College of Emergency Medicine

FELLOWSHIP EXAMINATION OF THE COLLEGE OF EMERGENCY MEDICINE

REGULATIONS AND GUIDANCE NOTES EFFECTIVE FROM SPRING 2009

Table of contents

Introduction 2
Overview - Content 3
Format 3
Marking 5
Marking scheme 5
Eligibility 5
Closing dates 7
Number of attempts 7
Section A (i) Review of published work 8
Section A (ii) Clinical topic review 12
Section B – Management viva 17
Section C (i) Short answer question paper (SAQ) 22
Section C (ii) Objective Structured Clinical Examination (OSCE) 23
Results 25
Administration 25
Examination arrangements for candidates with special needs 25
Data Protection 26
Feedback 26
Appeals 26
Improper conduct by examination candidates 26
Withdrawal 27
Procedure for re-sitting one or more sections of the FCEM examination 28
Fees for re-sitting the examination 28
Equal opportunities policy statement 29
Election to Fellowship 29
Annual subscription fees 30
Diploma ceremonies 30
Alison Gourdie Medal 30

Appendix 1 – List of sponsors for non-trainee applicants 31
Appendix 2 – Example of feedback form for unsuccessful candidates 34
Appendix 3 - Appeals process 36
Appendix 4 - Past questions & examiner's checklist 36
Appendix 5 - Provision of services for candidates with special needs .. 39

October 2008 – main changes to the regulations

- All parts of the examination must be sat at the first sitting – there is no opportunity to defer a section
- Doctors working/training overseas must have their application form signed/sponsored by a Fellow of the College of Emergency Medicine
- Trainees must have their application form signed by their programme director or Chair of STC/Head of school, educational supervisor signatures will not be accepted
- The Candidate must have been working in Emergency Medicine for the last six months (or pro-rata time if flexible)
- The whole examination must be completed within 6 diets of the first sitting (including the first sitting).
- Note should be made of the allocation of marks for original work within the CTR – including undertaking a meta-analysis
- Candidates who have successfully completed a PhD or MD thesis on a topic relevant to Emergency Medicine are considered to have already demonstrated the skills required for this part of the examination. Applicants who believe they may be eligible for exemption as a result of gaining these qualification BEFORE the FCEM, should write at least six months in advance of their intended application date. They should submit relevant information regarding the course work, the thesis word count and regulations, and the details of any viva undertaken. Candidates also need to send a copy of the thesis abstract and a certified copy of the University documentation showing successful completion of the degree with the thesis title. This will be considered by the Dean for eligibility and the candidate informed 3 months before the closing date of their exemption. Failure to submit evidence 6 months prior to the closing date will result in the candidate having to complete a CTR regardless of the previous qualification.
- For non-trainees and overseas candidates the feedback for unsuccessful candidates will be shared with the sponsoring Fellow for their information and to provide opportunities for the non-trainee/overseas doctor to have further structured and informed support.

Introduction

The Fellowship Examination of the College of Emergency Medicine (FCEM) is intended to allow the candidate to demonstrate the necessary skills and competences required to be a successful Consultant in Emergency Medicine in the UK and Ireland. As the specialty changes so will the examination. These regulations are effective from and including the spring diet of 2009 and aim to acquaint examiners and candidates with the way that the examination will be conducted and the specific focus of each of its components. They should also allow candidates to prepare appropriately and give an indication of the standard required.

The examiners' task is to assess whether the candidate's knowledge, skills, attitudes and expertise in Emergency Medicine are at a level suitable for a newly appointed Consultant working independently in the United Kingdom or Ireland.

The College recognises that the examination is a critical event in the candidate's career and examiners are aware that candidates are anxious. Examiners will therefore display courtesy, consistency and objectivity as well as endeavouring to create a relaxed and welcoming atmosphere. Unfortunately, there may be instances when a candidate's performance is judged to be below the acceptable standard. Failure may jeopardise a candidate's eligibility for specialist registration and preclude application for Consultant posts in the United Kingdom. With so much dependent on the outcome of the examination it is essential that decisions are clear cut and defensible. To this end a formalised matrix system is used describing the characteristics of performance judged to be good, acceptable, and unacceptable.

Overview - Content

The examination will be based on the College's curriculum. It will offer an opportunity for the candidate to demonstrate both the breadth of his or her knowledge of Emergency Medicine as well as the application of that knowledge to common clinical and managerial scenarios. The latter should include knowledge of the changing nature of health care delivery and the ability to run an efficient and effective emergency service as part of a multi-consultant team. The candidate will be expected to demonstrate knowledge of information resources relevant to emergency patient care both within and without the hospital setting. The candidate must be able to demonstrate good communication skills and knowledge of educational principles applicable to Emergency Medicine at both undergraduate and postgraduate levels. An understanding of research methodology will also be expected and the candidate should be able to assess the validity and clinical relevance of research work.

Proficiency will be expected in the clinical management of all conditions that can reasonably be expected to present to an Emergency Department. Candidates are advised to use the College Curriculum (which can be found on the website at www.collemergencymed.ac.uk/CEM) in preparation for the examination.

Format

There are three sections of the examination and these can be regarded as modules which must be passed independently. However all sections of the examination **MUST** be taken at the first sitting, there is no opportunity to defer a particular section except under extreme circumstances:

Section A – Academic viva – 1 hour preparation plus two 15 minute vivas

The two parts of the academic section are marked independently, a fail in only one part will require the candidate to resit only that part.

Part (i) Critical appraisal of published work viva – 15 minutes

The candidate will be given a recently published paper (without the abstract/summary/limitations of study sections) to appraise for one hour before a discussion of its content. The paper will be chosen for its general application to Emergency Medicine clinical practice as defined by the curriculum. Candidates will be expected to be able to appraise diagnostic, treatment or review papers.

Part (ii) Clinical Topic Review (CTR) viva – 15 minutes

This viva provides the opportunity for a detailed discussion of the Clinical Topic Review previously submitted in writing by the candidate. Candidates should note the word limit in place for the CTR.
There are some circumstances when a candidate will be exempt from this part of the Academic Section – please see section A (ii)

Section B - Management viva – 5 minutes preparation plus two 15 minute vivas

There will be an 'in-tray exercise' and a structured discussion of a developing clinically relevant management scenario. This will enable exploration of a variety of clinical and administrative topics identified in the curriculum as relevant to the specialty.

Section C - Clinical

Using the curriculum, the examination panel choose relevant clinical scenarios that may be encountered in the Emergency Department. The knowledge, skills and behaviours required to deal with these cases are tested in two ways:

(i) Short Answer Question (SAQ) Paper

There will be 20 questions in the short answer paper and it will last for two and a half hours.

These are structured questions using clinical scenarios accompanied by data. These data may include: diagnostic imaging (X-ray and CT), ECGs, pathology results, clinical photographs, pathology test results and other clinical data relevant to patients in the emergency setting. Candidates are required to evaluate the clinical scenario, interpret the data and suggest appropriate diagnosis and management. This examination is taken approximately 6 weeks before the remainder of the examination. Failure in this part will automatically result in the candidate being unsuccessful in gaining Fellowship on this diet. However, as the examination is modular, the candidate will be permitted to proceed to sit the other parts of the examination at this diet and are encouraged to do so.

(ii) Objective Structured Clinical Examination (OSCE)

An objective structured clinical examination with the equivalent of 16, eight minute stations will use patients, and/or actors simulating patients, and manikins for scenario and practical procedure assessment.

Both parts of the clinical section must be passed at the same sitting

N.B. The FCEM became a modular examination in November 2006. Candidates who have sat the examination before November 2006 are advised to note that they resit under the regulations that are current at the time of the resit, not those applicable at the time of the original application. The result of this is that a pass in any section of the examination under previous regulations will **not** be honored if there has been a fail in that section on a subsequent attempt.

Standard

The level of competence required for each component of the examination is based upon that expected of a newly appointed consultant in Emergency Medicine. This level is described in the curriculum of the College of Emergency Medicine and is commensurate with current practice in Emergency Medicine in the United Kingdom or Ireland. The standard for each section is set prior to the examination by the relevant examination subgroup and is validated by the panel of examiners at each diet.

Marking

There are two examiners per candidate for each part of the examination including the short answer question paper. Where appropriate, examiners will record details of their interviews with candidates, including brief summaries of questions asked and replies given. Subsequently each examiner will complete his or her marksheet without any reference to the other examiner. In the vivas, the examiners will then agree a mark. In the case of each OSCE station, the marks from the two examiners are merged and the mean taken.

Marking scheme

The pass mark for each section will be set prior to the examination and the candidate will be deemed to pass or fail each section. There will be no compensation between any sections of the examination. Candidates will have to pass both the OSCE and SAQ paper at the same sitting in order to pass the examination.

Eligibility

The Fellowship examination of the College of Emergency Medicine (FCEM) can be taken by those in specialist registrar training posts in the UK or Ireland.

