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JOHANNESBURG
ACADEMIC OFFICE

EXAMINATIONS GUIDELINES FOR CANDIDATES, EXAMINERS, CONVENORS AND MODERATORS FOR THE PART II EXAMINATION OF THE FELLOWSHIP OF THE COLLEGE OF EMERGENCY MEDICINE OF SOUTH AFRICA

The Fellowship of the College of Emergency Medicine Part II [FCEM(SA) Part II] examination is the qualifying examination for specialist emergency physicians in South Africa.

This document is intended to provide candidates, examiners, convenors and moderators with some background and information about the FCEM(SA) Part II examination.

1.0 BACKGROUND

The examiners, convenors and moderators for the FCEM(SA) Part II are selected by the Council of the College of Emergency Medicine of South Africa. The convenor provides examiners with the blueprint of the syllabus. The examiners are asked to provide the convenor with a range of questions (different types and different topics) together with model answers. This guides them in terms of choice of topic and allows the convenor to ensure that the current examination paper always covering a proportion of core topics and ensures a spread of topics over the examination.

The papers are reviewed by the moderator who may advise the convenor about balance in the papers, as well as considering relevance, validity, style and comprehensibility.

The final papers are submitted to the Academic Office of the Colleges of Medicine of South Africa.

Once the examination has been written by the candidates, the scripts are forwarded to the examiners anonymously and are marked. The marks are forwarded to the convenor for collation. Following this collation, any candidate who has failed a paper is flagged for moderation. All question scripts for candidates flagged for moderation are remarked based on the model answers provided.

Candidates are invited to participate in the clinical / oral examinations in accordance with the examination regulations. The list of successful candidates are published on the CMSA Website (www.collegemedsa.ac.za) under the candidates examination number on the date and time as indicated by the Colleges of Medicine of South Africa on application to the examination.

2.0 SYLLABUS

The full syllabus for the FCEM(SA) Part II can be found in the Examination Regulations on the CMSA website – www.collegemedsa.ac.za.

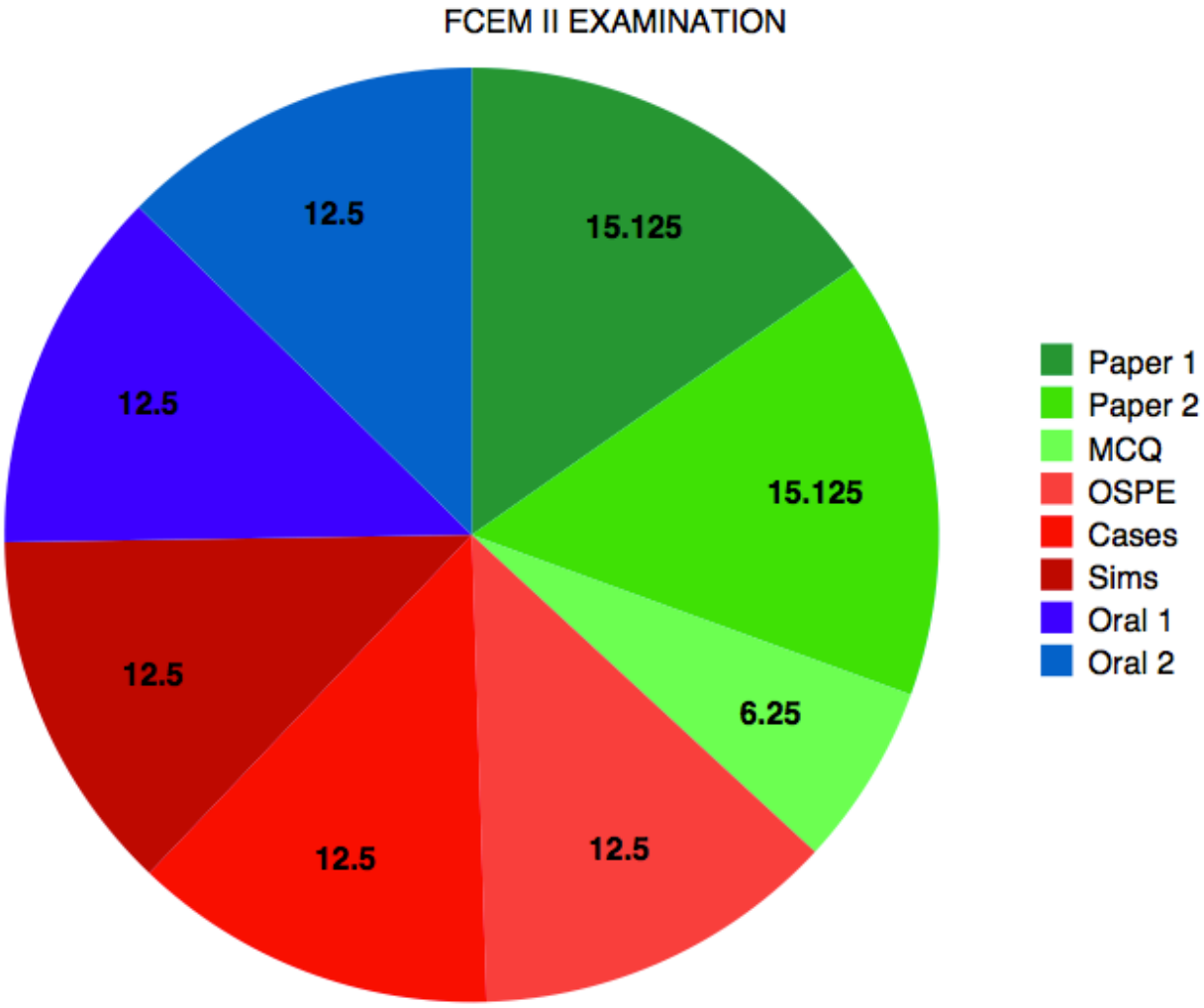
3.0 SYLLABUS BLUEPRINT

The syllabus for the FCEM(SA) Part II has been blueprinted to assist candidates in their preparation for the examination, and to assist examiners, convenors and moderators in ensuring an inclusive examination focussing on clinically important and / or frequently occurring conditions.

The blueprint of the syllabus is attached to this document as APPENDIX A. The full blueprint can also be found on the CMSA website – www.collegemedsa.ac.za.

4.0 EXAMINATION BLUEPRINT

The examination consists of eight separate components – three within the written component and 5 within the oral / practical component. The relative weightings of the various components of the examination are documented in the pie chart below.



5.0 THE WRITTEN COMPONENT

The written component consists of two written papers (each consisting of six questions and written over three hours) and one multiple choice paper (one hundred questions and written over two hours). The Examination is designed to cover the principles and practice of emergency medicine, including investigations, diagnosis, treatment and disposal.

In order to be invited to the Oral / Clinical component of the Final examination, the candidate must pass at least half of the questions in each paper, achieve 45% or more for each written paper (including the Multiple Choice Question paper), and an overall average of 50% or more across the entire written component of the examination.

6.0 THE ORAL / CLINICAL COMPONENT

The Oral / Clinical component consists of fifteen OSPE stations (where a range of skills will be examined – including problem solving, clinical judgment, interpretation of investigations, practical procedures and cost-effective management issues), two short clinical cases and two emergency simulations (where candidates will be expected to be able to elucidate and demonstrate relevant clinical signs, special investigations and procedures, and to synthesise and interpret their findings), and two thirty minute oral examinations with different sets of examiners.

7.0 SUCCESS IN THE EXAMINATION

In order to pass the FCEM(SA) Part II examination, the candidate must achieve 45% or more for all components, and an overall average of 50% or more across the entire examination. In addition, the candidate must pass at least half the questions in each written paper, pass at least four (4) of the five (5) practical components of the examination, and achieve a sub-minimum of at least 45% for all written and practical components.

