor approach.

SHORT ANSWER QUESTIONS

The SAQs are a demanding part of the exam mentally and physically. It’s a strenuous 2 hours and 10 minutes. Along with the VAQs, it is a section that requires considerable attention to technique and time management.

The familiar theme of ‘practice’ is imperative to success with this component of the exam. Technique plays a major role in confronting a SAQ, and although there may be numerous ways to write an answer, you need to develop your own method to approach these questions. Once you have done this, it is then a case of applying it to as many questions as you can lay your hands on.

Technique, technique and technique - probably the 3 most important aspects to successfully completing the SAQ exam. A lack of knowledge is rarely the reason for failing this section. Failure usually stems from an inability to translate your knowledge in an organised manner within a limited time frame. The ability to do this comes with directed practice such that your approach to answering various SAQs becomes almost ‘automated’.

From the outset, it is important you have a copy of the “Glossary of Terms” (Appendix III) used for the VAQs and SAQs. This defines what the examiners are after if a question uses the terms ‘discuss’, ‘describe’, ‘outline’, ‘assessment’ and ‘management’ etc. If you stray from these definitions in your answer, you will struggle to score marks regardless of how good your answer may be. So have it posted above your desk for easy referral as you practice.
questions. And don’t worry; you are given a copy in the exam to refer to. Also, practice utilising the answer booklets that will confront you in the exam (Appendix IV). They are widely spaced and importantly give you the opportunity to spread your work out.

The questions tend to focus on assessment and management issues. The questions will generally consist of one or two parts (i.e. (a) and (b)) and each part will indicate the percentage marks allocated to them. The 16 minutes 15 seconds you have to answer each question will test your ability to prioritise and organise your thoughts. The more you practice the easier this becomes.

One suggestion when you first begin practicing SAQs is to do so with an open book technique and ignore time limits. Early in your preparation, you may not have the content at hand to answer the question adequately, nor have developed a suitable technique. So open the books and take as long as necessary to create what you feel to be a ‘model’ answer that would be achievable to write in 16 minutes. You can ‘play around’ with your layout / structure until you’re happy with the way it flows. It is then a case of taking it to your mentor and seeking their opinion. Hopefully, with the content already there, it will be a case of simply assessing your technique and structure. Do this for a number of different types of questions (i.e. assessment, management, discussion questions etc), such that you develop an answer structure for most types of questions. Once you and your mentor are happy with your technique and structure, you can then close the book and start working to the time constraints. At this point, you may find that you need to make adjustments due to ‘running out of time’. A common problem is not being sure how much, or how little, to write in certain sections of your answer. This is often solved by reading the question again and deciding what it is driving at (i.e. is the question primarily an airway problem – thus, I need to be detailed in my airway management; or is the airway a secondary problem that I can just mention briefly). Otherwise, seek advice and a second (or third) opinion.

At all times, look for feedback on your answers. It’s useful if you have a college examiner to refer to, however anyone from emergency physicians familiar with the exam to your study colleagues will suffice. Please note that working in isolation may compound your errors. Form a study group and give each other practice SAQs and VAQs every week and compare answers. Do past papers to get a feel how the questions are worded in the exam. Overall, it is an evolutionary process as you practice more, receive feedback, and make further adjustments to your approach.
General Approach to SAQ Technique

Please also refer to the Answer Templates within the Appendices as you read below.

(1) Introductory Statement

Firstly, read the question carefully – every word is used for a reason. Note what you are being asked. Also pay particular attention to the weighting given to each part of the question, so that you can allocate your time appropriately.

Write an **introductory statement**. All answers MUST have an introductory statement. This statement can take many forms, considerations in formulating this statement include:

- Acknowledgement and synthesis of the clinical scenario provided in the question
- Aim(s) of assessment or management
- Differential diagnosis or risk stratification
- Key issues;

This process ensures you don’t miss important points within the wording of the question and will assist you in organising your thoughts. Remember this process is more for you than it is for the examiner reading your answer; though good introductory statements can give a good impression. Keep referring to your introductory statement as you progress through the question to ensure you have covered all the points you were aiming to address.

(2) Assessment SAQs

Assessment questions require you to give details regarding your history, examination and investigations for the given patient. There are many possible ways of answering assessment questions, however they all have important common points.

As mentioned, it will often be necessary to begin with a differential diagnosis of the given clinical problem to allow you to progress with and give meaning to your assessment.

With a history and examination, focus on the specifics of the case while avoiding the trap of providing generic lists that could apply to any patient. Try to divide it up into logical areas of interest, which concerns the patient in question. For instance, a history can generally be divided up into ‘symptoms of the complaint’, ‘symptoms of precipitants that may have caused the complaint’, ‘symptoms that define severity’, ‘symptoms of complications of the complaint’ etc. These divisions bundle information into a logical format that appears more impressive than a long unstructured list that a resident could write. Avoid writing PHx, Medications etc
without further definition – any resident can do that. What is it about the patient’s past history or medication list that is relevant in this situation?

Relate specifically to the patient. This statement cannot be overemphasized. You must give relevance to each of your points. For example, ask yourself what is it about this patient’s circulation that is likely to be a life threat in the scenario with the information you have? Anyone can write ‘assess ABC’s’ but a consultant level answer should be specific to the case presented.

Similarly, with your examination section ensure that you don’t just write a series of physical signs – tie them into the condition you are assessing for (e.g. ‘assess for evidence of CCF – raised JVP, pulmonary crepitations, peripheral oedema’). In some situations it may be suitable to only write the condition you are assessing for – remembering there is a degree of accepted knowledge in the exam (e.g. ‘assess for tension pneumothorax’).

When outlining investigations, be specific and where possible give reasons for the test (i.e. what are you looking for). It is also good practice to divide investigations into groupings: bedside, laboratory, radiology and other. This will help you not leave any out.

A good test for your answer is that your junior registrar could take it to the bedside and thoroughly assess the patient without seeking clarification from you.

Assessment questions are probably the most difficult question format to structure well. It is imperative that you show your answers to your DEMT / consultant mentor to ensure that your structure is maturing as you progress towards the exam.