It can also be taken by non-trainees who are judged to have appropriate experience and have reached the appropriate standard. Non-trainees would typically be taking the examination as part of the application process to the Postgraduate Medical Education and Training Board (PMETB) for specialist registration in Emergency Medicine under Article 14 of the General Medical Practice and Specialist Medical Evaluation Training and Qualification Order 2003. Success in the FCEM examination will assist an application under Article 14 but will not guarantee a successful application. Applicants should read the guidance produced by PMETB and the College of Emergency Medicine to ensure that they meet all the criteria.
Non-trainees may also choose to sit the examination for personal or other reasons. Doctors working or training overseas who wish to sit the examination are required to discuss the examination with a Fellow of the College of Emergency Medicine in order for them to determine whether they have the appropriate experience and have reached the appropriate standard. Overseas candidates must have their application form signed by a Fellow of the College of Emergency Medicine to confirm that they understand the format of the examination and the standard required.

Trainee's eligibility

The candidate must hold a medical qualification recognised for registration by the General Medical Council or the Medical Council of Ireland.

Specialist Registrars or Specialty Trainees holding National Training Numbers in the UK or Ireland

- For new style ST doctors this is applicable to those with the suffix /C or /E on their NTN.
- For old style SpRs (appointed prior to August 2007) this is applicable to type 1 and type 2 trainees.
- The candidate must have enrolled with the Training Standards Committee (TSC) of the College of Emergency Medicine or the Advisory Committee on Emergency Medicine Training in Ireland (ACEMT) of the Royal College of Surgeons of Ireland.
- The candidate must be within 15 months of their proposed CCT or CESR date and have passed the relevant RITA/ARCP *at the time of the SAQ component of the exam.* If the date of the relevant RITA or ARCP is after the closing date (but before the date of the SAQ), the College will accept a letter from the chair of the RITA or ARCP panel indicating that it is expected that the individual will have a successful assessment of progress. In the event of a delay in providing the documentation, the trainee's supervisor will be required to write a covering letter confirming the trainee has the competences to do the exam and the delay is outside the trainee's control.
- Trainees in Ireland must have similarly satisfied the ACEMT of progress to completion of training. The fourth year RITA (Record of In Training Assessment) must be signed prior to sitting the SAQ component of the examination.
- The candidate's programme director or Specialty Training Committee Chair / Head of School must sign the appropriate declaration on the application form. Educational supervisor signatures will no longer be accepted.
- Candidates who extend their CCT date to accommodate out of programme training (e.g. sub-specialty training or research) will still be governed by the rule above. Candidates still require the relevant RITA or ARCP documentation for eligibility. This RITA or ARCP relates to core training and thus may be completed even though the trainee will not gain full CCT until after the extension for sub-specialty training.

Non trainees

- The candidate must hold a medical qualification recognised for registration by the General Medical Council or the Irish Medical Council.
- The candidate must have been qualified and in active medical practice for at least six years after the initial two year foundation/intern posts. For overseas doctors this equates to a total of 8 years post qualification.
- The candidate must have worked in Emergency Medicine for at least four years, of which three was in a post above SHO grade (e.g. Registrar, Staff Grade, Middle Grade, Clinical Fellow, Associate Specialist, Locum Consultant or overseas equivalent). Within this post the candidate must have held middle grade or senior responsibility i.e. resuscitation team leader, senior shift doctor accepting undifferentiated adult and paediatric patients in the Emergency Department.
- The Candidate must have been working in Emergency Medicine for the last six months (or pro-rata time if flexible)
- Evidence of completion of relevant posts must be provided. Evidence can be the signature of the consultant supervisor on the appropriate part of the

application form or separate documentation on hospital headed note paper. Other evidence is acceptable at the discretion of the College of Emergency Medicine.

- There is no longer a specific requirement to spend time in related acute specialties outside EM. However, the competencies that may be gained in such experience outside EM will be tested in the FCEM examination, to the extent that they are included in the CEM curriculum. Thus, time spent in relevant specialties will still be of value, especially where this covers areas in which the doctor has little previous experience.
- The candidate must understand the structure, content and standard of the examination. It is therefore necessary for the candidate to discuss the application and the structure and standard required of the examination with a Fellow of the College of Emergency Medicine who should sign the appropriate declaration on the application form.
- For UK applicants we would recommend the Chair of the local STC for Emergency Medicine. For overseas applicants, we provide a list of Fellows of the College in the UK and Ireland who are prepared to give further information and guidance. A suggested list of contacts and guidance for those preparing for the examination and their sponsors is attached at Appendix 1.

Closing dates

Candidates are reminded that each diet has a closing date after which no applications will be accepted. This is to allow examiners time to adequately prepare as well as enable the College to plan the examination timetable. Candidates who have difficulty in obtaining all necessary documentation are advised to contact the College to register their intention to sit the examination, even if the final documentation is not received. The Dean will then decide on the best course for individual candidates.

Number of attempts

The College permits candidates to attempt the examination up to four times in addition to the initial attempt. The whole examination must be completed within 6 diets of the first sitting.

Any applications for resit any or all sections of the examination must be supported by a letter from an Emergency Medicine trainer/sponsor, who is a Fellow of the College of Emergency Medicine. This applies to all candidates, trainees and non trainees and includes overseas candidates. This will need to confirm that the candidate has addressed the educational deficiencies identified in the examination feedback and is now suitable to attempt the examination again. Educational requirements may be met by additional training or CPD.

After four resits, there needs to be a detailed review of the candidate's educational progress and re-assessment of his/her career aspirations. Any subsequent applications must be supported with letters from the Chair of the local training committee confirming that they support the application and consider that it is in the candidate's and the specialty's best interest that he/she has a further attempt. In the case of a non-trainee or overseas candidate, the Dean or Senior Examiner will require to determine the suitability of the candidate in conjunction with their local clinical supervisor.

Specific guidance on sections of the examination

Section A (i) Review of published work

15 minutes preceded by 1 hour reading.

The examiners will seek evidence that the candidates can effectively and systematically evaluate published work, in order that they may be able to modify their future clinical practice using valid published data as their guide. The paper is likely to be either an article evaluating diagnostic tests, treatments, or a clinical review . Candidates will have read the paper (without the abstract) during a 60 minute period immediately before the viva, and prepared their summary. Examiners will also have read the paper without the summary and composed their own summary. This is to help them approach the issue from the candidate's perspective and to develop an appropriate line of questioning. In addition there will be a pre-prepared critique and a matrix answer sheet for each examination that will indicate the core items/issues that must be raised by the candidate.

In the viva the examiners will start by asking the candidate to present an abstract/ overview of the paper. After approximately 2-3 minutes they will then go through the article in a systematic way, asking specific questions, and finish by enquiring about the candidate's overall impression (e.g. "will it change your practice?").

The examiners may interrupt the candidate during their answers, to either seek clarification of a point, or to ensure that there is the opportunity to answer all the questions. Candidates will be free to refer to the article and any notes made whilst reading the article.

The following guide indicates the anticipated generic structured approach for candidates as well as the standards to be applied in marking. The identification of potential weaknesses in the work should be supported by suggestions as to how the paper might be improved. Some broad general knowledge of statistics will be expected, but a detailed knowledge of specific tests is not required.

Guidance on the approach to critical appraisal is found on the website under http://www.collemergencymed.ac.uk/CEM/Training%20and%20Examinations/Exams/Resources%20for%20exam%20preparation/default.asp
A course outline and contents for a critical appraisal course can be found on the website.

Marking

To pass this part, the candidate must demonstrate a clear understanding of how to evaluate, interpret and use a research paper.

Any significant criticism of the paper must be supported by arguments based on the internal evidence presented within the paper. An ability to make a defensible case that, for example, the authors have misinterpreted the study's results will merit consideration for a higher mark.

Conversely candidates who do not identify all of the core issues or items for the paper will receive a lower mark. Failure to identify several of the core issues will result in a fail in this section.

Mark

The pass mark will be set by the academic section panel prior to the examination depending on the complexity of the paper. It is likely that this will be in the range of 60-70% of the total marks available. The latter will vary depending on the marksheet

developed for an individual examination. The marking sheet for April 2007 is shown below together with the summary critique used by the examiners.

Paper used:

Chong et al. Comparison of forearm and conventional Bier's block for manipulation and reduction of distal radial fractures. Journal of Hand Surgery (European volume 2007) 32E:1:57-59.