8.0 THE WRITTEN EXAMINATION

The written examination consists of two written papers of six questions each, and a multiple choice question paper of one hundred questions. These papers are usually written on three consecutive days within the first examination week of the CMSA examination session.

The written examinations are designed to test the candidate's knowledge of the principles and practice of Emergency Medicine at a specialist level. The examinations test knowledge of Medicine; Surgery and surgical specialities; Trauma and Orthopaedics; Paediatrics and neonatology; Obstetrics and gynaecology; Resuscitation and critical care; Toxicology and environmental emergencies; Unit Management; and Pre-hospital and disaster medicine. This topic list is not exhaustive and also includes Evidenced Based Medicine, Ethics, and Public Health that are appropriate and relevant to the practice of Emergency Medicine.

Whilst the syllabus lists most of the topics which will commonly be addressed, topics relevant to Emergency Medicine but not specifically listed may also be examined.

Sixty percent of the mark allocation in the written examinations (the long question papers and the MCQ) will incorporate the high priority (red/orange) topics as listed in the syllabus blueprint. The mark allocation per question is an indication of the time that should be allocated per question rather than the number of specific facts.

8.1 The Written Papers

The written papers consist of two written papers of six questions each. These questions are generally of the short answer type and may take numerous forms. The expectations of the various styles of these short answer questions are detailed below.

List – provide a list of items without explanations
Draw and label – provide a labelled diagram of the item requested
Tabulate – provided a table documenting the information requested (usually similarities and/or differences)
Compare and contrast – provide a comparison of two or more items documenting similarities and differences.
Write short notes – provide an overview of the topic under headings relevant to the topic
Describe – provide a brief overview of a specific aspect of a topic
Discuss – provide a balanced opinion on the topic which usually has a degree of controversy or multiple options
Management – refers to clinical management and includes disposal
Treatment – refers to clinical treatment only

8.2 The Multiple Choice Question Paper

The Multiple Choice Question Paper will consist of one hundred questions to be answered in two hours. Negative marking may be used and this will be clearly indicated on the question paper. This aspect may examine recall of theory as well as clinical application of knowledge.

The Multiple Choice Question Paper will be of the "Single Best Answer" type and will have five options. The single best answer format of multiple choice questions is recognised to be better suited to the assessment of the higher levels of knowledge essential for clinical practice, such as data interpretation, problem solving and decision making.

Example
A patient presents to her general practice with a history of joint pains, tiredness, oral ulcers and a rash on her hands and the front of her chest. Her husband, who accompanied her to the consultation, states how he has noticed her face to be brighter and redder than usual. Of note she was recently started on anti-tuberculosis treatment. Which ONE of the following is most likely to have caused the above symptoms in this patient?

A Isoniazid
B Rifampicin
C Pyridoxine
D Ethambutol
E Pyrazinamide

9.0 CLINICAL PATIENT EXAMINATION

9.1 Purpose of the Assessment:

To allow the candidate to demonstrate specialist level skills in:

- Focused history taking skills to elicit points of clarity
- Clinical Examination skills
- Patient Assessment and succinct presentation of clinical findings
- Appropriate Differential Diagnosis
- Appropriate Investigations for the presented patient
- Appropriate Management Strategy for the presented patient
- Disposal plan for the presented patient

9.2 Notes for the candidate:

- In the clinical examination the candidate will be expected to:
  - Take a focused appropriate history
  - Perform a general examination
  - Examine the system that is targeted by the examiners either directly or by patient presentation
  - Examine any other area or system required to refine the assessment of the patient
- Candidates will be expected to
  - Describe positive signs
  - Discuss negative features (absence of relevant signs)
  - Discuss important points to be sought in the history
  - Suggest provisional diagnosis/diagnoses based on history and examination
  - Request relevant investigations
  - Discuss management of acute and chronic problems related to the case
- The examiner will intervene if the patient is at risk of harm
- Where history taking is difficult the examiner may provide additional information directly
- Candidates will be expected to interpret commonly used investigations. Examples of common investigations are ECG's, X-rays, USS, contrast studies, CT scans, and routine blood tests (FBC, U&E, liver function studies, blood gases) and respiratory function tests.
- The objective of the Clinical Case is to test the candidate's diagnostic acumen, clinical insight and judgment, i.e. the ability to pick up all clinical signs, to correctly interpret imaging studies, to arrive at the correct diagnosis, and to make acceptable management decisions in a specific patient. Due to time limitations, the examiner will usually provide the relevant history, and guide the candidate's focus during the clinical examination.
- To pass the Clinical Case, the candidate should make the correct initial diagnosis or limited differential diagnosis and the correct management decisions in the specific patient presented.

9.3 **The Assessment Process:**

- 2 x 15-20 minute Clinical Cases with 2 examiners in each assessment
- The candidate is given an abbreviated appropriate history by the examiner and asked to do a complaint based examination. The candidate may be given a targeted system to examine: "We would like you to examine the system". Where a broader diagnostic approach is required the candidate may be given only the primary complaint and is asked to focus their examination on the most appropriate system.
- The candidate is given 15 uninterrupted minutes to examine the patient.
  - The clinical examination will not be observed by the examiners during this process.
  - During this time the candidate should assimilate their findings and construct an assessment.
- At the end of the 15 minutes, the examiners and candidate will proceed to the patient's bedside. The candidate then presents a concise structured clinical assessment and management plan as would be presented on a ward round. This assessment will include the summary of the patient problem, evidence for their differential diagnosis including clinical findings, the investigation strategy and a management plan including treatment both immediate and delayed, further investigations, prognosis and disposal of the patient.
- Questions for clarification are then directed to the candidate with regards the selected patient and the candidate's examination, management plan and disposal for the selected patient.
- The bedside case discussion may take up to 15 minutes.

9.4 **Notes for examiner:**

- Examiners must examine the case before and confirm pre-assessment findings and review investigations prior to the assessment.
- Confirm patient consent, ensure patient comfort and where appropriate brief the patient on the clinical history and the examination process.
- Give a brief focused history to the candidate.
- Provide written vital signs as per the TEWS (BP, HR, RR, O2 Sats) on a piece of paper.
- Ask the candidate to examine a focused system or direct examination with a specific patient presentation.
- Ensure that an observer or assistant is available at the bedside to ensure patient comfort and provide the candidate with any equipment required.
- Ensure that candidates cannot access patient investigations prior to the discussion with the examiners.
- Examiners must ensure strict timekeeping.
- This is not an oral examination. Questions should be clinically orientated and related to examining, investigating and managing the targeted patient (not the targeted condition). The clinical cases may not be used as a vehicle for an oral exam around the subject of the case.

9.5 **Notes for convener:**

- The patient is to be briefed on the assessment process.
- Ensure appropriate patients. Ideally those with clear clinical signs, who are relatively stable.
- Informed consent should be obtained from patients.
- Ensure patient safety and comfort throughout the examination session.
- Patients are to be remunerated as per the CMSA rate.

9.6 **The assessment forms:**

- Please refer to appendix 1 (Assessment rubric for patient examination)
  - Appendix 1 is the assessment rubric which is filled in per individual patient. The examiners will determine the key clinical findings and the critical items in the assessment to be included and excluded. The candidate briefing and direction is confirmed.
  - This rubric guides assessment for all candidates examining the patient.
- Please refer to appendix 2 (Marking sheet for patient examination)
  - Appendix 2 is the marking sheet for each candidate
  - It is filled in per candidate and documents their performance in each domain:
    - A Focused History and Physical Examination
    - B Identifying Physical signs
    - C Differential Diagnosis and Presentation
    - D Clinical Management
    - E Maintaining Patient Welfare
- Candidate's performance is scored as per the global matrix.
- These forms are collected at the end of the assessment and form the documentation of the assessment process.