(3) Management SAQs

It is useful to start by outlining where the patient is going to be in the ED, who is managing him, and if applicable what special equipment you may need. Think of it as area, staff and equipment. Small points but necessary detail - stating them now means you won’t forget.

From there, your answer should be divided up in to discrete management sections:
- Resuscitation (if applicable)
- Specific treatment
- General / Supportive treatment
- Disposition
A good test for your answer is that a junior registrar could take it to the bedside and manage the patient with what you have written, without seeking clarification from you.

(4) Discuss SAQs

This question format is where you are required to examine the advantages v disadvantages of a subject.

Generally, ‘discuss’ questions will require you to work through a list of options with respect to aspects of assessment (usually investigations) or management.

As a general approach we would recommend that you:
• Generate a list of the options / techniques you believe are relevant
• Then take each option one at a time and:
  o Briefly describe what the option is / entails (if applicable)
  o State when you would utilise this option (i.e. its indications), if applicable
  o Then outline this option’s advantages and disadvantages
  o You may also conclude with a statement summing up your view on the option (i.e. it is your method of choice etc); but this is not mandated.

If an option is associated with sensitivity, specificity, effectiveness rates etc ensure that you know these numbers and include them.

In the end you should have compiled a complete investigative or management pathway possible for the patient or condition in question.

A similar type of question that we will address here is the ‘compare’ and ‘contrast’ question. A good answer requires you to be able to generate a list of points on which to compare the two items. Generally, start with the basics such as epidemiology, precipitants, and then move through, as relevant, items on history, examination, investigations and management.

(5) Other General Points for SAQ questions

• Practice writing legibly under time constraints – poor handwriting frustrates the examiners. You do not want them in such a mood whilst marking your paper – a negative as well as a positive free-floating bias probably occurs.
Space your work out in the answer book – this will allow you to add further points / comments later without disrupting the flow or look of your answer. It is disconcerting to view an answer with extra points scribbled down the side, between lines; or with multiple arrows going to the top or bottom of the pages.

The examiner's job is not to guess or extrapolate the meaning of what you have written – you need to make it very clear what point you are attempting to get across.

Avoid the use of abbreviations unless they are well accepted ones i.e.: HR, BP, CVS etc

If you give a medication or fluid volume always state a dose or volume and a route.

If you are resuscitating – always provide end-point parameters to which you are resuscitating to.

If transfusing blood products – provide triggers for such actions and what end-point parameters you are resuscitating to.

Don’t forget to do the basics – they are often important, e.g. BSL, x2 large bore cannulae, IDC, keeping patient warm etc. These simple points on their own won’t give you a pass but if left out, will often mean you fail.

Avoid mentioning triage categories – emergency physicians don’t do this job in real-life (nurses do) and it only provides a source of contention (albeit minor) if you state you would make the patient Cat 2 (whilst an examiner may think it’s Cat1 or vice versa). More importantly, appreciate the patient is unwell and place them in an appropriate area with appropriate staff e.g. This patient is critically injured and at risk of imminent airway obstruction. Manage in a resuscitation room. Assemble the trauma team. Similarly:

Don’t feel the need to specify those that constitute your trauma team unless specifically asked or there are special circumstances (e.g. obstetric trauma, paediatric resuscitation, difficult airway etc) – it wastes time on something that is done slightly differently everywhere. There is an accepted level of knowledge for candidates by the examiners – they should know what you mean by ‘trauma team’ or ‘resuscitation team’ or ‘multi-personnel approach’.

Where to focus? A common problem is not knowing how much time to spend on certain parts of a question. Firstly, note the percentage weighting for marks allocated to that part of the question. Obviously if part (a) is worth 30% of the question then more of your time will be spent answering part (b), which is worth 70%. With respect to issues within a certain part of the question, read the question carefully and try to understand what it is driving at and what the ‘key issues’ are. For example, a question that involves a penetrating injury to the neck should ring alarm bells for a potentially difficult airway and thus in your
assessment and management you will need to spend some time detailing how you will manage this situation. On the other hand, an overdose that requires intubation for airway protection can have the airway component dealt with quickly and briefly, as the thrust of the question will be elsewhere. Even with a good technique and plenty of practice this dilemma of ‘focus’ often poses a challenge.

- Overall it can’t be stressed enough how important it is to read the question carefully, so you answer what is being asked and that your answer is specific to the case in question. Time and again this separates those that pass and those that fail.

**VISUAL AID QUESTIONS**

The VAQ component of the exam is a fast and furious 80 minutes. Time management is imperative and an efficient technique is essential.

In preparing for the VAQs, from the outset place yourself under time restrictions. In the exam, you have 8 questions to answer in 80 minutes – thus 10 minutes per question. Unlike the SAQs, the ‘trick’ with technique is not so much how to structure an answer (the structure is provided by the parts of the question); but to describe and interpret the visual aid in a systematic manner and then convey all the relevant information (usually in short point or list formats) via the structured parts to the question.

VAQs will generally require a description and interpretation of the visual aid.

With respect to the description, the answer is obviously in front of you. It is the interpretation that is often the challenge.

Some important points to always consider when describing and interpreting VAQs:

- As in clinical practice, be systematic in your description of ECGs and radiology props (i.e. for ECGs - rate, rhythm, axis, PR interval, QRS complexes, ST segments, QT intervals etc); it will ensure you do not miss anything.
- ECG paper has squares that allow you to measure time periods and elevation / depression of segments – measure them all.
- With clinical photos, make a note of what else is in the periphery of the picture. For example, a picture of a rash may have in the background the face of the patient in pain, or an IV running, or other features that may help with a diagnosis. Your observational abilities are on trial here.
• Your description should be such that it could convey a mental picture of the prop over the phone.
• Write down all the abnormalities, positives and relevant negatives, not just the most obvious.
• Use adjectives such as severe, moderate and mild to describe changes in laboratory results.
• Interpret means to provide a diagnosis, differential diagnosis or find meaning in a piece of data. Depending on the scenario, it may be relevant to also outline potential precipitants / causal agents, severity, potential complications and implications for the patient.
• The visual aid should ALWAYS be interpreted in light of the stem. You are essentially looking for features in the visual aid to explain the stem and what is (or possibly is) going on.
• Interpret all the abnormalities and relevant negatives, and look for the overarching explanation (s) as you would in clinical practice.
• Not all VAQs have a ‘black and white’ answer; ‘shades of gray’ are likely with respect to the diagnoses potentially in play (just as in clinical practice) – so allow your answer to reflect this through the use of ‘qualifications’ for each diagnosis if applicable.
• If creating a differential diagnosis list, put the most likely diagnosis at the top or the most sinister and work down in descending order.
• If asked to detail further investigations for the patient utilise a systematic approach to avoid leaving anything out (e.g. bedside, laboratory, radiology, other) and briefly state what you would be looking for with each investigation.
• If asked to outline treatment (specific and supportive), management (specific, general and disposition), or complications (early and late) it will usually require overarching principles and basic details rather than an in-depth description given the time frame.
5. CLINICAL EXAMINATION COMPONENTS – AN APPROACH TO PREPARATION AND TECHNIQUE

For many people the clinical exam provides the most anxious moments, as you are expected to ‘perform’ to an audience. A good preparation will not only provide you with a solid technique capable of dealing with any exam situation, but will desensitise you to the performance pressures associated with oral exams.

LONG CASE PREPARATION

The long case preparation can easily be left until after the written examination. It is potentially the easiest part of the exam to pass with the least amount of time and effort. That’s not to say you can walk in and get 8 out of 10 without trying; but with a short and focused preparation you can readily achieve a pass.

The long case essentially requires you take a good old-fashioned history and conduct a thorough examination – reminiscent of medical school days. However, given that history and examinations within the daily practice of emergency medicine are often truncated or system focused, you do need to practice a few times to refresh your memory and extinguish your bad habits. The difference from medical school days though, is your ability to now synthesise the clinical information and interpret it in the form of diagnoses and management plans. Most people should be comfortable with their technique and structure after 3-4 practice runs. Unless you are having problems, any more is probably just icing on the cake. Importantly, with any practice, do it under exam conditions, with an ‘examiner’ to present to and question you.

Some general points when conducting a long case:

- Write down on the blank paper provided your headings for history and examination on entering the room (i.e. personal details; presenting complaint; history presenting complaint etc).
- Don’t forget social issues – current living conditions, supports etc. as they may impact on management plans. A holistic approach is important.
- In practice runs, you may need to work out what works for you with respect to the time you spend on history and then examination. One method is to allow 15 minutes to work through a history before starting the physical examination. If there are aspects to the history you haven’t covered, or remember later, you can ask whilst you are examining them. Overall you have 35 minutes with the patient. If you finish early, start organising your thoughts and notes for presentation. In particular, start on
a problem list or diagnosis list and subsequent management plans that are holistic in nature.

- In the exam, you have 5 minutes before you meet with the examiners. If you haven’t started organising your presentation as outlined above then do so now.
- You will be asked to present the case to the examiners. Generally they won’t interrupt until you have finished. If you manage to speak for the 20 minutes and cover all the major points, there may be little the examiners can ask.
- You should provide a comprehensive history of the presenting complaint, past history, social history, medication history, systems review and findings on examination.
- When presenting the case move through the history in a logical manner. Mention any positives or significant negatives in your systems review. Your examination findings should begin with general statements about the patient’s appearance etc and then vital signs. Don’t forget to mention IV lines or infusions running if present. Then progress through each system, again detailing positives and relevant negatives.
- At the conclusion of this, provide a brief summary and then outline a problem list (for active and inactive problems).
- You should then proceed on to describe how you would assess and manage your patient with these problems if they had presented to your ED. For outpatients you may have to speculate on possible ways the patient could present to the ED in the future, as there may be no current acute problem to deal with.
- Address each problem with a management plan that may include investigations and treatment. If relevant, mention allied health or other similar disciplines involvement. Consideration of psychosocial issues is important.

**SHORT CASE PREPARATION**

Generally speaking, most people have acquired a lot of bad habits since their medical student days, which is probably the last time anyone had their examination technique put under the microscope. Obviously after the ‘writtens’, you can immerse yourself in the daily ritual of finding and doing cases. However 10-12 weeks is really the bare minimum to build an examination technique that will withstand the glare of two examiners in any situation. Essentially, you need to have practiced so much that a fluent and technically correct exam is instinctive. You need to be concentrating on the patient and interpreting their signs in the exam, not thinking about what part of the respiratory examination comes after percussing the chest. The knowledge you require for the short cases, in terms of examination technique and lists of causes for certain clinical findings, is different
for what you need in the written exam, so it does require time and effort.

You can of course address some aspects of your short case preparation prior to the written component. Keep a clinical examination book handy at work and start practicing on patients you see in your day-to-day activities. Have other colleagues around to critique and present to from time to time. This will allow you to develop the habit of good clinical examination technique from an early stage.

Once the written examination has been successfully negotiated, short case practice should dominate your life. Most of your waking hours will be spent looking for, or doing short cases. In some respects, the process of tracking down patients in the ward to examine is not very time efficient, especially if there is a group of you. However, you have little choice in the matter. Make yourself a nuisance to all the medical registrars in the hospital as you hound them for patients with signs. Ensure those in the ED grab you the moment anyone comes through the door with signs suitable for a short case.

Some general points on short cases:

- You usually have 7 minutes to conduct your examination and then 3 minutes for discussion with the examiners. Unlike the long case, the examiners are with you watching your interaction with the patient and your examination technique.
- Remember, it is a performance – regardless of your personality type attempt to put on a good show.
- You generally cannot ask questions of the patient. Other than ensuring they are comfortable and that you are not causing them discomfort with your examination.
- When conducting any examination – be courteous and friendly to the patient. This is being looked for. In particular, your rapport with paediatric patients and their carers is almost as important as your examination findings. Bring small toys or stickers for varying age groups.
- The systems that appear in the exam without fail include CVS; Resp; GIT; Neuro; and a paediatric case. So know them well.
- Practice different ways of being asked to examine a system e.g. “this patient has had problems with walking, examine his lower limbs”; “examine this patient’s eyes”. Also body parts or systems that you may not expect e.g. knees or hands. Being able to adapt your examination or blend different aspects of different systems into an overall examination is important and usually a good discriminator.
• Spend time on the simple things such as inspection. Note the general appearance of the patient and how well they look or otherwise. Note medications / infusions running or O2 that’s required. Be observant.