This marksheet must be used in conjunction with the "crib sheet" provided Summary,

Summary – 1 mark for each item up to 4 **See crib sheet below**	**5,4,3,2,1**
Study undertaken as common problem and still unanswered questions re best method of anaesthesia	**2,1,0**
Design	
Randomisation has been used	**1**
Use of sealed envelopes until after entry to trial reduces bias	**1**
Some blinding but full blinding not possible	**1**
Although authors say reduced dosage is reason to do forearm block they used same dose in the end	**1**
Sample size	
Underpowered as diff in pain score of <25mm is clinically important	**1**
Not got sufficient power to identify important diff in complications rates	**1**
Analysis	
Not stated about intention to treat, but all analysed in group allocated to	**1**
95% confidence intervals would allow for type 2 (false neg) error to be identified	**1**
Population (low age, m=f) means might not be representative of "normal" Colles population	**1**
Results/outcomes	
Other outcomes could have been measured (degree reduction, remanipulation etc)	**1**
Unknown if other analgesia given	**1**
Conclusions / applicability – sound method but underpowered and unlikely to change practice as traditional Biers is generally safe	**2**
Global	
Appears novice, competent, or completes well	**2,1,0**
	Max 22

Pass mark set 14
Overall impression

Pass Fail

Summary for examiners:

Candidates should mention the following points:

- The study was a randomised controlled trial
- The study population was adults with a distal radial fracture requiring manipulation
- Forearm Bier's block was compared to conventional Bier's block.
- The main outcome was pain, measured on a 10cm visual analogue score (VAS)
- There were no differences between the two groups in VAS pain scores or complications.

Critical appraisal

Candidates should mention the following essential points:

1. Randomisation has been used to ensure that there are no systematic differences between the two study groups prior to treatment.
2. It is impossible to blind the patients and impractical to blind the treating clinicians to the type of Bier's block used. The researchers have tried to reduce bias by blinding the observer who collected the outcomes. However, patients may have been influenced in their VAS scoring by awareness of the technique being used.
3. It is not stated whether an intention-to-treat analysis was used, but all patients appear to have received the allocated treatment and been analysed in the group they were allocated to.
4. The results should report the difference in pain score between the treatment groups with a 95% confidence interval. This would allow the reader to judge whether the potential for a type II (false negative) statistical error, i.e. do potentially important differences in pain score lie within the 95% confidence interval?
5. The study has not been designed with sufficient power to detect potentially important differences in complication rates.

Candidates may receive additional credit for mentioning the following:

1. The use of sealed sequentially numbered envelopes to achieve allocation concealment should ensure that patients and clinicians are not aware of the allocated treatment until the patient is irreversibly entered into the trial. This ensures that patients and clinicians cannot create bias by choosing whether or not to take part in the trial once they know what treatment will be given.
2. The relatively low mean age and equal numbers of males and females suggest that the study population may not be representative of the wider population with distal radial fractures, who are typically elderly and female.
3. The sample size calculation appears have been appropriately undertaken, but it could be argued that differences in pain score less than 25mm are clinically important and the study is therefore underpowered.
4. The use of forearm Bier's block is justified in the introduction on the basis of, amongst other things, reduced lignocaine dose and increased safety, but the same dose of lignocaine was used for both forearm and conventional blocks.
5. Other outcomes could have been measured, such as radiological degree of reduction, remanipulation rates and patient satisfaction.
6. It would have been helpful to report whether any other analgesia was given, such as morphine or nitrous oxide.

Conclusion

This is a methodologically sound study, but it is too small to detect potentially important differences in outcome, particularly complication rates. Given the generally good efficacy and safety profile of a properly administered conventional Bier's block, this study is unlikely to change practice.

Comments

This is a short, simple, well-written article that should present candidates few problems if they have received appropriate training in critical appraisal.

Section A (ii) Clinical topic review

The assessment of the CTR is in two parts:

i) Written CTR review – 60% of marks
ii) Viva of the CTR – 40% of marks. This will be for 15 minutes, immediately following the review of published work.

The CTR should be less than 3,500 words in length and be of direct relevance to clinical practice in Emergency Medicine rather than departmental management or the wider aspects of service provision. However, primary research dealing with topics relevant to Emergency Medicine will be accepted. The Clinical Topic Review manuscripts will be sent out to the examiners one month before the examination.

Candidates should note that excessive use of tables to reduce the total word count will not be accepted, it is recommended that no more than four tables should be used.

Any CTR longer than 3,500 words (excluding tables and references) will not be considered.

The CTR should be:

- The sole work of the candidate
- Typed using 12-font typeface with double spacing and 2 cm margins
- Referenced throughout using the Vancouver style
- Stapled and not submitted in folders, poly wallets or binders
- Include a header at the top of each page containing the candidate's name, title of review and page number
- The front sheet should include the title, the candidate's name and word count and a signed declaration that the manuscript is all their own work
- Contain correct spelling, grammar and formatting.

The CTR may be submitted electronically if the candidate wishes, on CD or DVD, but the document must be in Word 2000 format. NO other format will be accepted. The format of the document should be such that on printing, the above stipulations are met (other than stapling). The CTR will be disqualified if the document is not formatted correctly on the electronic version.

Objectives of the CTR written report review (60% of total marks)

The CTR represents the opportunity for the candidate to demonstrate the following key skills:

- Identifying a topic or problem related to Emergency Medicine
- Conducting of an appropriate literature search
- Selecting and reviewing scientific papers from the search
- Synthesising the findings of the literature review
- Creation of a well presented, pithy but comprehensive report of the findings of the review
- Conducting personal audit or research that contributes to what is known on the topic
- Constructing of conclusions from the work
- Presenting recommendations from the work to improve patient care.

Consequently, a detailed up to date knowledge of the body of relevant evidence is required along with an ability to evaluate the relative importance of each reference

cited. The CTR should include evidence of deductive thought and not be restricted to a presentation of established opinion. Organisational aspects of patient care may be reviewed but questioning should chiefly impact on clinical practice. The choice of topic is crucial and must be of direct relevance to Emergency Medicine. Questions relating to therapy and diagnosis are common, hence a well phrased three-part question with written argument is often used (as in the BestBETs series – www.bestBETs.com) but this is not essential. Topics outside this area e.g. health education and implementation of guidelines require additional knowledge of areas outside Emergency Medicine and often considerable original work. Additional other work i.e. experimental work, audit (typically completion of one cycle and proof of change), surveys, systematic review and meta-analysis not previously undertaken are worth a maximum of 8 out of 46 marks. This type of work indicates a greater degree of application and reflection and so will score higher marks. Educational interventions which improve patient care or patient safety may also be considered but must be clinically relevant to the practice of Emergency Medicine.

The choice of topic will not be criticised, as the candidate in consultation with his or her trainer would have decided this. However, candidates should be able to defend the importance of the topic and indicate its relevance direct clinical care in the Emergency Department.

Experience has shown that candidates need a significant amount of planning in order to complete satisfactory reviews. **It is strongly recommended that:**

- **The subject of the candidate's review is agreed with trainers by at least the second year of training**
- **The CTR should be completed no later than 6 months before the submission date**
- **The candidate's trainer or other Fellow who is familiar with the examination critiques the CTR before it is submitted. The Fellow should not attempt to rewrite the CTR – but simply to make observations on direction of the discussion, presentation and conclusions.**

Further information and advice on preparing a CTR can be found at
http://www.collemergencymed.ac.uk/CEM/Training%20and%20Examinations/Exams/Resources%20for%20exam%20preparation/default.asp

Each examiner will read the CTR and independently record their mark for the written content presentation before the examination. The written report will carry 60% of the total marks for the CTR. Prior to the viva the two examiners will confer and the agreed mark for this part will be noted on the first examiner's mark sheet.

	Poor	Acceptable	Outstanding	Total marks
Topic/title	Long, unclear, boring	One line and easy to understand	Short, punchy and arresting	2/1/0
Presentation and layout including spelling and formatting	Multiple spelling mistakes, incorrect underlining/use of bold, tables poor	Minimal spelling mistakes, grammar acceptable and tables can be understood	No spelling or grammatical mistakes, excellent use of language, tables simple and demonstrate relevant points	4/2/0
Clinical dilemma clearly identified and right question	Unclear what the main question to be answered is, or dilemma stated but search and CTR not	Question stated but no background or relevance stated	Well phrased problem which is given relevant background and should provide the	2/1/0

asked to solve the dilemma	relevant to solving the problem		answer to the clinical dilemma	
Reason for choosing stated	No personal relevance stated	Some relevance to personal practice	Clearly states why the issue interests the author in their own practice	2/1/0
Literature review	Search not described appropriately or inappropriately completed	Search outlined, with minor flaws in strategy	Good search strategy clearly defined	2/1/0
Appraisal of literature	No attempt to critique papers quoted	Some attempt to evaluate standard of papers	Good evaluation of the standard of evidence presented	4/2/0
Synthesis of and conclusions from evidence	No summary of evidence or conclusion presented	Some summary but not overall conclusion from evidence	Good overview of all papers synthesised into overall conclusion	4/2/0
Additional other work – value and standard	No additional work	Additional work – limited as survey or small audit	Good quality original research that enhances CTR	4/2/0
Makes suggestions for how changes personal practice	No suggestions for change in practice or suggestions that are unjustified	Limited suggestions to change practice – or not based on lit review or own work	Good clear suggestions as to how this will change practice, justifiable from the literature review and own work	4/2/0

Total 28 marks

Objectives of the CTR viva (40% of total marks)

The oral examination will focus on areas that the examiners wish to explore in more depth. The specific points are listed in the mark sheet (see below) but in general these consist of:

- Identifying the critical components of a clinical problem
- Reviewing the background material and appraise its value
- Presenting a clinical topic succinctly but comprehensively
- Defending opinions and recommendations

The candidate should bring his or her copy of the review with them into the examination. The copy for the viva may be annotated beforehand if the candidates wish and may be referred to during the viva. This is not a test of memory but of the ability to defend a given argument. Candidates are strongly recommended to organise mock vivas with their trainers well before the examination.