10.0 SIMULATION

10.1 **Purpose of the Assessment (What are we assessing?):**

- To assess a candidates management of an unstable/ critically unwell patient in a simulated environment.

10.2 **The Assessment Process:**

- 2 x 12-20 min simulations with 2 examiners in each Simulation.
- There may be 1-2 assistants per room.
- The candidate walks into the room and is given 1-2 min to check and familiarise themselves with the equipment setup.
- Then the candidate is given the scenario written down on paper and the scenario is read to them. The candidate is asked if they're ready to proceed. Then timing starts.

10.3 **Notes for examiner:**

- Agree on critical points.
- 1 examiner runs the simulation.
  - Reacts to candidates actions
  - Feeds information not available from the manikin
  - Must keep to time
- 1 examiner completes the checklist and records actions.
- The simulation will not be used simply as a vehicle for an oral exam around the subject of the case.
- Brief the assistants.
- The assistant does not form part of the marking process.
- Run through the simulation prior to the candidate's arrival and change any time related/ actions as needed.

10.4 **Notes for convener:**

- Assistants to be pooled from college examiners where possible to ensure candidate confidentiality and should ideally not know the candidates
- Equipment
- Set the sim
- Try to run through sim practically to check timing and equipment
- Send to moderator prior
- Venue (shouldn't be overheard by candidates waiting)

10.5 **The assessment forms:**

- Please refer to appendix 3 (Simulation worksheet for examiner)
  - This worksheet is to be set up by the convener/ an examiner prior to commencement of the examination after topic has been agreed on between the convener and moderator.
  - One simulation document per simulation outlining the information to the candidate, vital signs and their response to treatment, the progression of the simulation, if possible how the simulation may digress depending on the candidates choices.
  - If needed then appropriate timing for deterioration should actions not be taken should also be outlined.
  - The critical points that deem success are to be clearly identified and agreed upon by all examiners and this is the final list that one decides on the success of a candidate.
  - The critical points need to include:
    - Some indication/point of safety awareness.
    - Some indication/point that the airway was managed appropriately throughout the simulation including whatever directed airway management may have been needed.
    - Some indication/point that the breathing/oxygenation/ventilation was assessed and managed appropriately throughout the simulation including whatever directed management may have been needed.
    - Some indication/point that the circulation system was assessed and managed appropriately throughout the simulation including whatever directed management may have been needed.
    - Some indication of no harm being done to the patient.
    - The other points may be particular to the simulation.
    - Please refer to appendix 4 (Simulation marking sheet)
  - This is filled in per candidate and a mark is given based on the marking grid and matching the candidates actions to the critical points identified.
- These forms are collected at the end of the assessment and form documentation of the assessment process.

11.0 OSPE

11.1 **Purpose of the Assessment (What are we assessing?):**

- To assess the candidate's performance of practical skills required in Emergency Centres.
- To assess a candidates ability to use emergency care related equipment.
- To assess a candidates interpretation of investigations.
- To assess a candidates knowledge of emergency related topics via visual aids.
- To assess a candidate's performance in non-clinical competencies required of an Emergency Physician (teaching skills, communication skills, people management skills).

11.2 **The Assessment Process:**

- 15 Stations of 5 minutes each.
- 30 second change over period to allow for resetting of practical stations and candidate movement.
- Between 5 and 10 stations to be practical skills assessment.
- Between 5 and 10 stations to be visual aided questions.
- Each OSPE will have equal weighting on the overall marks (out of 10).
- The practical skills:
  - A mark sheet for each practical skill is to be generated and used to assess each candidate's performance.
  - The practical skill is to be assessed by a single examiner. These examiners are to be pooled from the current examiners *or any other registered specialist Emergency Physician is vetted by the President of the college or designated deputy*.
- Visual aided questions
  - Move on after 5 minutes (may involve candidate movement or question movement)
  - No time to return to question/station
  - The questions must be specific to the VAQ and not test other theory
  - Examples include, but are not limited to:
    - Analyse
    - Describe
    - Diagnose
    - Interpret
- Prior to the OSPE, the examiners are to agree on the questions, marking grids and model answers.
- The practical and visually aided questions are to be run at the same time and the candidates are to rotate between the stations (this may not be a physical rotation of candidates, but may be virtual).
- The convener is to ensure that the practical skills stations are well screened or in separate rooms so that candidates are not able to overhear or see one another while doing the practical skills.
- The convener is to ensure that all VAQ's are of adequate quality to allow for interpretation.
- The convener is to ensure that there is enough lighting to allow for adequate interpretation of each VAQ.
- Computers will be allowed for displaying of images if it is felt that the computer images are superior to printed images.

11.3 **Notes for examiner:**

- If equipment setup forms part of the assessment marking sheet then the equipment must be covered so that the candidate can list required equipment.

11.4 **Notes for convener:**

- Examiners may be asked to create OSCEs on specific topics and create the marksheets to supplement them.

11.5 **The assessment forms:**

- Please refer to appendix 5 (example of skills station, example of skills teaching station and example of a visual aided question set up)
  - This is an example of a mark sheet for a skills station.
  - As can be seen the mark sheet gives 7 marks to the procedural aspects of the skill and 3 marks is to the performance of the skill.
  - Safety and sterility can be added as key points either with marks subtracted if not performed or as critical points.
  - Within the skill there may be critical points that indicate failure (eg unsafe defibrillation) and then these need to be indicated in some way on the form.
  - Also on the form there needs to be an indication if the procedure was actually performed or not – obviously if the procedure was not performed satisfactorily, then the candidate fails irrespective of the rest of the mark sheet.

- These forms and the candidate's answer sheets are collected at the end of the assessment and form documentation of the assessment process.

12.0 ORALS (VIVA VOCE EXAMINATION)

12.1 **Purpose of the Assessment (What are we assessing?):**

- To examine the candidate's approach and clinical reasoning to the theory and practise of emergency medicine.
- To allow exploration of the depth and breadth of the candidates knowledge.

12.2 **The Assessment Process:**

- Two 30 minute oral examinations with 2 examiners in each oral.
- Each examiner will examine for a max of 15 min.
- An examiner will document the candidate's response.
- An observer may be present.
- The moderator may be present.

12.3 **Notes for the candidate:**

- No paper will be allowed inside the room
- The examination will be conducted

12.4 **Notes for examiner:**

- Submit questions for oral.
- The convener will be tasked with asking the questions(s) that were poorly answered in the written.
- The examiners will submit a list of 5 questions and key points for discussion.
- The examiner should push each candidate to their individual limit of knowledge within the time limit.
- Each question will be documented (the examiner not asking the question will document the answer).
- Each examiner will give an individual score and a consensus score will be awarded to the candidate.

12.5 **Notes for the convener:**

- Privacy for oral examination.
- A desk may be provided.
- There should be water available in the room for candidates if necessary.
- Examiners need clipboards to write on if a desk is not provided.
- Observers should be outside of the eye sight of the candidate.

12.6 **The assessment forms:**

- Please refer to appendix 6 (Oral marking sheet)

13.0 EXAMINATION CONDITIONS

Candidates should note that the entire Clinical and oral examination compoenet is conducted under examination conditions and electronic devices, mobile telephones and communication via social media are not permitted.

The dress code for the examination should be professional attire. Neat and clean scrubs are considered appropriate for the Clinical, Simulation and OSPE components only.