• Do not cause pain or distress to the patient. This is a huge no-no. It may mean altering your usual examination technique to accommodate this.

• Know your equipment well. Carry a kit with all that you need for a neuro exam, but ensure you can lay your hands on everything quickly with minimal fuss. It will make you appear professional and provide an impression that you do this all the time. On a similar note, close to the exam, practice in the clothes you will wear during the exam. It might sound strange, but a suit can feel more restrictive than your usual attire. However, it may also allow you to place a lot of instruments in pockets that can be easily accessed.

• With any examination look fluent. Your actions are being watched carefully. Ensure each of your movements are efficient and purposeful. Avoid going back and forth, or repeating aspects of your examination. Do it once, do it properly and then move on.

• It is your choice as to whether you talk and relay your findings to the examiners as you go, or wait until the end. However, some examinations, or parts of an examination, do suit you verbalising findings (positives and relevant negatives) as you proceed (e.g. the peripheral components of the CVS and GIT exam, examination of the hands etc). The value of verbalising your findings is that you may well be mentioning a lot of minor details (observation of scars etc) that are important and are considered ‘minor’ findings that score you marks. Also these important minor findings are easily forgotten when you come to summarise at the end, so worthwhile having already mentioned them.

• Ask for a blood pressure in a CVS exam or a temperature if relevant – the examiners will provide it.

• At the conclusion of your examination you may be asked what else you may want to do. This may allow you to state other aspects of the exam you had yet to complete or other systems you may want to examine in light of your findings.

• When you are asked to present your findings, do so with a good posture and clear voice. Start with general appearances etc and then move through your findings including positives and relevant negatives. At the end summarise and interpret your findings to give a diagnosis. If you are good enough and sure of your diagnosis you can approach this the other way by stating the patient’s diagnosis at the beginning and then outlining the
clinical findings that support this. It sounds impressive when you nail it.

- However, either way, attempt to further clarify a diagnosis in terms of severity with supportive clinical findings. For instance, a patient’s diagnosis of mitral incompetence can be defined further by stating a degree of severity (presence of LVF etc.).
- Questions will generally follow – such as severity of the condition (if you haven’t already stated it) and causes for the condition (e.g. causes of hepatomegaly).
- Overall, a good examination technique will help you through. Even if you don’t pick up all the signs or interpret them all correctly – it may act as a safety net from failure.

**STRUCTURED CLINICAL EXAMINATION PREPARATION**

The SCEs are a component that requires some attention before the written examination. However, the practice doesn’t necessarily have to be in the form of a formal SCE session. Unlike the short and long cases, the knowledge you have obtained in preparation for the written exam is what is required in the SCEs. What you need to develop is a technique for approaching SCEs and an ability to concisely convey your thoughts in a logical manner in a pressure situation.

Whether it is in the setting of a formal SCE or simply asking questions on various topics, candidates need early exposure to verbally answering questions on the spot in an organised manner. Once the ‘writtens’ are completed formal SCEs should be conducted under exam conditions until you can take no more. Quite often candidates find the most harrowing times in a SCE are during practice sessions.

Some general points on SCEs:

- Remember SCEs test your ability to organise your thoughts, prioritise, and convey management principles. It is not the arena for testing minute detail. It does involve you thinking quickly on your feet, but with good preparation in the 3 minutes of reading time you can take some of the guesswork out of it.
- Read the scenario carefully. Every word is there for a reason. Prepare your answer to the first question if it is provided with the prop outside the room. Also, a general brief opening statement that could be used regardless of the examiners' first question can be helpful e.g. *This represents a life threatening injury etc.* or *This presentation has a broad differential diagnosis that would include etc.* and give the impression of being on top of the scenario from the start. Try to anticipate where the line of
questioning may go and prepare your thoughts, though don’t be thrown if it tacks in a completely different direction.

- From the start and then throughout the SCE interpret all the information given to you and convey back to the examiners your understanding of it. Convey an appreciation for the seriousness of a situation if applicable. If a scenario poses a difficult management problem, then say “This is a difficult management problem, however I would undertake to...”. If given results to interpret, avoid spending excessive time staring at them, talk your thought processes through as you synthesise the information if it helps, but then summarise your findings (e.g. ‘in light of these results you have shown me, the patient has a diagnosis of ... and I will now commence the following treatment...’).

- As with the rest of the exam, the examiners want to know what YOU would do. Avoid phrases such as “I might”, “You could”, and “I guess”; instead use “I will”, “I would”.

- Be conscious of your posture; avoid excessive movements esp. with your hands – sit them comfortably on your lap or on the desk; look interested and maintain good eye contact with the examiner who is asking you the questions – avoid staring down at the SCE which will be in front of you to refer to if necessary.

- If a ‘list’ is called for ensure it has a logical order to it.

- “Administration” and “medico-legal” questions are common, so practice these frequently. They often provide a whole question or the ‘sting in the tail’ of a scenario.

- Often you are asked to make preparations to receive a patient in a certain scenario (usually a paediatric patient or a patient with special needs who is currently being transported to your ED). Ensure you talk about preparing an area to receive the patient; the staff you will need; and the equipment you may require. If it is a paediatric patient you will also mention calculations of weight, equipment size, drugs and fluids (doing this before you enter the room is a good idea – because it will inevitably come up).

- Remember if you are asked about assessment you need to include – history, examination and investigations. If it is management that is questioned – attend to life threats, specific and general treatments, and disposition. Make your response focused and specific to the scenario.

- Similarly, refer to age-specific parameters in paediatric questions and consider psychosocial issues and non-accidental injury where appropriate.

- If you institute a treatment, mention to what parameters you are resuscitating to.

- Be precise in drug doses and fluid volumes (mg/kg or ml/kg).
• Practicing a general structure to different types of SCEs is important. Similar to SAQs, trauma scenarios or toxicological scenarios have a structure to which you can simply add the detail depending on the case in question.