Marking will be based on how completely the candidate addressed the following in both their written report and viva:

1. Why the topic was chosen. The justification for the importance of the topic should be made along with setting it in context with the rest of Emergency Medicine practice.
2. The conduct of the literature search – for example the demonstration of its thoroughness through description of the search methods used, databases explored, bibliographic searching and the use of limited hand searches.
3. Appropriate critical appraisal of the literature.

4. Ability to synthesise the evidence, appreciating the limitations of the literature, demonstrating the candidate's in-depth understanding of the topic.
5. The relevance of the findings of the CTR to current and future clinical practice. Discussion on how the candidate has, or intends to, use the knowledge gained.
6. Evidence of activity other than the literature search and review that was generated by this piece of work.

Mark

The CTR viva will be marked using the following mark sheet and the pass mark will be approximately 65%.

PLEASE COMPLETE EACH SECTION & indicate on the back of this sheet the areas identified for discussion prior to the viva. Continue on a separate sheet if necessary

	Below standard	**Standard**	**Above standard**	**Mark**
Written mark agreed by both examiners				(out of 28)
Why chosen-relevant to Emergency Medicine	Not able to justify (0)	Partial justification (1)	Convincing justification that topic relevant to clinical practise (2)	
Conduct of literature search	Unable to describe literature search, significant papers missing (0)	Reasonable search but at least one missing relevant paper , describes search adequately(1)	Appropriate search, papers all relevant and well referenced, deals with questions on search and describes process including grey literature etc (2)	
Critical appraisal	No comment on quality of evidence (0)	Clearly comments on quality – identifies some weaknesses (2)	Able to judge quality of any reference cited, gives reasons for judging as high quality or poor papers (4)	
Synthesis of evidence	No in depth evaluation of evidence, simply regurgitation (0)	Cam summarise the evidence but unable to give balanced judgement (1)	Good appraisal of current thinking and identification of limitations of evidence. Able to judge whether evidence should influence practice (2)	
Relevance to clinical practice	No application to clinical practice (0)	Can apply generally to EM work (2)	Able to give clear indication of how this work changes practice in real terms (4)	
Evidence of other work	No evidence of personal work (0)	Good summary of work done but limited relevance or contribution (2)	Good summary of work and justifies how relevant to the topic(4)	
			Total	**/46**

Please also note the following important information:

- Each candidate must submit their clinical topic review **at the same time as their application form** by the deadline stated for the examination for which they are applying.
- The submission must **include a statement declaring that it is the candidate's own work and there has been no plagiarism** (see below).
- Candidates will not be permitted to submit an amended clinical topic review after the examination closing date.

Plagiarism

This is the act of including or copying, without adequate acknowledgement, the work of another in one's work as if it were one's own. It is academically fraudulent and not compatible with the College's code of conduct.

All work submitted for assessment by candidates is accepted on the understanding that it is their own unassisted effort. Candidates are expected to offer their own analysis and presentation of information gleaned from research. In so far as candidates rely on sources, they should indicate what these are according to the appropriate convention in their discipline.

The innocent misuse or citation of material without formal and proper acknowledgement can constitute plagiarism, without a deliberate intent to cheat. Work is plagiarised if it consists of close paraphrase or unacknowledged summary of a source, as well as word-for-word transcription. Plagiarism is a serious disciplinary offence. Any failure to adequately acknowledge or properly reference other sources in submitted work could lead to lower marks or to a mark of zero being returned, or to disciplinary action being taken.

Ref: http://www.registry.ed.ac.uk/staff/Examinations/collegesandplagiarism.htm

Permission to use Clinical Topic Reviews for educational purposes.

A Clinical Topic Review may be identified by members of the Panel of Examiners for educational purposes and/or publication on the College website or in medical journals as "a good example" for the benefit of future FCEM candidates. In such cases it is the responsibility of the Dean to write to the candidate following the examination to seek permission for their CTR to be used in this way. The source of any work will be acknowledged appropriately.

Exemptions

Candidates who have successfully completed a PhD or MD thesis on a topic relevant to Emergency Medicine are considered to have already demonstrated the skills required for this part of the examination. The PhD or MD must have required a viva voce examination for its award. An MSc or equivalent degree will not be accepted.

Applicants who believe they may be eligible for exemption as a result of gaining these qualifications **BEFORE** the FCEM, should write at least six months in advance of their intended application date. They should submit relevant information regarding the course work, the thesis word count and regulations, and the details of any viva undertaken. Candidates also need to send a copy of the thesis abstract and a certified copy of the University documentation showing successful completion of the degree with the thesis title.

This will be considered by the Dean for eligibility and the candidate informed 3 months before the closing date of their exemption. Failure to submit evidence 6 months prior to the closing date will result in the candidate having to complete a CTR

regardless of the previous qualification. The acceptance of a previous work as exemption is at the discretion of the Dean and his/her decision is final. Candidates who have been given exemption by these qualifications should complete the relevant part of the application form.

Section B – Management viva

35 minutes.

The candidate will be expected to have a basic understanding of the management of the Emergency Department and also of general NHS management. In particular he or she must be able to discuss methods available to resolve day-to-day organisational problems and the wider aspects of service provision, planning and future strategy.

The candidate will be given an in-tray exercise and one management scenario. Five minutes will be given for reading and thinking (examiners are not present at this time), followed by 15 minutes each for the in-tray exercise and scenario.

In-tray Exercise

Candidates are given a typical morning's in-tray containing letters, memos, circulars and email along with the day's timetable and department staffing. Candidates should spend the 5 minutes' preparation time to read through the in-tray papers, organise and prioritise them. The candidate is then expected to be able to indicate their anticipated actions in response to the papers and to discuss the likely outcomes. Additional credit is given for lateral thinking, linking papers within the in-tray and to the diary events.

Management Scenario

Following on from the in-tray will be a scenario which will be linked with at least one of the in-tray topics. The scenario will be discussed and themes developed by the examiners for 15 minutes.

The marksheet is constructed to record the performance in the various domains of management, and for each examination there will be specific descriptors for each topic (see example).

Candidates will be expected to be able to think around the subject and to indicate clearly what their proposed action would be in response to every item.

Candidates will be expected to consider both current healthcare policy, local initiatives and issues current to Emergency Medicine.

If the examiners are required to prompt or ask direct questions to elicit the specific criteria, the candidate will gain fewer marks.

Candidates should note that there are additional marks allocated for prioritisation, lateral thinking and the candidate's general approach as well as the marks allocated for dealing with the individual topics or papers.

The management viva marksheet for the November 2006 diet is shown below together with the suggested ideal answers for the examiner's use. The in-tray papers relating to the marksheet are available on the website

http://www.collemergencymed.ac.uk/CEM/Exams/FCEM.asp

FCEM Management Examination November 2006 Day 2
CONFIDENTIAL SCORE SHEET

Issue / topic	Notes of candidate's answers	Score
Prioritising papers and diary management (score 0 - 4)		0-4
Informing HSE or Police about patient with neck injury (score 0 - 4)		0-4
Complaint from patient with threatened miscarriage (score 0 - 4)		0-4
Documentation of Major Incident patients (score 0 - 4)		0-4
Letter from Florence Stroud, retired matron, about doctors' clothing (score 0 - 4)		0-4
Staff Grade's request to bring dog Jess into ED overnight (score 0 - 2)		0-2

Long case scenario Locum consultant and the chest drain (score 0 - 12)		0-12
General approach and style (score 0 - 3)		0-3
Lateral thinking (score 0 - 3)		0-3
Overall score (examiner 1)		out of 40
Overall score (examiner 2)		out of 40
Agreed score		out of 40