FCEM II Blueprinting 2012

SYLLABUS	IMPACT	FREQUENCY	SUBJECTIVE	WEIGHTING
Pre-hospital emergency care:				
· Emergency medical services	2	3		6
· Pre-hospital medical devices	2	2		4
· Rural EMS systems	2	2		4
· Alternatives to road medical transport	2	2		4
· Neonatal and paediatric transport	3	2		6
· Disaster medical services	3	1	*	3
· Mass gatherings	2	2	*	4
· Triage and referral to appropriate facilities	2	3		6
· Injury prevention	2	2		4
Resuscitative problems and techniques:				
· Basic cardiopulmonary resuscitation	3	3		9
· Ethics of resuscitation	2	2		4
· Advanced airway support	3	3		9
· Peripheral and central vascular access	2	3		6
· Invasive monitoring and pacing techniques	2	2		4
· Cerebral ischaemia	3	3		9
· Current research in resuscitative techniques	2	2		4
· Neonatal resuscitation and emergencies	3	3		9
· Paediatric cardiopulmonary resuscitation	3	3		9
· Acid-base problems	2	3		6
· Pathophysiology and interpretation of blood gases	2	3		6
· Fluid and electrolyte problems	2	3		6
· Disturbances of cardiac rhythm, conduction and repolarisation	3	2		6
· Pharmacology of anti-arrhythmic and vaso-active medications	2	3		4
· Financial, medico-legal and political aspects of resuscitation	1	2		2
· Termination of resuscitation and diagnosis of death	2	3		6

FCEM II Blueprinting 2012

· Organ donor, ethical and forensic considerations	2	2	4
Acute signs and symptoms in adults:			
· Chest pain	3	3	9
· Dyspnoea, hypoxia and hypercapnoea	3	3	9
· Haemorrhagic shock	3	3	9
· Septic shock	3	3	9
· Anaphylaxis and acute allergic reactions	3	2	9
· Cyanosis	2	2	4
· Syncope	2	2	4
· Abdominal pain	2	3	6
· Gastrointestinal bleeding	3	2	6
· Coma and altered states of consciousness	3	3	9
· Systemic analgesia and sedation for procedures in adults	2	3	6
· Pain management, care and comfort	2	2	4
Acute signs and symptoms in children:			
· Fever	2	3	6
· Diarrhoea and vomiting	2	3	6
· Fluid and electrolyte therapy	3	3	9
· Upper respiratory emergencies	3	3	9
· Paediatric analgesia and sedation	2	2	4
· Hypoglycaemia in children	2	2	4
· Altered mental status in children	3	2	6
· Syncope and breath-holding	2	1	2
· The uncontrollable child	1	1	1

PRIORITY DISTRIBUTION: **Total items =313**

Red	**38**	**12%**
Orange	**61**	**19.5%**
Yellow	**92**	**29%**
Nil	**122**	**39%**

SYLLABUS	IMPACT	FREQUENCY	SUBEJECTI	WEIGHTING
Emergency wound management:				
· Evaluation and management of wounds in the emergency department	2	3		6
· Local and regional anaesthesia for wound repair	2	2		4
· Wound preparation and care	2	2		4
· Methods for wound closure	1	2		2
· Technical considerations in the repair of difficult wounds	1	1		1
· Soft tissue injuries to the face	1	1		1
· Fingertip injuries	1	1		1
· Puncture wounds and animal bites	2	2		4
· Post repair wound care and advice	1	1		1
Cardiovascular emergencies:				
· Myocardial ischaemia and infarction	3	3		9
· Pre-hospital and ED fibrinolytic therapy	2	2		4
· Acute interventions in myocardial infarction	3	3		9
· Heart failure and pulmonary oedema	3	3		9
· Endocarditis and valvular emergencies	2	2		4
· Cardiomyopathies, myocarditis and pericardial disease	2	2		4
· Pulmonary embolism	3	3		9
· Hypertensive emergencies	3	2		6
· Thoracic and abdominal aortic aneurysms	3	2		6
· Mesenteric ischaemia	3	2		6
· Acute extremity ischaemia and thrombophlebitis	2	2		4
· Cardiovascular physiology of aging	1	2		2
· Cardiac transplantation	2	1		2
Cardiac dysrhythmias	3	3		9
Pulmonary emergencies:				
· Bacterial pneumonias	2	3		6
· Viral and mycoplasma pneumonias	2	2		4
· Pneumonias in immuno-compromised patients	2	3		6

· Aspiration pneumonia, empyema and lung abscess	2	3	6
· Tuberculosis	3	3	9
· Spontaneous and iatrogenic pneumothorax	2	2	4
· Haemoptysis	2	3	6
· Acute asthma in adults	3	3	9
Chronic obstructive pulmonary dis	2	3	6
Gastro-intestinal emergencies:			
· Oesophageal emergencies	2	1	2
· Swallowed foreign bodies	2	2	4
· Peptic ulcer disease	2	3	6
· Perforated viscus	2	2	4
· Acute appendicitis	2	3	6
· Intestinal obstruction	2	2	4
· Hernia in adults and children	2	2	4
· Ileitis and colitis	2	1	2
· Colonic diverticular disease	2	1	2
· Anorectal disorders	1	2	2
· Gastroenteritis and diarrhoeal diseases including food poisoning	2	3	6
· Cholecystitis and biliary colic	2	3	6
· Acute jaundice and hepatitis	2	3	6
· Acute pancreatitis	3	2	9
· Complications of general and urologic surgical procedures	2	1	2
Liver failure and transplantation	2	1	2
Renal and genito-urinary emergencies:			
· Emergency renal problems	2	2	4
· Urinary tract infections	2	3	6
· Male genital problems	1	2	2
· Renal transplant patients	2	1	2
· Emergencies in chronic dialysis patients	2	1	2
· Urologic stone disease	2	3	6

SYLLABUS	IMPACT	FREQUENCY	excluded	WEIGHTING
Gynaecological and obstetrical emergencies:				
· Gynaecologic emergencies	2	2		4
· Vulvovaginitis	1	1		1
· Emergency medical problems in pregnancy	3	2		6
· Blunt abdominal trauma during pregnancy	2	1		2
· Emergency delivery and post-partum care	3	1		3
· Common complications of gynaecologic procedures	1	1		1
Paediatric emergencies:				
· Normal child development and failure to thrive	1	1		1
· Common neonatal problems	2	1		2
· The premature infant	2	1		2
· Sudden infant death syndrome	3	1		3
· Heart disease	2	1		2
· Otitis and pharyngitis in children	1	3		3
· Skin and soft tissue infections	1	2		2
· Bacteraemia, sepsis and meningitis in children	3	2		6
· Viral and bacterial pneumonias in children	3	2		6
· Vulvovaginitis and paediatric urinary tract infections	1	2		2
· Asthma and bronchiolitis	3	3		9
· Seizures and status epilepticus in children	3	3		9
· Gastroenteritis	3	3		9
· Paediatric abdominal emergencies	3	2		6
· The diabetic child	3	2		6
· Paediatric exanthemas	2	2		4
· Musculoskeletal disorders in children	1	1		1
· Evaluating the handicapped or disabled child	1	1		1

Infectious diseases and allergy:			
· Sexually transmitted diseases	2	2	4
· Toxic shock syndrome and toxic shock-like syndrome	2	1	2
· HIV infection and AIDS	3	3	9
· Tetanus	2	2 *	4
· Rabies	2	2 *	4
· Malaria	3	2	6
· Common parasitic infections	2	1	2
· Tick-borne diseases	2	1	2
· Fever, including haemorrhagic fevers	3	1	3
· SARS and avian flu syndromes	3	1 *	3
· Travel medicine principles	2	1	2
· Universal precautions	2	3	6
Toxicology:			
· General management of poisoning	3	3	9
· Tricyclic antidepressants	3	2	6
· Current antidepressants and serotonin syndrome	2	1	2
· Monoamine oxidase inhibitors	2	1	2
· Neuroleptics	2	2	4
· Lithium	2	1	2
· Barbiturates	2	1	2
· Benzodiazepines	2	2	4
· Non-benzodiazepine sedatives and hypnotics	2	1	2
· Alcohols	2	2	4
· Narcotics	2	2	4
· Cocaine	2	2	4
· Amphetamines and amphetamine-like drugs	2	2	4
· Hallucinogens	2	1	2
· Salicylates	2	1	2
· Paracetamol/Acetaminophen	3	2	6
· Non-steroidal anti-inflammatory agents	1	2	2
· Xanthines	2	2	4
· Digitalis glycosides	2	1	2
· Beta blockers	2	2	4