• Use of general statements and phrases that convey a lot of information in a short time is very useful. Although the examiners attempt to drag you through the whole SCE to give you a chance of accessing as many marks as possible, they can only do so much if you continue to waffle on about unimportant or unnecessary detail. For example, this patient has sustained life-threatening injuries to multiple body systems. I will manage him in a resuscitation room with my trauma team, which includes a surgeon, in waiting. The patient needs high-flow O2 applied via NRB. On primary survey, with respect to his airway and breathing I am concerned for the following injuries...etc. This conveys a lot of information in a concise manner.

• Once again, the more you practice and develop a solid technique that also allows flexibility to adapt to different situations, the more likely it is to stand up to the rigours of the actual exam.
6. EXAM DAY

WRITTEN EXAM

This will be a day long remembered in the universe. What seemed a long way off 3 months ago is now today. You will hopefully be at a stage where in the last week you will be sick of practising SAQs, VAQs and MCQs. All you want to do is get in there and do the exam.

Ideally, you will want to taper your study in the week(s) leading up to the exam. Avoid a panic driven, haphazard scramble through your notes and books. It will be hard to retain detail at this stage. Instead, take a more leisurely approach through the week if your personality allows. In computing lingo, ‘defrag’ your brain. Allow time for some pleasurable activities (movies where good prevails etc) where you can ‘escape’ for a while. Ensure you get plenty of rest. It may all sound like common sense but the levels of anxiety and pressure that can build at this time will surprise you.

With respect to study, keep ‘on the boil’ with a review of ‘lists’ and ‘answer templates’ you have compiled. Review SAQs and VAQs you have done in the past and received feed-back on, to remind yourself of what to do and not to do. Concentrate on the main topics and avoid the minutiae.

The day itself is a long one. Ensure a good night’s sleep prior. Eat a reasonable breakfast even if you don’t feel like it. Allow yourself plenty of time to travel to the exam site and know where you need to go (perform recognisance if needed). Arrive with time to spare, at least 15 minutes. You do not want to feel rushed before the exam starts. There will be plenty of time to embrace that emotion in the exam itself. Bring along pens, pencils (B or 2B for MCQ paper), eraser and any other stationary you wish to use. Ensure that you have practiced writing with your pen and you can do so for hours in a legible fashion.

The exam room will usually provide water, tissues and a clock. On entering synchronise your watch with the clock in the room to ensure you don’t inadvertently throw out your timing. Bring along some paracetamol if you are prone to headaches, or chewing gum / lollies if you so desire.

The exam starts with the VAQs, followed by the MCQs and then the SAQs after a lunch break. As mentioned previously, time management is everything – stick to your pre-determined time limits. Remember, in the SAQs and VAQs it is not worth spending an additional few minutes answering a question you have probably
already passed in the 16.25 minutes / 10 minutes you have already taken. It is hard to improve your answer from a 6/10 to a 7/10 with these extra minutes. It is of greater value to move on at the determined time to the next question and gain the first few relatively ‘easy’ marks of the next question.

Note that while there is no perusal time allocated, better candidates invest a few moments to read through all questions, consider which questions will need prior planning and in what order they will tackle the questions. Remember to carefully read each question – every word is there for a specific purpose. With the VAQs, carefully inspect the prop making sure you have seen all images (they may be spread over multiple pages) and considered the units for lab results. With the SAQs, read each question carefully, get an appreciation for what the question or scenario is ‘driving’ at and start to briefly plan your answer. Candidates should consider requesting an additional answer book to use as a scrap or planning book. In it you should jot down important words, points that you want to include in your answer, mnemonics or other memory prompts and a brief outline to questions which may be difficult to answer with a more standard template. Remember to allow for this in your time limits for each question.

With the VAQs and SAQs, answer first the questions you find easiest or most intuitive. It will provide you with confidence and allow you to build momentum. By the time you reach the harder questions you may find your thoughts flowing more readily and the nerves have dissipated.

With the MCQs, consider completing a first pass of the exam answering those questions you feel confident with. Then return to go through those of which you are more uncertain – you will probably now have relatively more time per question to answer these difficult ones. A word of advice is that your first instincts are probably correct. It is rare to have time problems with this section and many will finish early.

At the end of the exam day, no matter what, go out and enjoy yourself. It is a difficult exam to gauge your level of success and everyone feels apprehensive as to how they have performed.

**CLINICAL EXAM**

The weeks between sitting the written exam and receiving confirmation of your invitation to the clinical exam are extremely frustrating and anxiety provoking (approximately 4-5 weeks). Following the build up to the written exam you tend to plummet into
a state of inertia afterwards. Understandably it is hard to find the enthusiasm to restart studying. Cut your losses and take a break for a week from the grind of study. Importantly, when you recommence you are focusing on different aspects and skills for the clinical exam. Approach the next 4-5 weeks as if it’s a ‘fait accompli’ that you will be invited to the exam. Do not wait for confirmation of your invite to the clinical component before recommencing your study – you will not have left yourself enough time to prepare.

Spend some time going over what the college expects you will bring to the clinical exam.

Historically, approximately 90% of candidates invited to the clinical exam pass overall. Thus once you’ve been invited the odds are heavily in your favour. So from this point on leave no stone unturned in your quest for success now that you are this close. Keep a logbook of short cases to see on wards etc. Do that extra SCE, or see that other short or long case. You do not want to have regrets about the effort you put in during this time if you fail.

As for the week preceding the clinical exam, similar thoughts are echoed as for the lead up to the written exam. Try to stay relaxed and ease off on the workload. Try not to have any deflating experiences with SCEs or clinical cases in the days before the exam. If you are reviewing notes, concentrate on ‘lists’ you have compiled. With the clinical exam, you will find the focus is not on detail – this has been tested for in the written exam. The focus is on priorities, organisation, lists, broad concepts etc – there is no time to test for minutiae.