FCEM Management viva November 2006 Day 2

CONFIDENTIAL SUGGESTIONS re ANSWERS and SCORING

Topic	Needed to PASS	Extra marks
Diary and in-tray papers (score 0 - 4)	Consider delegating work if appropriate, e.g. Staff Grade or Clinical Fellow could do the Review Clinic and ask for help if they need it. Prioritise items sensibly, e.g. urgent/non-urgent and important/not important	Notice links between different items.
Informing Health and Safety Executive or Police about patient with neck injury. (score 0 - 4)	This was a serious accident, apparently on a building site, but very few details are known about the incident and where it occurred. The Estonian building worker is being treated for his cervical fracture but he is unlikely to know what should be done about reporting the accident, nor how he might get compensation. Ask the neurosurgeons how the patient is and whether they have reported the incident (which is unlikely). It seems sensible to discuss this incident by telephone with the Health and Safety Executive who could arrange to interview the patient with an Estonian interpreter. The HSE could then involve the Police if necessary.	A cervical spine fracture is a "major injury" reportable to the Health and Safety Executive under RIDDOR '95 (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations). The employer is responsible for reporting this incident but the circumstances as stated by the SpR suggest that the employer is unlikely to report it. Confidentiality is unlikely to be an issue in this case, but the patient would not have to tell the HSE anything if he did not want to.
Complaint from patient with threatened miscarriage. (score 0 - 4)	This is a formal complaint which must be passed on immediately to the Complaints Department for acknowledgement, with a full reply from the Chief Executive within 25 working days. Review and copy the Emergency Department notes. Discuss the complaint with the doctor involved. This patient is understandably unhappy and angry, despite not losing her baby, and needs an appropriate apology.	Discuss complaint with Emergency Department Business Manager (who is usually responsible for Emergency Department Reception staff) and Matron (meeting at 11.00). This case is relevant for Risk Management meeting at 13.00 and also SHO teaching at 14.30. The Emergency Department doctor was too precise if he said "90-95% certain" pt had lost or was losing her baby, which she interpreted as 100%. Fetal heart monitor could be useful in Emergency Department. If ultrasound scan was available at weekends much worry would have been avoided: discuss with Gynaecology/Radiology Departments.

Documentation of Major Incident patients. (score 0 - 4)	Pre-numbered packs of documentation are needed if many patients arrive together, since it would take too long to register them immediately on a computer system, but patients must be registered as soon as possible. Patients' major incident numbers must be compatible with the Emergency Department computer system and also with the hospital patient record system and Pathology, Blood Bank and Radiology computers. Major incident plans must be updated and tested regularly: NHS Emergency Planning Guidance specifies as a minimum requirement a live exercise every three years and a tabletop exercise every year.	The NHS Emergency Planning guidance includes advice on patient documentation. Major incident patients are likely to be distressed and may have been deafened by a bomb or may not speak English, so getting important details may be difficult and time-consuming. Ideally major incident patients would be flagged on the Emergency Department computer system so they can be identified, tracked and analysed in reports. Some patients may arrive before an incident is declared and need Majax flags adding later. Some patients not from the incident might be flagged incorrectly as Majax patients, so it must be possible to unflag patients.
Letter from Florence Stroud, retired matron, about nursing care and doctors' clothing. (score 0 - 4)	This letter needs a prompt response from the Emergency Department consultant and matron, thanking the retired matron for her kind observations about the clinical care and the attentive nurses, and stating that her letter will be shown to all the staff. They should also thank her for her observations on the doctors' clothing and promise appropriate action.	If possible a female consultant or SpR should advise the junior staff on the need for appropriate "joined up" clothing. It would be best to have all clinical staff in proper uniforms or scrub suits which look professional and reduce the risk of contamination. Funding these for all staff may be difficult. Check with Elderly Medicine what has happened to Florence Stroud's elderly mother: if she has died the reply letter should offer commiserations.
Staff Grade's request to bring dog Jess into Emergency Department overnight. (score 0 - 2)	A prompt response is needed since this doctor is due to work tonight. It would be easiest to say yes, as long as Jess would not be seen by patients and no one who uses the office is allergic to dogs, but other staff might complain, e.g. about infection risk (which is small). Allowing the doctor to bring her dog into the Emergency Department would create a precedent which might cause problems in future if other people wanted to bring in animals, but in practice this is unlikely.	If Jane comes by car she could perhaps park outside the Emergency Department and leave Jess in the car overnight, with occasional walks around the car park. If the middle grade doctor on the earlier shift worked later and the next day doctor started earlier, Jane could work a shorter shift and leave Jess at home overnight, but this would be awkward to organise for tonight and would only be possible if the doctors get on well and are prepared to help each other.

<u>Scenario</u> Locum consultant and the chest drain. (score 0 - 12)	This raises serious concerns about the locum consultant's judgement and competence. If the facts are as stated a chest drain was not needed, and the lung was damaged by the trocar (which should not have been used). Review and secure this patient's Emergency Department notes and make good copies. Discuss with ICU consultant how the patient is now and what has been said to pt and relatives. Review chest x-rays. Find which SHO and nurses were involved and discuss with them to confirm what happened. Ask middle grade doctors and senior nurses if they have had any concerns about Dr Y. Discuss findings with consultant colleague when he/she arrives at 15.00 for the late shift. Arrange to talk to Dr Y as soon as possible. At least two other consultants should be present for any discussion with Dr Y, and detailed notes must be taken. Consider informing Clinical Director and Trust's Medical Director and discuss whether this incident should be reported formally as a Serious Untoward Incident. Risk Management Department should be warned of a potential claim for negligence.	Copy hospital notes (especially medical and nursing notes after admission from Emergency Department, operation notes and observation charts). Copy the x-rays taken in Emergency Department and make sure the original films are kept securely. Check the British Thoracic Society guidelines on the management of spontaneous pneumothorax and the insertion of chest drains, and print these and ATLS chest drain procedure before any discussion with Dr Y. Find out what size chest drain was used and keep one or two of the same size (with trocars) for reference. Warn the Emergency Department SHO and nurses involved that they may need to write statements and they should not discuss the case in the Emergency Department, but reassure them that they are not being criticised. Review Dr Y's CV and references. Review Dr Y's notes of some other patients. Consider telephoning consultants at other Emergency Departments where Dr Y has worked to ask about any concerns. Depending on all these findings it may be necessary to suspend Dr Y from his locum post and inform the locum agency. The Medical Director and Director of Personnel could decide to inform the National Clinical Assessment Service, which can investigate concerns about a doctor's competence. It would not be appropriate to discuss this case at today's Clinical Governance meeting but when it has been resolved it could usefully be discussed at a future meeting.

Section C (i) Short answer question paper (SAQ)

2 hours and thirty minutes in length

This paper comprises 20 questions and lasts 2 hours and 30 minutes. **This will take place approximately 6 weeks before the main body of the FCEM examination**. Candidates who fail the SAQ will be unable to attain the Fellowship on this diet but are strongly advised to sit the other sections of the FCEM.

The question paper will be in booklet form. It will be accompanied by another booklet containing the relevant images, ECGs, blood results, clinical descriptions or photographs appropriate for each question. Candidates will use the data presented to answer questions on diagnosis, management of clinical problems, complications and associated conditions. The answers should be clearly written in the space provided in the question paper. Marks will be awarded for the first answers given only, candidates are advised to prioritise possible answers and write the most important answers only.

The format of each question will be a description of a clearly defined clinical scenario. The expectation is that the candidate's response will be based on the evidence available in the question and their knowledge of the subject. Examples include descriptions of clinical scenarios (with questions about investigations, differential diagnosis and initial management) and the interpretation of radiographs, electrocardiographs, blood results and other investigations.

Each question is worth 10 marks. Prior to the examination the SAQ committee set a minimum competency mark for each question. These marks are aggregated so that an overall minimum competency mark (MCM) for the SAQ paper is set. Assessment of the candidate's performance occurs in a closed session with two examiners marking each question to ensure reliability and consistency.

Candidates should note that any candidate writing after the end of the examination has been declared will be disqualified and automatically given a fail on this part. No reason will be accepted for continuing to write.

Section C (ii) Objective Structured Clinical Examination (OSCE)

This is comprised of 12 stations of 8 minutes each and 2 double stations of 17 minutes each (giving a total equivalent to 16 single stations). There is one minute between each station and two rest stations. The total time, including two rest stations, is therefore 162 minutes.

The stations will consist of interactive scenarios using actors or patients, manikins or models, and may involve using equipment or demonstrating practical procedures and teaching. Examiners will be provided with "checklists" for each station of core actions the candidate must take in order to be successful.

Each station is independently marked by two examiners with a pre-determined pass mark for that station. **The total number of stations needed to pass is the equivalent of 12 stations out of 16 where a pass in a double length station counts as two passes. Failure in both of the double length stations will result in automatic failure of the OSCE and therefore failure to achieve the Fellowship on this diet.**

As 20 - 25% of Emergency Department cases are children – 3 or 4 of the stations will deal with children.

Assessments in the OSCE stations will cover specific areas of competency including:

a) History taking
b) Examination of a patient
c) Communication skills
d) Practical procedures
e) Team leadership skills
f) Teaching

The stations will be made up of the following[1]:

Practical procedures

There are three practical procedure stations. The candidate will have to demonstrate competence in the following areas:

Airway

- Examples: managing the difficult airway including creating a surgical airway.