· Calcium channel blocker	2	2	4
· Clonidine	1	1	1
· Phenytoin toxicity	2	2	4
· Iron	2	2	4
· Hydrocarbons	2	2	4
· Caustic ingestions	2	2	4
· Organophosphate and carbamate poisoning	3	2	6
· Cyanide	3	1 *	3
· Anticholinergic toxicity	2	2	4
· Heavy metals	2	1	2
· Use of Poison Information Centres	1	2	2

SYLLABUS	IMPACT	FREQUENCY	SUBJECT]	WEIGHTING
Environmental emergencies:				
· Frostbite and other localised cold-related injuries	2	1		2
· Hypothermia	3	2		6
· Heat emergencies	3	2		6
· Insect and arachnid bites	2	2		4
· Reptile bites and scorpion stings	2	2		4
· Trauma and envenomations from marine fauna	2	1		2
· High altitude emergencies	2	1		2
· Aviation emergencies	2	1		2
· Dysbarism, barotraumas and diving emergencies	2	2		4
· Near drowning	3	2		6
· Thermal burns	3	3		9
· Chemical burns	2	2		4
· Electrical and lightning injuries	3	2		6
· Carbon monoxide poisoning	2	2		4
· Acute exposure to toxic agents	2	1		2
· Radiation injuries	3	1	*	3
· Mushroom poisoning	3	1		3
· Poisonous plants	2	1		2
· Terrorist related environmental agents of mass destruction	2	1	*	2
· Wilderness related emergencies	2	1	*	2
Endocrine emergencies:				
· Hypoglycaemia	2	3		6
· Diabetic keto-acidosis	3	3		9
· Alcoholic keto-acidosis	2	2		4
· Hyperosmolar non-ketotic coma	3	3		6
· Lactic acidosis	3	2		6
· Thyrotoxicosis and thyroid storm	2	2		4
· Hypothyroidism and myxoedema coma	2	2		4
· Adrenal insufficiency and addisonian crisis	2	2		4
· Phaeochromocytoma and hypertensive crisis	2	1		2

Haematologic and oncologic emergencies:			
· Evaluation of the bleeding patient	2	2	4
· Acquired bleeding disorders	2	1	2
· Haemophilias and von Willebrand disease	2	1	2
· Hereditary haemolytic anaemias	1	1	1
· Acquired haemolytic anaemias	1	1	1
· Blood transfusions and component therapy	2	3	6
· Emergency complications of malignancy	2	2	4
Neurological emergencies:			
· The neuralgic examination	1	1 x	1
· Headache and facial pain	2	1	2
· Management of cerebro-vascular incidents	2	3	6
· Vertigo and dizziness	2	2	4
· Seizures and status epilepticus	3	3	9
· Acute peripheral neurological lesions	2	1	2
· Multiple sclerosis	2	1	2
· Disorders of neuromuscular transmission	2	1	2
· Meningitis, encephalitis and brain abscess	3	3	9
Neuroleptic malignant syndron	3	1	3
Eye, ear, nose, throat and oral emergencies:			
· Ocular emergencies	2	2	4
· Otolaryngology emergencies	2	2	4
· Nasal emergencies and sinusitis	2	2	4
· Maxillo-facial fractures	2	2	4
· General dental emergencies	2	2	4

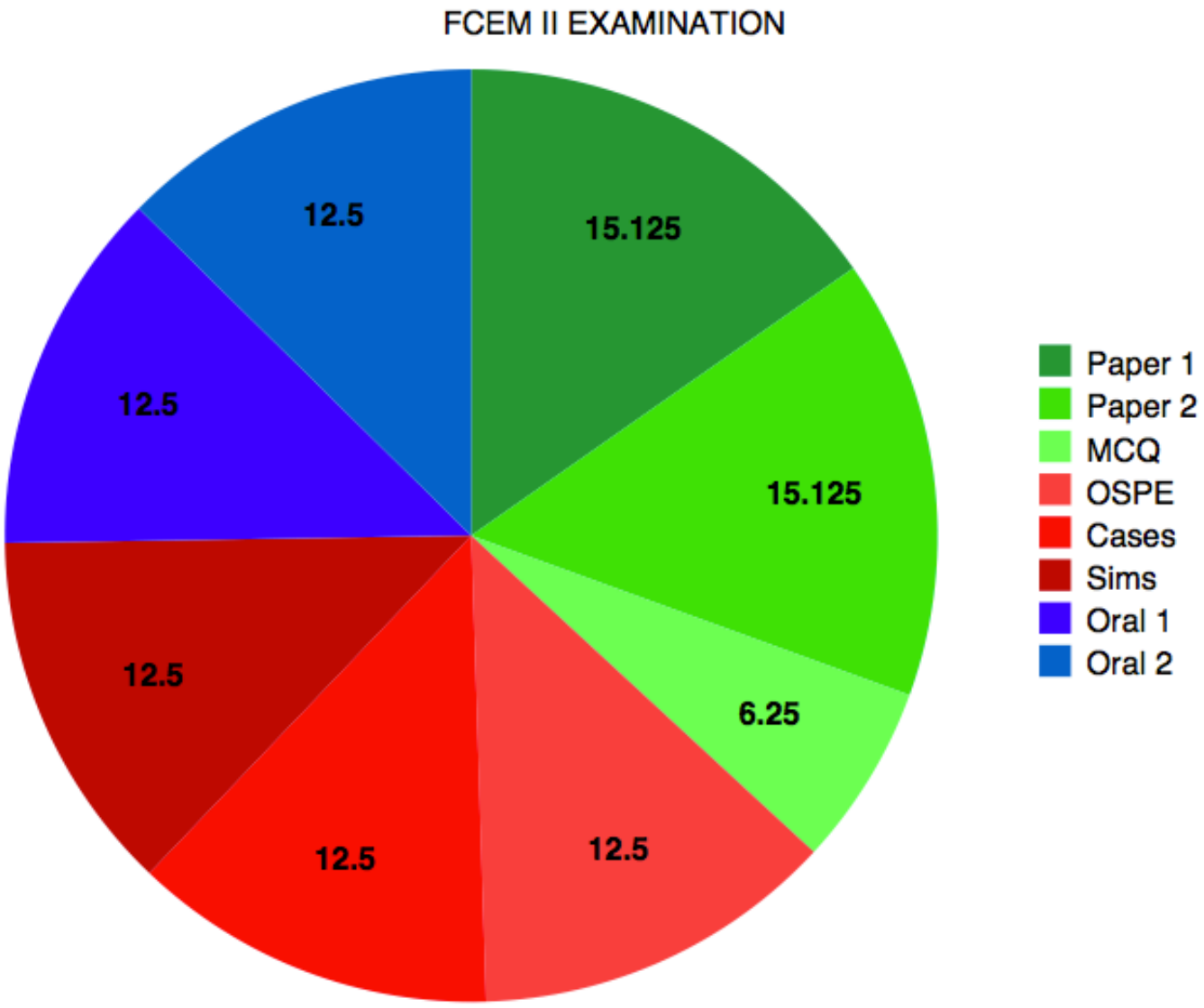
SYLLABUS	IMPACT	FREQUENCY	Subjectiv	WEIGHTING
Dermatological emergencies:				
· Toxicodendron dermatitis	1	1		1
· Exfoliative dermatitis	1	1		1
· Erythema multiforme	2	1		2
· Toxic epidermal necrolysis and the staphylococcal scalded skin syndrome	2	1		2
· Cutaneous abscesses	1	3		3
· Soft tissue infections	2	4		4
· Petechial and purpuric emergencies	3	1		3
· Psoriatic and related emergencies	1	1		1
· Porphyria and related emergencies	2	1		2
Trauma:				
· Initial approach to the trauma patient	3	3		9
· General principles of paediatric trauma	3	3		9
· General principles of geriatric trauma	3	2		6
· Head injury	3	3		9
· Spinal injuries	3	2		6
· Penetrating and blunt neck trauma	3	2		6
· Thoracic trauma	3	3		9
· Abdominal trauma	3	3		9
· Penetrating trauma to the posterior abdomen and buttock	2	2		4
· Trauma to the genitourinary tract	2	3		6
· Wound ballistics	2	1		2
· Emergency management of vascular injury	3	2		6
· Trauma of the pregnant patient	3	2		6
· Physical abuse syndromes	2	2		4
· Explosives injuries	3	1	*	3
· Crush syndromes and related injuries	3	2		6
· Multiple organ failure and ARDS	2	2		4
· Crash dynamics and related patho physiology	1	2		2
· Entrapment and other amputation techniques	2	1		2
· Specialised burns; phosphorus, napalm	1	1		1