The clinical exam is conducted over 2 days. The short and long cases are held on the first day and the SCEs the next. Depending on the hospital, this may occur at multiple sites. So again, plan ahead to ensure you’re never rushed or arriving late to your exam site. Similarly, if you are travelling interstate for the clinical exam do so a day or two before. Whether you travel with your partner/family or just other colleagues doing the exam is a personal decision – whatever puts you in a positive frame of mind will be right. When discussing this with your partner, be reminded that is likely to be the most stressful weekend of your life.

Some general points:

- In the long case:
  - Stick to your pre-determined time limits with respect to how long you will spend taking a history and how long on examining the patient.
Always ask the patient if there is anything other people have asked that you haven’t, don’t be afraid to ask them if there was anything that the first two people who saw them (the examiners) focused on. Remember they can tell you anything if you ask.

- **In the short cases:**
  - Time moves quickly and you may find the examiners constantly interrupt to move you through the stations. Generally, at each station one examiner will be doing the talking whilst the other will be taking notes.
  - Remember to display your best interpersonal skills with the patients (and carers) and the examiners. In many ways you are putting on a show, so make sure everyone likes it. In particular, your interaction with the paediatric patient is probably as important, if not more so than your findings.
  - If you have a bad case you need to block it out for the remaining stations. It sounds hard and is. The only way a perceived poor station will lead to a fail is if you allow it to. Don’t let negative thoughts of a previous station destroy your chances on what you have left. Often what you interpret as a disastrous ‘short’ was actually a ‘pass’.

- **In the SCEs:**
  - Do not wallow in any perceived deficiencies from your previous SCE that could trigger a vicious cycle of deflating confidence and worsening performance. So compartmentalise any bad station and refocus on the next.
  - During the SCEs you may find you are interrupted and ‘pushed’ through the scenario, such that you cover all the points that are deemed important. This can be frustrating when you have a good knowledge of the subject and wish to express it. It can also at times throw you off your ‘train of thought’, so be prepared.
  - If you haven’t covered specific points in your answer that are integral to the scenario then you will be prompted to address these. If it is obvious to the examiners you do not know, they will in the interests of time move on and enable you to score marks in the remainder of the scenario. If at any stage you are unsure of what the examiners are striving at, or you don’t understand the question, simply ask them to repeat the question.
7. CONCLUSION

The ACEM Fellowship Exam is a rewarding process that involves an exhausting and complex preparation.

As with most specialty training programs candidates will be approaching the exam having spent many years in advanced training. With this comes an expectation that a successful undertaking of the exam is a mere formality. Living up to these expectations may not be easy. Focus on your own preparation, not others expectations.

The textbooks, journal articles and other resources required to prepare for the exam is easily obtainable. Utilising all the information you will have at your fingertips in a time efficient manner is challenging. Knowing how to apply your knowledge to the specifics of the exam is crucial.

This manual has sought to assist candidates in meeting the challenges and overcoming the problems encountered in their exam preparation.

Overall, to be successful you do need to have put in a lot of time and effort; and a little luck never goes astray!
8. APPENDICES

APPENDIX I – ACEM RECOMMENDED REFERENCE BOOKS.

- Chan T et al (eds), *ECG in Emergency Medicine and Acute Care* (Elsevier Mosby)
- Roberts JR, Hedges JR (eds), *Clinical Procedures in Emergency Medicine* (WB Saunders Company)
- Murray L et al (eds), Toxicology Handbook (Churchill Livingstone)
- Peat JK, *Health Science Research* (Allen & Unwin)
APPENDIX II – RECOMMENDED JOURNALS

- Emergency Medicine Australasia (Australia and NZ)
- Annals of Emergency Medicine (USA)
- Journal of Emergency Medicine (USA)
- Academic Emergency Medicine (USA)
- Emergency Medicine Journal (UK)
- New England Journal of Medicine
- Lancet
- British Medical Journal
- Medical Journal of Australia
- Circulation
- Journal of Trauma
APPENDIX III – GLOSSARY OF TERMS

- **Assessment** – History taking, physical examination and investigations.

- **Describe** – State the characteristics or appearance of the subject, **including relevant negatives**

- **Discuss** – Examine the pros and cons of each alternative asked for on a subject

- **Disposition** – Where the patient is sent following care in the emergency department, including follow-up if discharged.

- **Interpret** – State a conclusion or conclusions which includes a differential diagnosis, but excludes management.

- **Investigations** – Specific tests undertaken to make a diagnosis or monitor the patient’s condition.

- **List** – A numerical ordering of related items.

- **Management** – Those aspects of care of the patient encompassing treatment, supportive care and disposition.

- **Outline** – A brief description of the subject.

- **Protocol** – A set of instructions on how to deal with a particular situation.

- **Treatment** – Measures undertaken to cure or stabilise the patient’s condition.
APPENDIX IV – EXAMPLE OF ANSWER BOOKLET

CANDIDATE NO.....

ANSWER BOOK

SECTION (B OR C).................

QUESTION NUMBER..............

INSTRUCTIONS TO CANDIDATES

1. Ensure that you have read the examination room instruction sheets.
2. Write your answers legibly in ink – use both sides of the paper.
3. Ensure that supplementary answer books are placed inside the cover of the main answer book and that they are clearly labelled.

DO NOT REMOVE THIS BOOK FROM THE EXAMINATION ROOM
APPENDIX V – SAQ ANSWER TEMPLATES AND NOTES

(1) INTRODUCTORY STATEMENT for all SAQs

All answers MUST have an introductory statement. This statement can take many forms, considerations in formulating this statement should include:

- Acknowledgement and synthesis of clinical scenario
- Aim(s) of assessment or management
- Differential diagnosis or Risk stratification
- Key issues

Format will depend upon the individual question and candidate preferences.
(2) ASSESSMENT SAQs

• **Introductory statement:**
  - Acknowledgement and synthesis of clinical scenario
  - Aim(s) of assessment
  - Differential diagnosis or Risk stratification
  - Key issues

Where possible state the reason(s) for each assessment point.