Breathing/CVS

- Examples: chest drain insertion/stabilisation; assessing inhaler technique; insertion of arterial, umbilical, intra-osseous or central line; stemming haemorrhage.

Other

- Examples: suturing a complex wound; log rolling & transferring; limb splintage; use of crutches & walking aides; local anaesthesia.

Clinical evaluation

There are five clinical evaluation stations. The candidate will have to demonstrate competence in interviewing patients, as well as eliciting physical abnormalities in the following areas:

- Respiratory/Cardio-vascular system
- Neurological (CNS or PNS) system

Upper/Lower limb musculoskeletal assessment

Examples are given but the ability to perform any procedure contained in the FCEM curriculum may be tested.

- Psychiatric

Communication

There are three stations – one from each of the following general categories:

- Breaking bad news
- Dealing with confrontation or conflict
- Teaching a junior doctor. Examples: instructing on how to carry out a practical procedure or interpret a blood result, radiograph or ECG.

Scenario (double time stations)

The candidate will have to demonstrate competence in two of the following scenarios:

- ATLS moulage – dealing with a polytrauma case
- ALS CASTEST - dealing with a peri-arrest case, going on to cardiac arrest and, hopefully, post-resuscitation care
- APLS – dealing with a "sick child" scenario

The time allowed for these is twice that of the other stations.

In one scenario the candidates will be expected to act as a leader of a team of competent but junior clinical staff. In the other he/she will be working with only one assistant.

Difficult case

There will be one difficult case station. This is used to assess the candidate's ability to take a good history in difficult circumstances. Examples of the type of cases include lower abdominal pain of unknown origin, backache, or headache, often in a patient who may be difficult to interview or present additional issues (underage girl, overseas visitor, intoxicated). Candidates should be able to identify the key facts, realise there could be several possibilities, prioritise according to likelihood and risk, and explain their thoughts to the patient.

General points

Each part or section of the examination is marked to a standard set prior to the examination – i.e. it is criterion referenced.

The candidate's performance in each part or section of the examination will be judged pass or fail.

There is no compensation between any parts of any section or between sections.

The raw scores will be used to derive information for formative feedback to candidates and to identify the Alison Gourdie medal winner.

Final criteria for pass

- To pass the examination, a candidate must pass each section independent of the other sections.
- To pass the clinical section the candidate needs to pass both OSCE and SAQ at the same sitting.

Results

Overall results will be made available within two weeks of the examination wherever possible. Candidates will not be informed of the results on the day of the examination. Feedback will be provided as soon as possible after the examination (see below)

Administration

A senior member of the administration staff at the College office will be present throughout the entire period of every section of the examination. Candidates are strongly advised to contact the Dean or the administrator if they have problems of any kind during the examination.

Examination arrangements for candidates with special needs

Special examination and other assessment arrangements may be made for candidates with permanent or temporary disability (see Appendix 5). These arrangements are intended to allow candidates to perform to the best of their ability whilst not giving any unfair advantage.

It is the responsibility of the candidate to notify the College's Examinations Office when they submit their application of any special circumstances. Applications for special consideration must be supported by written evidence in the form of a medical report from their General Practitioner and relevant evidence and support from their Consultant trainer or Postgraduate Dean. In certain cases, such as dyslexia, a current *Dyslexia Assessment* report from an educational psychologist will be required. In these cases additional time may be given for the SAQ and further support as required in the other sections of the examination.

In the case of a temporary disability due to ill health, or accident that occurs after the application has been submitted, candidates must inform the Examinations Office as soon as possible **before** the examination in writing and enclose a valid doctor's certificate.

Candidates who are on sick leave from their employment at the time of the examination will not ordinarily be permitted to sit the examination, as the College considers this to be an eligibility exclusion criterion.

Each case will be assessed by the Examination's Administrator together with the Dean. Candidates will be informed in writing of the outcome of their application for

special consideration and of the arrangements that will be made to meet their needs.

Data Protection

All personal information held by the Examinations Office of the College will be held in accordance with the Data Protection Acts of 1984 and 1998. Identifiable data collected will not be released outside of the College without the candidates consent.

Feedback

In the event of a fail in the examination, candidates will be told whether the fail was outright or borderline. They will not, under any circumstances, be given their raw scores in any section.

Further information based on written comments made by the examiners will be also provided for the viva sections (see Appendix 2).

Trainers and STC Chairs/Heads of School will be provided with copies of the feedback but not the raw scores. Subsequent counselling will be a matter for the local trainer. For non-trainees and overseas candidates the feedback will be shared with the sponsoring Fellow for their information and to provide opportunities for the non-trainee/overseas doctor to have further structured and informed support.

This feedback will normally be available within four weeks of the examination. The examination panel will not enter into any further correspondence regarding feedback.

The matrices described in these guidelines will be used as the marksheets for the examination. These, and any other documentation used during the examination, will be retained by the College and not released to the candidate or to their trainer under any circumstances.

Appeals

Candidates who wish to make an appeal about the conduct of their examination must address it to the College within 30 days of the publication of results.

Appeals will be considered if they allege maladministration, bias or impropriety whether in the conduct or in the determination of the result of the examination. Allegations disputing the academic judgment of the examiners will not be discussed. Appendix 3 provides details of the appeals process. The fees charged are available from the College office.

Improper conduct by examination candidates

No calculators, IT equipment, phones or food, and only clear fluid will be permitted to be taken into the examination, unless there are certified medical reasons to allow this.

A storage area for personal belongings, (bags and coats) will be provided but candidates are advised that space is severely limited and suitcases and other large items will not be accommodated.

Specialty trainees (after ST4 year or second SpR year) and non-trainees/overseas candidates may not apply for the Membership examination at the same time as the Fellowship examination. This is considered to be inappropriate behaviour as it may lead to an unfair advantage (see below).

In the case of improper conduct of an examination candidate as defined below, the College may refuse a candidate entry to the current or future examinations. Improper conduct is defined as[2]:

1. Dishonestly obtaining or attempting to obtain entry to the examination by making false claims about eligibility for the examination or falsifying any aspects of the entry documentation.
2. Obtaining, or seeking to obtain, unfair advantage during an examination, or inciting other candidates to do the same. Examples of unfair advantage are:
   - having on the person any material that would give advantage in an examination once the examination has commenced (this includes electronic communication devices),
   - communicating or attempting to communicate with reference to the content of the examination with another candidate once the examination has commenced including candidates due to appear on subsequent days,
   - refusing to follow the instructions given by examiners or examinations staff concerning the conduct of and procedure for the examination.
   - continuing to write in the SAQ examination after the bell has rung.
3. Removing or attempting to remove from the examination any confidential material relating to the examination.
4. Obtaining or attempting to obtain confidential information concerning the examination from an examiner or examination official.
5. Passing confidential information on the content of the examination to a third party.
6. Passing information about vivas or the OSCEs during a sitting to candidates attending on subsequent days of the same sitting.

In accordance with its Standing Orders, where serious misconduct is alleged which is not related to the examination, the College may also decide that a candidate should not be allowed to proceed further with the examination or, having passed the examination, may not be admitted to Fellowship.

In the event of suspected improper conduct, the Dean of the College must, in conjunction with the Examinations Administrator, instigate an immediate enquiry. The candidate and trainer will also be informed. The results of this enquiry must be made available for the College Council within 30 days of the examination.

Withdrawal

Candidates withdrawing from the examination must do so in writing to the Examinations Administrator.

The candidate may choose to have the full entrance fee returned or transferred to a future examination when written notice is received prior to the closing date for receipt of applications.

The candidate may choose to have half the entrance fee returned or transferred to a future examination when written notice is received more than 21 working days before the commencement of the examination (SAQ) but after the closing date.

When written notice is received less than 21 working days before the

[2] The list given above is not exhaustive.

commencement of the examination, no refund will be made to a candidate who withdraws or fails to attend.

Candidates should note that if the fee for the examination is increased between diets, candidates who have withdrawn will be required to pay the revised fee for the next examination.

Procedure for re-sitting one or more sections of the FCEM examination

1. Once candidates have passed a section (where both parts of the clinical examination is considered one section) they no longer need to resit that section, even if they fail other sections of the examination.
2. Candidates who passed a section prior to November 2006 will not be exempt from that section if they have subsequently resat and failed that section.
3. Any candidate who is awarded a pass in the CTR is exempt from the CTR on subsequent diets in the event of having to resit the critical appraisal viva or the other sections of the examination.
4. If the candidate fails the CTR, the candidate will need to submit a new written CTR and undergo a repeat viva. The CTR can be on the same subject but is expected to be updated and areas of weakness that have been identified must be corrected. The Dean will give advice on what is required to individual candidates in the event of a failure in the CTR.
5. Candidates must pass both the OSCE and Short Answer Question paper, **at the same diet**, to pass the clinical section of the examination.

To assist the candidate in preparing for a re-test, he/she will receive feedback on the original examination performance.