· Advanced trauma life support principles	3	3	9
Fractures and dislocations:			
· Early management of fractures and dislocations	2	3	6
· Injuries to the wrist and hand	2	2	4
· Injuries to the elbow, forearm and wrist	2	2	4
· Injuries to the shoulder girdle and humerus	2	2	4
· Trauma to the pelvic girdle, hip and femur	2	2	4
· Injuries to the knee, leg, ankle and foot	2	2	4
· Compartment syndrome	3	2	6
· Immobilisation and alignment techniques	2	2	4
Muscular, ligamentous and rheumatic disorders:			
· Neck pain	1	2	2
· Thoracic and lumbar pain syndromes	1	2	2
· Shoulder pain	1	2	2
· Overuse and degenerative syndromes	1	2	2
· Muscle ruptures	2	1	2
· Compartment syndromes	3	2	6
· Rheumatic disorders in adults	2	1	2
· Infections and non-infectious inflammatory states of the hand	2	2	4
· Soft tissue problems of the foot	2	1	2
· Common sport-related injuries	2	2	4
Psychosocial disorders:			
· Emergency assessment and stabilisation of behavioural disorders	2	3	6
· Psychotropic medications	2	2	4
· Anorexia nervosa and bulimia nervosa	1	1	1
· Hysteria and panic disorder	2	1	2
· Conversion reactions	2	1	2
· Crisis intervention	1	2	2
· Emergency evaluation of prisoner and substance abuse patients	2	2	4

· Physician well-being	2	2	4
· Debriefing techniques	2	2	4

SYLLABUS	IMPACT	FREQUENCY	Subjective pı	WEIGHTING
Abuse and assault:				
· Spectrum of child abuse and neglect	2	2		4
· Male and female sexual assault	2	2		4
· Domestic violence	2	2		4
· Abuse in the elderly and impaired/disabled	2	2		4
· The violent patient	2	2		4
· Post-traumatic stress management	1	1		1
Newer imaging modalities:				
· Non-invasive vascular studies	1	2		2
· Cardiac ultrasound	1	1		1
· Abdominal sonography	2	2		4
· Pelvic ultrasonography	1	2		2
· Computed tomography	1	2		2
· Principles and applications of MRI	1	1		1
· Radionuclide imaging	1	1		1
Common implantable devices:				
· Complications of central nervous system devices	1	1		1
· Complications of GI and urologic devices	1	1		1
· Complications of cardiovascular and intravenous devices	1	2		2
· Orthopaedic devices and reconstructions	1	1		1
Complications of airway devices	2	1		2
Medico-legal and ethical principles related to emergency care:				
· Patient autonomy and informed consent	2	1		2
· Advance directives and living wills	2	1		2
· The principle of futility	2	1		2
· Duty to treat and the doctor-patient relationship	1	1		1
· Professional and vicarious liability	2	1		2
· Termination of care	2	2		4
· Organ and tissue donation	2	2		4
· Family involvement and support	2	2		4
· Business ethics	1	1		1

· Religious and cultural considerations	1	1	1


FCEM II EXAMINATION
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12.5
12.5
12.5
Paper 1
Paper 2
MCQ
OSPE
Cases
Sims
Oral 1
Oral 2

Appendix 1

Assessment Rubric for EXAMINATION of Patient:_____

Patient Information for the Examiners:		
Physical Examination and focused history (A)	What key steps to examination should a successful candidate do? /20	
Identifying Physical Signs (B)	What Clinical Signs are agreed to be present and which should a successful candidate elicit? /20	
Differential Diagnosis And Presentaion €	What diagnosis should a satisfactory candidate consider? /30	
Clinical Management (D)	What key steps in management should a satisfactory candidate consider? (Investigations, therapy, disposal) /30	
Maintaining Patient Welfare €	Treats patient respectfully and sensitively and ensures comfort, safety and dignity /% SUBTRACTED	See answer sheet

APPENDIX 2

PATIENT EXAMINATION MARKING SHEET:

Candidate's Name: _____ Date: _____

Clinical skill	Satisfactory	Unsatisfactory	COMMENTS
Physical Examination (A)	Correct Thorough Fluent Systematic and professional technique of system	Incorrect techniques Omits significant or important tests Unsystematic Hesitant and lacking in confidence Unprofessional	
Identifying Physical Signs (B)	Identifies correct physical signs Does not find signs that are not present	Misses important physical signs Finds signs that are not present	
Differential Diagnosis And Presentation (C)	Constructs a sensible differential diagnosis, including the correct diagnosis. Concise presentation	Poor differential diagnosis Fails to consider the correct diagnosis	
Clinical Management (D)	Selects a sensible and appropriate management plan including investigation, therapy and disposal plan	Unfamiliar with correct management plan Selects inappropriate management Incorrect therapy Uncertain investigations or indications No disposal plan	
Maintaining Patient Welfare (E)	Treats patient respectfully and sensitively and ensures comfort, safety and dignity	Causes patient physical or emotional discomfort Jeopardises patient safety	*Adjusts above mark down if inappropriate. If jeopardizes patient's safety then marks are adjusted to a fail* *-__%*
General Comments:			

Candidate's Name: _____ Date: _____

GLOBAL RATING:

100%	Perfect		
85%	Excellent	Excellent examination skills, clinical findings contextualised and interpreted, Well structured complete assessment, interprets complex diagnostics, complete management strategy, excellent patient rapport	
75%	Very Good	Good examination skills, all clinical findings elicited and contextualised, comprehensive assessment, good interpretation of simple diagnostic investigations and solid management plan, good patient rapport	
65%	Good	Reasonable examination skills, picks up all clinical findings, reasonable assessment, diagnostic and management strategy	
55%	Satisfactory	Fair Examination skills. Picks up most clinical findings – may miss 1 or 2, Fair assessment, diagnostic and management strategy, safe	
45%	Unsatisfactory and component failure	Poor Examination skills, misses key clinical findings, incomplete or incorrect assessment, no or poor understanding or interpretation of diagnostics, no or poor management plan	
Less than 45% Actual Mark: _____	Unsatisfactory and examination failure	Harms patient, Dangerous assessment or management plan Examiner to clarify: _____ _____	

Examiner 1: _____ ***Examiner 2:***_____

Appendix 3

Adult/Paed/Infant/Neonate Simulation: Topic

BRIEF CASE SUMMARY: Write down brief summary for examiners.