• **History**
  • **Examination**
  • **Investigations**

• **History:**
  - Should include history from patient and appropriate collateral.
  - Attempt to organise historical features into related lists with the use of sub-headings such as:
    - *Symptoms of the complaint*
    - Symptoms of precipitants that may have caused the complaint
    - Symptoms that define severity
    - *Symptoms of potential complications of the complaint*
    - *Past history*—
      - relevant to the complaint
      - relevant to physiological reserves
      - other relevant past history
    - *Medications* – specifically those relevant to the complaint, condition or that may compromise physiological reserves
  - **Allergies**
  - **Social history**

• **Examination:**
  - Again use sub-headings to organise your lists.
  - Depending on scenario may structure as:
    - *Identifying immediate life threats*
    - OR (if obviously no perceived life threats)
    - *Assess vital signs*
    - *Focused systems examination*
      - systems likely to be affected by complaint / condition
      - signs of conditions that may be precipitants
      - signs of severity
      - signs of complications

• **Investigations:**
  - Bedside
  - Laboratory
  - Radiology / Imaging
  - Other
(3) MANAGEMENT SAQs

- **Introductory statement:**
  - Acknowledgement and synthesis of clinical scenario
  - Aim(s) of management
  - Differential diagnosis or Risk stratification
  - Key issues

All actions MUST have defined end points and appropriate detail.
- **Preparation**
- **Resuscitation / Specific treatment**
- **General / Supportive measures**
- **Disposition**

- **Preparation:**
  - Some questions may ask specifically what preparations will you make prior to the patient’s arrival. In which case you need to address preparing your:
    - **Area**
    - **Staff**
    - **Equipment**
  - If the question doesn’t specifically ask you to detail your preparation then you should have a standard spiel that introduces your management – essentially covering area, staff and equipment in a broader sense such as:
    - Assemble resuscitation team
    - Manage patient in a resuscitation room

- **Resuscitation / Specific treatment** (always define goals / end-points of a treatment / intervention):
  - Aim to treat the condition(s) and their potential complications through the framework of:
    - Airway / breathing
    - Circulation
    - Disability
    - Other systems

- **Supportive measures**
  - This should cover issues such as:
    - Positioning
    - Tubes – NGT, IDC etc
    - Fluids – ongoing / maintenance
    - Medications – analgesia, sedation, paralysis, antibiotics, tetanus etc
    - Monitoring – responses to treatment
    - Other –splinting fractures, vascular access.
• **Disposition:**
  - Cover the options and give reasons / indications for each
  - Consider other follow-up that may be required – esp. psychosocial issues
(4) TRAUMA ASSESSMENT and MANAGEMENT

• **Introductory statement:**
  • Acknowledgement and synthesis of clinical scenario
  • Aim(s) of assessment and / or management
  • Differential diagnosis or Risk stratification
  • Key issues

• **Preparation:**
  • Manage in a resuscitation room
  • Assemble trauma team +/- specific personnel (i.e. a surgeon)

• **ASSESSMENT:**

  • **History:**
    • History of event – mechanisms of trauma
    • Symptoms since
    • Treatment given pre-hospital – response
    • Past history – relevant to scenario / condition
    • Medications (relevant) / allergies / tetanus status

  • **Examination:**
    • Primary survey – identify immediate life threats:
      • Airway / breathing – assess for a patent / protected airway, evidence of respiratory distress; identify the likely life threatening injuries within the scenario given e.g. upper airway obstruction, or tension pneumothorax, or flail chest etc.
      • Circulation – assess vital signs / perfusion; identify likely areas of bleeding – internal / external
      • Disability – GCS, pupils, gross movements
      • Expose the patient
    • Secondary survey:
      • Head to toe examination – inc. specific areas of interest considering mechanism / scenario

  • **Investigations** (inc. reasons why / what looking for/ important considerations)
    • Bedside
    • Laboratory
    • Radiology / Imaging
    • Other

• **MANAGEMENT:**

  • **Resuscitation / Specific treatment** (always define goals / end-points of a treatment / intervention):
    • Airway / breathing with c-spine control
    • Circulation with haemorrhage control
- Disability
- Environment
- Treat condition
- Treat potential complications

- **Supportive measures** (always define goals / end-points of a treatment / intervention):
  - Positioning
  - Tubes – NGT / IDC etc
  - Fluids – ongoing / maintenance
  - Medications – analgesia, sedation, paralysis, antibiotics, tetanus
  - Monitoring / assessing response to treatment measures
  - Other – splint fractures etc

- **Disposition:**
  - Options and reasons / indications for each
(5) TOXICOLOGY

• **Introductory statement:**
  - Acknowledgement and synthesis of clinical scenario
  - Aim(s) of assessment and / or management
  - Differential diagnosis or Risk stratification
  - Key issues

• **Preparation:**
  - Assemble resuscitation team –if applicable
  - Manage in an appropriate area (monitored room or resuscitation room)

• **ASSESSMENT:**

  • **History:**
    - Circumstances of ingestion – what taken / how many / what time / co-ingestants
    - Symptoms since ingestion
    - Formulate your **Risk Assessment**
    - Precipitant / trigger to overdose
    - Consider differentials for presentation if not clearly an overdose (i.e. infection etc)
    - Mental state – ongoing suicidality / mood disturbance / perceptual disturbance / insight and judgement
    - Past history – relevant medical (effected by ingested substance) and psychiatric (previous self-harm etc)
    - Medications / allergies – relevant (interactions with ingested substance)

  • **Examination:**
    - Identify immediate life threats – relevant to scenario (i.e. airway, breathing, circulation)
    - General head to toe examination – esp. systems likely to be affected, evidence of toxidromes, consider differentials for presentation if not clearly an overdose (i.e. infection etc)

• **Investigations** (include reasons why / what looking for/ important considerations)
  - Bedside
  - Laboratory (consider levels and timing)
  - Radiology / Imaging
  - Other

• **MANAGEMENT:**
  - Decontamination.
  - **Specific treatment** (always define goals / end-points of a treatment / intervention):
- Airway / breathing
- Circulation
- Disability
- Environment
- Specific antidotes
- Treat condition
- Treat potential complications

- **Supportive measures** (always define goals / end-points of a treatment / intervention):
  - Positioning
  - Tubes – NGT, IDC etc
  - Fluids – ongoing / maintenance
  - Medications
  - Monitoring responses to treatment
  - Other