Fees for re-sitting the examination

The examination fee for re-sitting individual sections will be displayed on the website and will reflect the relative complexity and cost of each section. Candidates will need to apply for the examination by completing a resit application form. This requires them to have their educational supervisor confirm that they have had an educational plan to correct the weaknesses identified in the examination. Candidates must submit the completed application form and cheque for the correct amount by the closing date for the examination they wish to attend. It will not be assumed that candidates wish to resit unless an application form is received.

Equal opportunities policy statement

The College of Emergency Medicine aims to make every effort to provide an environment for candidates that is free from discrimination. It is the policy of the College that no candidate receives less favourable treatment than another on the grounds of age, gender, sexual orientation, marital or parental status, race or ethnic origin, colour, creed or religion, disability, political belief or social class or other irrelevant distinction. The College aims to assess candidates solely on the basis of merit and competence.

To achieve this, the College has implemented the following strategies:

- formal mechanisms for training examiners
- improved equal opportunities awareness for departmental staff with regard to examinations practice and service
- monitoring admissions and examination results in relation to changes in the candidate population profile
- monitoring of:
  - modes of assessment
  - examiner behaviour
  - examiner population profile
- a review of results and appeals procedure
- review of policies and practices for fairness and relevance
- special arrangements policy for candidates with disabilities and/or other specific requirements
- policy for consideration of candidates' exceptional circumstances

The College is committed to inclusivity and promoting a diverse workforce within the specialty. Candidates and examiners are therefore required to complete an equal opportunities monitoring form. Personal details of candidates will be kept confidential in line with the Data Protection act. The College monitors success of different groups as part of Quality Assurance.

The College will not accept behaviour from staff, members, examiners or candidates, which constitutes sexual or racial harassment or that which results in unlawful discrimination on any grounds. The College adheres to the provision for the protection of the rights of the individual within the following legislation:

- *The Sex Discrimination Act – 1976/1986*
- *The Disability Discrimination Act – 1995*
- *Special Educational Needs and Disabilities Act 2001*
- *The Race Relations (Amendment) Act – 2000*
- *Data Protection Acts 1984 and 1998*

The College maintains the right to discriminate lawfully in the interests of the medical/dental profession and this policy encompasses any regulations applied by relevant statutory or regulatory bodies such as the General Medical Council and General Dental Council.

Election to Fellowship

Persons holding a medical qualification who have been successful in the Fellowship examination established by the College may be elected to Fellowship of the College by the College Council.

Annual subscription fees

Every Fellow shall pay each year such annual subscriptions as may be determined by the Council of the College. Payment of the annual subscription fees entitles the Fellow to use the post-nominal FCEM.

Diploma ceremonies

New Fellows will be invited to a Ceremony for the presentation of a diploma that normally takes place after a College Council meeting at Churchill House.

Alison Gourdie Medal

Each year, the candidate with the best overall performance from all successful candidates in both sittings will receive the Alison Gourdie Medal, awarded at the College Autumn Scientific Meeting.

Appendix 1 – List of sponsors for non-trainee applicants – to be updated

REGION	CHAIRMAN OF STC	REGIONAL ADVISOR
NORTHERN	Mr Vincent Foxworthy Consultant in EM Cumberland Infirmary Newtown Road Carlisle Cumbria , CA2 7HY vincentfoxworthy@hotmail.com	Mr Peter Goode Consultant in EM Newcastle General Hospital Westgate Road Newcastle Upon Tyne Tyne And Wear , NE4 6BE peter.goode@nuth.northy.nhs.uk
YORKSHIRE	Mr Alastair Wass Consultant in EM Pinderfields Hospital Aberford Road Wakefield WF1 4DG Alastair.Wass@midyorks.nhs.uk	Dr Ros Roden Consultant in EM St James University Hospital Beckett Street Leeds LS8 7TF rosalind.roden@leedsth.nhs.uk
LNR (LEI)	Mr Demas Esberger Consultant in EM Queens Medical Centre Nottingham NG7 2UH Demas.Esberger@nuh.nhs.uk	Mr Gautam Bodiwala gg@bodiwala.freeserve.co.uk
TRENT (NOT)	Mr Demas Esberger Consultant in EM Queens Medical Centre Nottingham NG7 2UH Demas.Esberger@nuh.nhs.uk	Mr Gautam Bodiwala gg@bodiwala.freeserve.co.uk
S YORKS & S HUMBER (SHF)	Mr Biniam Tesfayohannes EM Consultant Northern General Hospital Herries Road Sheffield South Yorkshire, S5 7AU biniam.tesfayohannes@sth.nhs.uk	Mr Gautam Bodiwala gg@bodiwala.freeserve.co.uk
EASTERN	Mr Christos Maimaris Consultant in EM Addenbrooke's Hospital Box 97 Cambridge CB2 2QQ chris.maimaris@addenbrookes.nhs.uk	Mr Christos Maimaris Consultant in EM Addenbrooke's Hospital Box 97 Cambridge CB2 2QQ chris.maimaris@addenbrookes.nhs.uk
LONDON NORTH WEST	Ms Peta Longstaff Consultant in EM Chelsea and Westminster Hospital 369 Fulham Road London, SW10 9NH Peta.Longstaff@chelwest.nhs.uk	Mr Huw Millington Consultant in EM Charing Cross Hospital Fulham Palace Road London, W6 8RF HMillington@hhnt.org
LONDON NORTH EAST	Dr Helen Cugnoni EM Department The Royal London Hospital Whitechapel London E1 1BB	Mr Roger Zwink Consultant in EM Broomfield Hospital Court Road, Broomfield Chelmsford, CM1 7ET

	Helen.Cugnoni@homerton.nhs.uk	roger.zwink@meht.nhs.uk
LONDON SOUTH EAST	Dr Chris Lacy Consultant in EM Kings College Hospital Denmark Hill London, SE5 9RS Chris.Lacy@kingsch.nhs.uk	Mr Khalid Pervaiz Consultant and Specialty Tutor Queen Mary's Hospital Frognal Avenue Sidcup Kent DA14 6LT Khalid.pervais@qms.nhs.uk
LONDON SOUTH WEST	Dr Chris Lacy Consultant in EM Kings College Hospital Denmark Hill London, SE5 9RS Chris.Lacy@kingsch.nhs.uk	Vincent O'Neil Consultant in EM ST Peters Hospital, Chertsey Guildford Road Chertsey Surrey, KT16 0PZ Vincent.oneill@asph.nhs.uk
WESSEX INSTITUTE	Mr John Heyworth Consultant in EM Southampton General Hospital Tremona Road Southampton SO16 6YD John.Heyworth@suht.swest.nhs.uk	Mr Michael Reichl Consultant in EM Poole General Hospital , Longfleet Road Poole Dorset, BH15 2JB MReichl@poole-tr.swest.nhs.uk
OXFORD	Mr Peter Thomas Consultant In EM Milton Keynes General Hospital Standing way Eaglestone Milton Keynes, MK6 5LD peter.thomas@mkgeneral.nhs.uk	Dr Phil Hormbrey Consultant in EM John Radcliffe Hospital Headley Way Headington Oxford, OX3 9DU PHILHORM@aol.com
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ARMED FORCES	Col. Tim Hodgetts Academic Dept of Military EM Birmingham Research Park Vincent Drive Birmingham, B15 2SQ Prof.ADMEM@rcdm.bham.ac.uk	

Appendix 2 – Example of feedback form for unsuccessful candidates

Candidate number and name	Dr Sample F0600000

ACADEMIC

Review of published work

% Passing this section	Pass mark	Your performance
78%	11	Outright fail

Analysis of the marking matrix and examiners' comments

Average ability let down by "applicability" section:
No apparent idea of comparability between study group and general population
Vague review of application of the study's findings

Clinical topic review

% Passing this section	Pass mark	Your performance
82%	13	Borderline fail

Analysis of the marking matrix and examiners' comments

Written material – spelling & grammatical errors; abbreviations unexplained & difficult to follow; no title page; poorly presented tables; no textual appraisal of papers; limited criteria for paper selection

MANAGEMENT

% Passing this section	Pass mark	Your performance
71%	22	Borderline fail

Analysis of the marking matrix and examiners comments

Has average knowledge but let down by limited ability to think around problems.