ACTIONS EXPECTED (Critical *):

- Safety throughout the simulation/ Appropriate safety precautions taken
- Adequately assess the patient (good clinical examination)
- Manage airway appropriately
    - RSI correct drug choice
    - RSI technique safe and effective
- Oxygenation appropriate throughout
- Ventilation appropriate throughout
- …
- …
- …
- No harm to patient
  (Write down the critical actions of the simulation that the candidate is required to accomplish.)

EQUIPMENT NEEDED

Usual Equipment (Delete what not needed and add no or sizes where applicable):

Adult/Paed/Neonate Patient	Oxygen tubing	Syringes 10ml x
Simulator	Face Mask O2	Syringes 5ml x
Yankauer suction size	NonRebreather	Syringes 2ml x
Soft Sucton catheter size	Nasal cannula size	Insulin syringes x
OPA sizes	Nasogastric tubes	Needles (drawing up) x
ETT sizes	Webcolls no	Glucosticks
ETT tie	Jelcos sizes/nos	Urine Dipsticks
Magills size	IV lines 60 drops/ml no	BP Cuff
EDD	IV lines 20 drops/ml no	Sats Monitor
Bougie/Introducer size	IV lines 10 drops/ml no	Capnography
Laryngoscope/blades	1 L Ringers no	Defibrillator with/without
BVM size	200ml NS no	Pacing
Mask size	Tegaderm	
Oxygen reservoir	Syringes 20ml x	……. Add other equipme

SIMULATION WORKSHEET

INFORMATION FOR CANDIDATE:

Write down the information that the candidate gets given on commencement of the simulation. You are on call in a fully stocked Emergency Centre. Your assistant is a competent sister who will follow your direct instructions….

INITIAL EXAMINATION:

Mental Status:
Airway:
Breathing:
Circulation:
Other: HGT
Temp
Secondary Survey Findings/ Clinical examination findings:

ADDITIONAL INFORMATION (AS CANDIDATE ASKS):

Allergies:
Medications:
Past Med Hx:
Last Meal:
Events Prior:

SPECIAL INVESTIGATIONS

ABG:
CXR:
ECG:
…. Any other investigations. If possible have actual examples of these, otherwise just verbalise the results)

PROGRESSION OF EVENTS:

Give an expected progression of events and expected patient management
Indicate vitals sign changes that occur as a result of treatment
Indicate what is to occur should treatment be delayed or not done or incorrectly done
Should specific timings be applicable indicate this.

Appendix 4

Simulation Marking Sheet

Candidate name: __ _____

ACTIONS EXPECTED (Critical *):

- Safety throughout the simulation/ Appropriate safety precautions taken
- Adequately assess the patient (good clinical examination)
- Manage airway appropriately
    - RSI correct drug choice
    - RSI technique safe and effective
- Oxygenation appropriate throughout
- Ventilation appropriate throughout
- …
- …
- …
- No harm to patient

  (Copied from beginning of document and lists the critical actions to give the examiners the checklist to evaluate competence)

Intervention	**(Y/N)**	**Comments (MUST be completed if 'no' entered in column 2)**
Airway assessed		
Breathing assessed		
Circulation assessed		
RSI and Intubation		
Confirmatory devices attached (sats/ETCO2)		
…List other action whether critical actions or not		

Other Comments

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

GLOBAL RATING:

100%	Perfect		
85%	Excellent	Care beyond required basics according to tick sheet. Everything on tick sheet completed smoothly, uneventfully. Basics taken care of. No morbidity or mortality.	
75%	Very Good	Everything on tick sheet completed smoothly, uneventfully. Basics taken care of. No morbidity or mortality.	
65%	Good	Everything on tick sheet completed	
55%	Satisfactory	Basics done. May have one or two mistakes, but no mortality from the mistakes/ no significant morbidity	
45%	Unsatisfactory and component failure	Basics not sorted out/ not done. Any event (action or non-action) that would have resulted in mortality or morbidity	
Less than 45% Actual Mark: __	Unsatisfactory and examination failure	Significant morbidity or mortality in patient. Examiner to clarify: _____ _____	

Examiner 1:_____ Examiner 2:_____

Appendix 5

OSCE : Name – MARKING template

MARKING GRID:		Y	N
Safety: • This may not be applicable for the station although most practical skills require gloves/ glasses		0	-1
Sterility • This may not be applicable for the station		0	-1
Procedure technicality	Equipment setup •	+1	
	Patient setup •	+1	
	Procedure: • Step 1 • Write down the steps the candidate needs to do to complete the skill • Any of these points can receive a *(star) to indicate that they are critical and failure to do so results in failure of skill station. If a * is indicated then these points are not "counted" as they are pass fail points. • The "Y" ticks/points need to add up to 7	+1	
	• Step 2	+1	
	• Step 3	+1	
	• Step 4	+1	
	*Procedure performed?	PASS	FAIL
	Post Procedure Care •	+1	
Total for Procedure	Add up the marks from the "Y" ticks		
Overall Approach to Procedure	3 = Excellent Approach 2 = Very Good Approach 1 = Satisfactory Approach 0 = Poor or No Approach		
	TOTAL FOR PROCEDURE		/10

OVERALL RESULT FOR PROCEDURE:								
GOOD (mark 8-10)		SATISFACTORY (mark 5-7)		UNSATISFACTORY (Unsatisfactory is mark 0-4 or a critical point* failed) Or the skill was not performed.				
				Safety	Sterility	Equipment	Procedure	Other