- **Disposition:**
  - Options and reasons / indications
  - Psychiatric follow-up
(6) PAEDIATRICS

- **Introductory statement:**
  - Acknowledgement and synthesis of clinical scenario
  - Aim(s) of assessment and / or management
  - Differential diagnosis or Risk stratification
  - Key issues

- **Calculate weight and age-specific clinical parameters** (HR, BP, RR)

- **Preparation** (often asked specifically to address prior to patient arrival)
  - Assemble staff (inc. any specific staff you may require)
  - Prepare your area (resuscitation room or monitored area)
  - Prepare your equipment (tube sizes, fluid volumes etc)

- On arrival:
  - Allow carer to stay with child for psychological support where possible

- **ASSESSMENT:**
  - History – when relevant peri-natal history, developmental milestones, immunisations etc
  - Examination
  - Investigations

- **MANAGEMENT:**
  - Specific treatment
  - Supportive measures
  - Disposition:
    - Options and reasons / indications
    - Consider safety issues regarding discharge
(7) DISASTER PREPARATION

- **Prepare:**
  - ED
  - Hospital
  - Region

- **Prepare ED:**
  - Notify and prepare staff – roles, teams etc
  - Prepare your area – empty department etc; prepare resuscitation areas and walking wounded areas
  - Prepare decontamination areas
  - Prepare equipment – obtain additional resuscitation equipment, antidotes etc
  - Organise disaster triage – met-tags
  - Organise communication systems
  - Security

- **Prepare hospital:**
  - Activate disaster code
  - Liaise with hospital management – disaster management team
  - Ensure hospital teams prepared – theatre, ICU blood bank etc
  - Temporary morgue
  - Media
  - Administrative personnel
  - Pastoral care and social work

- **Prepare region:**
  - Notify regional disaster coordinator
  - Other hospitals notified
  - By-pass usual workload
  - Walking wounded to go to different hospitals than resuscitation patients
  - Police - security
  - Fire brigade / HAZMAT – identification / decontamination
(8) ADMINISTRATION

(8.1) PURCHASING EQUIPMENT

- **NEED** (is there a need)
  - Define a need / benefit
  - Reasons for acquiring it
  - Specific clinical indications in question
  - Current / Alternate options
  - Is it justifiable

- **RESEARCH** (check it out)
  - Types / options; properties / capabilities; costs; servicing; warrantees; technical support.

- **CONSULTING** (asking and benchmarking)
  - Own staff; other EDs, other users etc.

- **COSTING** (how much)
  - Purchase costs, running costs, maintenance costs, cost-effectiveness, funding, staff training

- **ADMINISTRATING**
  - QA / auditing; medico-legal, accountability, protocols

- **TRAINING** (who)
  - Who, how will they be trained, skills maintenance, in-servicing / education

- **TRIALLING** (lets go)
  - One or all options; set trial period, audit / feedback / surveys etc
(8.2) PROTOCOL DEVELOPMENT

- Assess need – get the evidence
- Involve relevant stakeholders in protocol development

- Consider options
  - Research best evidence –
    - Literature
    - Other EDs
    - ACEM guidelines

- Protocol
  - Components:
    - Aim
    - Scope
    - Inclusions / exclusions
    - Procedure / process itself
    - Documentation requirements
    - Review date
    - Authors

- Administration requirements
  - Staff
  - Documentation
  - Costs
  - Medicolegal

- Training / education
  - Staff
  - Initial / ongoing

- Evaluation / Quality assurance
  - Audit
  - Total quality improvement
(8.3) ED SYSTEMS

- If asked to review / audit / construct an ED system consider it in terms of 3 issues:
  - **Process**
  - **Information**
  - **Decision making**

- **Process** – includes the ‘structure’ of the system (i.e. how it works). Includes the staff, what they do, the equipment, any protocols etc.

- **Information** – relates to the information generated within the process of the system and importantly where it goes (e.g. is it going to the correct people with respect to decision making).

- **Decision making** – refers to the decision making taking place within the process of the system by various people (e.g. are the decision makers getting all the information necessary; correct information?; information in a timely manner?; are the decision makers appropriately trained / educated etc).
(8.4) ED MEDICAL STAFFING ISSUES

- **Rights of patients** – to be seen in acceptable time according to clinical urgency

- **Rights of staff** - to safe and manageable work conditions / job satisfaction

- **Determine clinical workloads** –
  - Patient numbers
  - Acuity of patient load (presentations per triage category)
  - Admission rates (overall and per triage category)
  - Length of ED stay
  - Seasonal variability
  - Degree of access block
  - Benchmark against peer hospitals

- **ACEM and other statutory policies:**
  - Consultant: Reg: Resident ratios
  - Consultant: attendances ratios
  - Safe working hours

  Performance with **ED clinical indicators** (esp. waiting time by triage category, NEAT); benchmark against peer hospitals.

- **Clinical and non-clinical time** balance
  - Education
  - Research
  - Professional development

- **Rostering practices**
(8.5) QUALITY IMPROVEMENT ISSUES

- **Total Quality Improvement (TQI)** and **Continuous Quality Improvement (CQI)** – ongoing process providing a service that meets needs and also leads itself to continuous improvement

- **Process**: (circle of continuous QI):
  - **Specify performance indicators**
  - **Data collection** – evaluate performance / analyse / identify deficiencies
  - **Plan** to correct deficiencies / improve performance
  - **Re-evaluate** the process to assess for improvement
(8.6) COMPLAINTS

- **Respond promptly**

- **Interview** with complainant
  - Patience, empathy, listen
  - Apologise

- **Document** complaint
  - Acknowledgement – verbal / written

- **Gather** information
  - Investigate

- **Interview** with person complained about
  - Document meeting / neutral party present

- **Response** / action (prompt)
  - Written response to complainant
  - +/- mediation with all parties present

- **Inform** hospital executive / +/- medical board
  - May require further mediation at hospital executive level – adversarial

- Staff involved may need to be advised to inform their medical defence company.

- **Review** systems that may have contributed to problem / complaint
  - Continuous quality improvement
  - Education etc