CLINICAL

Candidate number F0600000 - Short answer question

Question	Median score	Your score
LVF - pathophysiology, Starling	8	9
SBO - biochemistry and fluids	6.5	6
COPD - BIPAP guidelines	6.5	8
Urinary retention management with antibiotic cover	4	1.5
HONK - fluids and osmolarity	7	7
Vertigo central vs peripheral	6	6
Puerperal psychosis - and organic causes, management of acutely disturbed patients in Emergency Department	7	7.5
Sepsis – SIRS	5.5	7.5
Hypothermia and frost bite	7	6
UTI in pregnancy	7	8
Pelvic pain and chaperone guidelines	6	6
Post streptococcal joint pain in child	6.5	7.5
Jaundice in a baby	8	9
Travellers diarrhoea	7.5	7.5
Major trauma - chest trauma	7.5	6.5
Orbital cellulitis	8	9
Epistaxis	7	7
Paracetamol overdose	7	7
Gout	7	7
Laceration and tetanus status	4	8.5

Your overall score for SAQ : Pass

Objective Structured Clinical Examination
Candidate number F060000

	Pass rate for this station	Your result
Package and arrange transfer	59%	Pass
Management of hypovolaemic shock (double station)	78%	Pass
Teach ENP how to look at an Xray	69%	Pass
CVS examination	45%	Fail
Suture a laceration	89%	Pass
Examine a knee	89%	Fail
Manage an SVT in a baby (double station)	87%	Pass
Convince a nurse of a possible NAI case	85%	Pass
Take a history in renal colic	91%	Pass
Examine the cranial nerves	91%	Pass
PV for PID	80%	Pass
Explain BM measurement to father	70%	Pass
Discuss chronic pain management with a patient	91%	Fail
Take a history in suicide	89%	Pass

Overall result of the OSCE: Pass

Overall assessment: Fail

Dr Sample has passed the clinical section but must resit the viva sections. He can re-apply to do these sections using the resit application form sent with the results. [Please note that this will require his trainer to confirm that his educational needs have been addressed].

Resit: Management; Critical appraisal, resit CTR vivas & needs to submit a re-written CTR taking into account the points mentioned above.

Appendix 3 - Appeals process

Appeals will be considered if they allege misadministration, bias or impropriety whether in the conduct or in the determination of the result of the examination. Those allegations disputing the academic judgment of the examiners will not be discussed.

Any appeal must be submitted by the candidate in writing within 30 days of the publication of the results. This should set out in full the details of the case indicating the precise nature of the complaint, the time, the place, and if possible the name(s) of the examiner(s) concerned. A cheque must accompany any appeal for an amount determined by the College to cover the administrative expenses and, in the event it is deemed necessary, to convene a panel to consider the appeal. Further details are included in the appeals procedure available from the College office.

Appendix 4 - Past questions & examiner's checklist

Critical appraisal - Publications used

- Dexamethasone in adults with bacterial meningitis. Gans J et al. N Eng J Med 2002;347:1549-56.
- Amiodarone as compared with lidocaine for shock-resistant ventricular fibrillation. Dorian et al NEJM March 2002, 346, 884-890.
- Use of Whole Blood Rapid Panel Test for Heart-Type Fatty Acid-Binding Protein in Patients with Acute Chest Pain: Comparison with Rapid Troponin T and Myoglobin Tests. Seino Y et al. The A J Med 2003; 115:
- Noninvasive Ventilation in Cardiogenic Pulmonary Oedema. A Multicenter Randomized Trial. Nava S et al. Am J Respir Crit Care Med 2003;168:1432-1437.
- Outpatient oral prednisone after Emergency treatment of chronic obstructive pulmonary disease. Aaron et al. NEJM 2003, 348; 2618-25.
- Delta Creatine Kinase-MB Outperforms Myoglobin at Two Hours During the Emergency Department Identification and Exclusion of Troponin Positive Non-ST-Segment Elevation Acute Coronary Syndromes. Fesmire F et al ,. Ann Emerg Med 2004; 44:12-19
- Prehospital Hypertonic Saline Resuscitation of Patients with Hypotension and Severe Traumatic Brain Injury. A Randomized Controlled Trial. Cooper DJ et al 2004 American Medical Association. JAMA 2004; 291
- Diagnostic performance of venous lactate on arrival at the Emergency Department for myocardial infarction. Gatien M et al. Academic Emerg Med 2005;12:106-113.
- Cooper et al. A randomised clinical trial of activated charcoal for the routine management of oral drug overdose Q J Medicine 2005 98 655-660
- Soundappen et al. Diagnostic accuracy of surgeon-performed focussed abdominal sonography (FAST) in blunt paediatric trauma. Injury 2005> 36: 970-975

- A prospective comparison of supine chest radiography and bedside ultrasound for the diagnosis of traumatic pneumothorax. Academic Emergency Medicine 2005 12:9 844-849

Questions used in Fellowship examination 2006

	OSCE = 16 (two double)	SAQ = 20
Cardiology/CT	examine the CVS	LVF - pathophysiology, Starling
GI		SBO - biochemistry and fluids
Respiratory		COPD - bipap guidelines
Renal/Urology	take a history of renal colic alternating with history of haematuria	urinary retention management with antibiotic cover
Endocrine		HONK - fluids and osmolarity
Neurology	examine cranial nerve palsy alternating with peripheral nerve palsy	vertigo central vs peripheral
Psychiatry	suicide alternating with mania	Puerperal psychosis - and organic causes, management of acutely disturbed patients in ED
Haematology	discuss with patient chronic pain management – conflict	Sepsis - SIRS
Dermatology		Hypothermia and frost bite
Obstetrics		UTI in pregnancy
Gynaecology	pelvic examination (PID/ectopic)	Pelvic pain and chaperone guidelines
Children	take a peak flow and explain asthma medication alternating with diabetic BM and explanation in a child	a) post streptococcal joint pain in child b) Jaundice in a baby
Infectious diseases		travellers diarrhoea
Major Trauma	teach X-ray interpretation of the cervical spine to ENP	Major trauma - chest trauma
Adult Resuscitation	shocked patient double station	
Paeds resus	one double station - SVT in a child	
Organisation of healthcare	refer and transfer a child with serious head injury- communication	
Eyes		orbital cellulitis
ENT		epistaxis
Toxicology		paracetamol overdose
Ethics	NAI- communication	
Orthopaedics/Rheumatology	examine the knee/shoulder	Gout
Minor injuries	suturing of wound	laceration and tetanus status

Appendix 5 - Provision of services for candidates with special needs

The following table indicates the special provisions available for candidates with special needs. Any candidate who wishes to have special provision made must indicate the requirements at the time of application.

In general, candidates who are **not working** at the time of the examination due to temporary ill-health are considered to be ineligible for the examination and will need to submit written medical evidence to the Dean that they are able to take the examination if they wish to sit.

Pregnancy
A deferral may be permitted to a candidate supplying an appropriate medical report which satisfies the Dean indicating that:
a) the candidate has any pregnancy related problems or illness and/or
b) the candidate's confinement is due shortly before or around the date of the examination;
in such circumstances a deferral will be permitted and no further fee will be required.

Any candidate who does not inform the College of her pregnancy and is consequently unable to sit for that examination will not normally be allowed to defer this examination without submission of another fee. Details of the candidate's expected week of confinement should be notified to the College and where possible, at the time of the application.

Category	Special Provision(s)		
	Separate Rooms	**Extra Time**	**Other**
Visual Impairment	Yes	Yes	All written material whether in written examinations, orals or clinics enlarged • Possible use of a computer in written examinations Possible use of a scribe to transfer MCQ answers to optically marked sheet • Additional lighting • Any photographic material should be enlarged • Inform relevant examiners in orals and clinics
Hearing Impairment or deafness	Yes (for orals)	Possibly in orals	• Written instructions issued at the start of an examination or seated near front of examination hall • Sign language interpreter • Inform relevant examiners
Speech Impairment	No	Possibly (in orals & clinical examinations)	• Inform the relevant examiners in orals and clinics
Dyslexia	Yes	Yes	• All written material in 'dyslexic friendly' fonts • All written material on appropriately coloured paper if required • Use of computer in essay style examinations • Additional lighting

		• Specific formatting • Double marking of scripts
Mobility problems which may: • Restrict access to Certain rooms or ability • to carry out clinical examination of patients	Yes if access difficult	Not normally	• Ensure access is possible for all rooms and appropriate toilet facilities are available • Adjustable desk • In clinical examinations – patients in adjustable beds
• Reduced ability to sit for long periods e.g. back or neck problems or later stages of pregnancy	Yes	Yes	• Extra time of 5 min per hour to allow candidate to move around • Adjustable desk
Difficulties with writing e.g. Arthritis or RSI	Yes	Yes	• Use of a Scribe appointed by the College • Computer + voice recognition Software
Reduced stamina e.g. ME	Yes	No	• Timetable oral or clinical examination in morning
Dietary problems e.g. Diabetes			• Allowed to bring food/drink into the Examination hall • Provide refreshments at orals & Clinical examinations
Mental Health Problems such as: • Claustrophobia • Agoraphobia • Panic attacks	Yes Yes Yes	No No No	Provision of a separate room in case the candidate suffers an attack and behaves in a manner that would disrupt the other candidates
Mitigating Circumstances: • Recent Bereavement • Temporary conditions due to illness or injury on the day of the examination	No Possibly	No Possibly	Possible effect on performance • To be considered by the examiners at the adjudication stage • May need scribe or disabled access depending on nature of injury
• Disruption during the examination	No	No	Possible effect on performance • To be considered by the examiners at the adjudication stage