Examiner Name: _____ Signature: _____ Date: _____

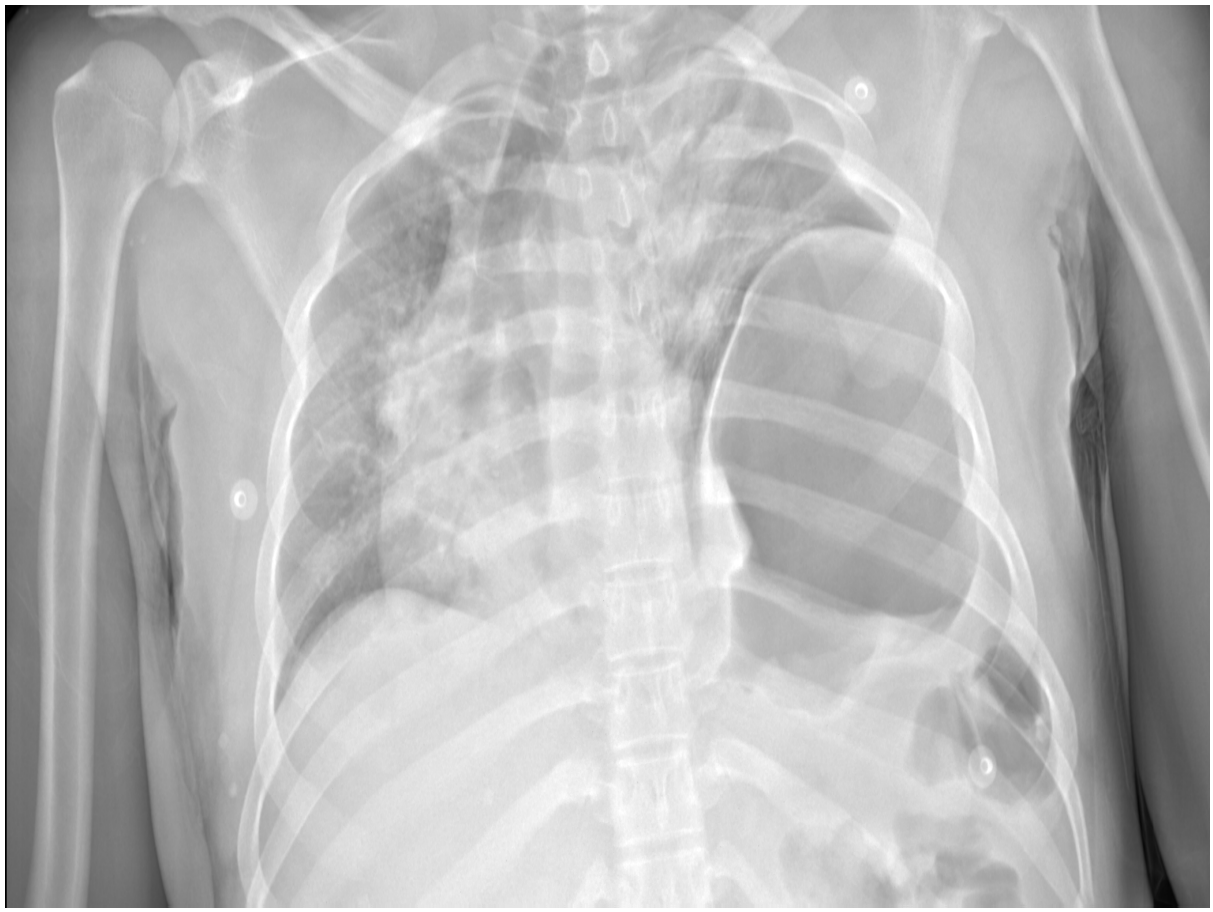
OSCE : Teaching OSCE – MARKING template

MARKING GRID:		
Items	Marking Guideline	Marks
Interaction/ interpersonal skills: a. Introduce self and ask student name. b. Approachable c. Not harsh/ critical	1 = Done 0 = not done or harsh, critical and unapproachable	
Teaching skills: a. Establish the objectives of the session b. Determine baseline knowledge c. Allows for questions d. Wraps up/summarises at end	1 = 2 or more items done adequately 0 = 1 or none items done adequately	
Explain and Demonstrate by: a. ……. b. …… c. ……	4 = Explained well, correctly and in order. Demonstrated well covering all facts 3 = Good explanation, possibly leaving out a few non essentials 2 = Satisfactory explanation/ demonstration, in order. Some less vital info omitted 1 = Poor explanation or poor demonstration or vital info omitted 0 = no knowledge/ not done	
Allow student time to practise/perform and corrects as needed - Identifies mistakes - Correctly intervenes	2 = Done well and corrected student 1 = Did do it, but didn't do it well 0 = Didn't do it	
Overall Impression of knowledge translation	Knowledge translation to student: 2 = Good to Excellent 1 = Satisfactory 0 = poor to non-existent	
TOTAL FOR TEACHING OSPE		/10

Examiner Name: _____ Signature: _____ Date: _____

OVERALL RESULT FOR OSPE:									
GOOD (mark 8-10)		SATISFACTORY (mark 5-7)		UNSATISFACTORY (Unsatisfactory is mark 0-4 or a critical point* failed)					

5C: Example of a visual aid question



Look carefully at the x-ray on the screen and answer the questions in your answer book.

X-ray 1

A) Describe the x-ray (6)
B) What is the diagnosis (2)
C) How can the diagnosis be confirmed (2)

5d Visual Aid Question Mark Sheet

NAME:	**NUMBER:**
QUESTION 5c **A)** **B)** **C)**	

Appendix 6

VIVA VOCE MARKING SHEET:

Candidate's Name: _____ Date: _____

Question 1 : _____

	Unsatisfactory (<45%)	Satisfactory (55-59%)	Very Good (60-74%)	Excellent (≥75%)
Understanding	Shows no or a very superficial understanding of the topic	Shows an understanding of the topic	Shows a deep understanding of the topic	Demonstrates an exceptional understanding of the topic
Prompting and handling of probing questions	Wrong answer despite prompting or a significant amount of prompting required	Some prompting required (a few probing questions)	Did not have to prompt at all. Answered probing questions	Anticipated and pre-empted probing questions
Scope of the answer	Did not answer the critical points in the MEMO/ on the topic	Covered the critical points in the MEMO/ on the topic	Covered all the critical points and then most of the non-critical points in the MEMO/ on the topic	Covered all the points in the MEMO and extended the answer beyond the memo/ on the topic

Mark from Examiner 1: _____ Mark from Examiner 2: _____ **Consensus Mark:___**

Question 2 :

	Unsatisfactory (<45%)	Satisfactory (55-59%)	Very Good (60-74%)	Excellent (≥75%)
Understanding	Shows no or a very superficial understanding of the topic	Shows an understanding of the topic	Shows a deep understanding of the topic	Demonstrates an exceptional understanding of the topic
Prompting and handling of probing questions	Wrong answer despite prompting or a significant amount of prompting required	Some prompting required (a few probing questions)	Did not have to prompt at all. Answered probing questions	Anticipated and pre-empted probing questions
Scope of the answer	Did not answer the critical points in the MEMO/ on the topic	Covered the critical points in the MEMO/ on the topic	Covered all the critical points and then most of the non-critical points in the MEMO/ on the topic	Covered all the points in the MEMO and extended the answer beyond the memo/ on the topic

Mark from Examiner 1: _____ Mark from Examiner 2: _____ **Consensus Mark:___**

Question 3 :

	Unsatisfactory (<45%)	Satisfactory (55-59%)	Very Good (60-74%)	Excellent (≥75%)
Understanding	Shows no or a very superficial understanding of the topic	Shows an understanding of the topic	Shows a deep understanding of the topic	Demonstrates an exceptional understanding of the topic
Prompting and handling of probing questions	Wrong answer despite prompting or a significant amount of prompting required	Some prompting required (a few probing questions)	Did not have to prompt at all. Answered probing questions	Anticipated and pre-empted probing questions
Scope of the answer	Did not answer the critical points in the MEMO/ on the topic	Covered the critical points in the MEMO/ on the topic	Covered all the critical points and then most of the non-critical points in the MEMO/ on the topic	Covered all the points in the MEMO and extended the answer beyond the memo/ on the topic

Mark from Examiner 1: _____ Mark from Examiner 2: _____ **Consensus Mark:___**

Question 4 :

	Unsatisfactory (<45%)	Satisfactory (55-59%)	Very Good (60-74%)	Excellent (≥75%)
Understanding	Shows no or a very superficial understanding of the topic	Shows an understanding of the topic	Shows a deep understanding of the topic	Demonstrates an exceptional understanding of the topic
Prompting and handling of probing questions	Wrong answer despite prompting or a significant amount of prompting required	Some prompting required (a few probing questions)	Did not have to prompt at all. Answered probing questions	Anticipated and pre-empted probing questions
Scope of the answer	Did not answer the critical points in the MEMO/ on the topic	Covered the critical points in the MEMO/ on the topic	Covered all the critical points and then most of the non-critical points in the MEMO/ on the topic	Covered all the points in the MEMO and extended the answer beyond the memo/ on the topic

Mark from Examiner 1: _____ Mark from Examiner 2: _____ **Consensus Mark:___**

Examiner 1:_____ ***Examiner 2:***_____

OVERALL MARK:

EXAMINER PEER REVIEW

Examiner: _____ Exam: FCEM DipPEC Date: _____

If answered no to any of the questions, please give examples

1.	**ORAL EXAMINATION**	
a.	Were the questions asked appropriate in terms of scope, standard and content?	
b.	Were the questions phrased appropriately?	
c.	Did the examiner give the candidate appropriate time to answer the questions?	
d.	Was the examiner fair and objective throughout the exam process?	
e.	Was the examiner adequately prepared?	
2.	**OSCE**	
a.	Was the examiner fair and objective throughout the exam process?	
b.	Was the examiner adequately prepared?	
	CLINICAL EXAMINATION	
a.	Were the questions asked appropriate in terms of scope, standard and content?	
b.	Were the questions phrased appropriately?	
c.	Was the examiner fair and objective throughout the exam process?	
d.	Was the examiner adequately prepared?	
	GENERAL COMMENTS	