



Standardised Case Based Discussions

1. Introduction

A Standardised Case-Based Discussion (SCBD) is primarily designed to examine the domains of Medical Expertise (medical knowledge) and Prioritisation and Decision Making (higher-level clinical reasoning/clinical decision-making skills), however knowledge from other domains may also be examined.

2. Format

Two examiners will independently mark the station. One examiner will lead the discussion by asking scripted questions and will provide further clinical information to the candidate as the case evolves, including any relevant test results. The second examiner will observe the candidate's performance.

A series of **standardised scripted lead in questions** will be asked of all candidates and, as per all stations in the Fellowship Clinical Examination, candidates will be assessed at the level expected of a junior FACEM.

Where a candidate has already raised a topic or an issue, the examiner may provide an unscripted probe to the candidate for further clarification or elaboration on that issue.

Example of such probes that may be asked:

"You mentioned fluid management. Can you elaborate on that?"

"You previously mentioned treating bradycardia. Can you explain why you chose that treatment?"

Probing questions ask a candidate to go into further detail on a topic that they have already initiated or mentioned. As this examination is assessing higher order medical knowledge and clinical skills, candidates will not be prompted for important issues that they have not spontaneously considered and introduced as part of their response.

Examples of prompts that will NOT be asked:

"Would fluid management be part of your plan?"

"Would you use isoprenaline as part of your treatment?"

"Are you sure about that?"

Prompting questions such as these, provide a cue or a clue that suggests the candidate may have made an error or an omission that they should have already identified or addressed from the information provided.

Scripted questions and prompts may be included where new or additional information is presented to the candidate, particularly where that information raises multiple issues that need addressing. These prompts may repeat the initial information or remind the candidate about an issue for which clinical reminders would occur in the work place (e.g. abnormal signs).

Candidates' responses will be marked against the key criteria for each domain. Examiners will then independently allocate marks.

Better candidates will cover more areas and in greater depth, will require fewer probing questions, and will be able to justify all their actions and respond appropriately to new clinical information as they receive it. As a result, they will achieve higher domain and global rating scores.

3. Station example

On the following pages, an example of a Standardised Case-Based Discussion is provided. Please note, this is an example only of the type of format, questions and expected responses required for a SCBD station, to assist candidates in their preparation. Candidates would be expected to elaborate and provide more detailed responses to the broader areas outlined.

The following is provided:

- The **Candidate Instructions** that are provided outside the room during the 4 minutes reading time – there will also be a copy in the room.
- The type of scripted questions that would be asked by the leading examiner.
- A copy of the **Prop** – in this case an ECG.
- The **Candidate Expectations** or responses that a candidate would be expected to cover as a junior consultant.

Candidate Instructions

This is a **7 minute** Standardised Case-Based Discussion station.

You will be interacting directly with an examiner who will ask you about your assessment and management of the following clinical situation. Further information will be provided as the case evolves.

Case Information:

You are the duty consultant of a regional base hospital emergency department. A 58 year old male has presented after a possible overdose of slow release verapamil. He has no current symptoms. He is in the resuscitation room. IV access has been achieved and initial bloods have been sent.

His vital signs are:

HR	66 bpm
BP	110/55 mmHg
SaO ₂	95 % on room air
RR	24 /min
GCS	14 (E4, V4, M6). Appears intoxicated with alcohol.

His examination is unremarkable. There are no focal neurological deficits or signs of injury.

Collateral history reveals:

- The ingestion occurred 1 to 3 hours ago. One empty card (30 tablets) found of Verapamil 240 mg SR – uncertain how full it was. Patient said he had ‘taken them all’. Has drunk up to one bottle of vodka at the same time.
- He denies other ingestions: has access to atorvastatin/pantoprazole/diazepam
- History of ischaemic heart disease (IHD), hypertension, hypercholesterolaemia, gastro-oesophageal reflux, depression.

This SCBD will assess the following domains:

- Medical Expertise (60%)
 - Initial Management (20%)
 - Specific/further Management (40%)
- Prioritisation and Decision-making (40%)

Candidate Questions

Part 1

What are your key priorities in the initial assessment of this patient? Please also explain why these are your priorities.

- What initial treatment would you commence for this patient?
 - What are the benefits and risks of this treatment?

The patient is offered charcoal and whole bowel irrigation, but he refuses this treatment.

- How does this influence your management plan? Please provide details and reasoning.
 - *Note: If candidate has adequately answered this question previously, examiner may bypass this question.*

Part 2

It is now one hour later. The patient has been intubated and decontamination has commenced. His heart rate is now 34/min. BP 80/55. Other observations are unchanged.

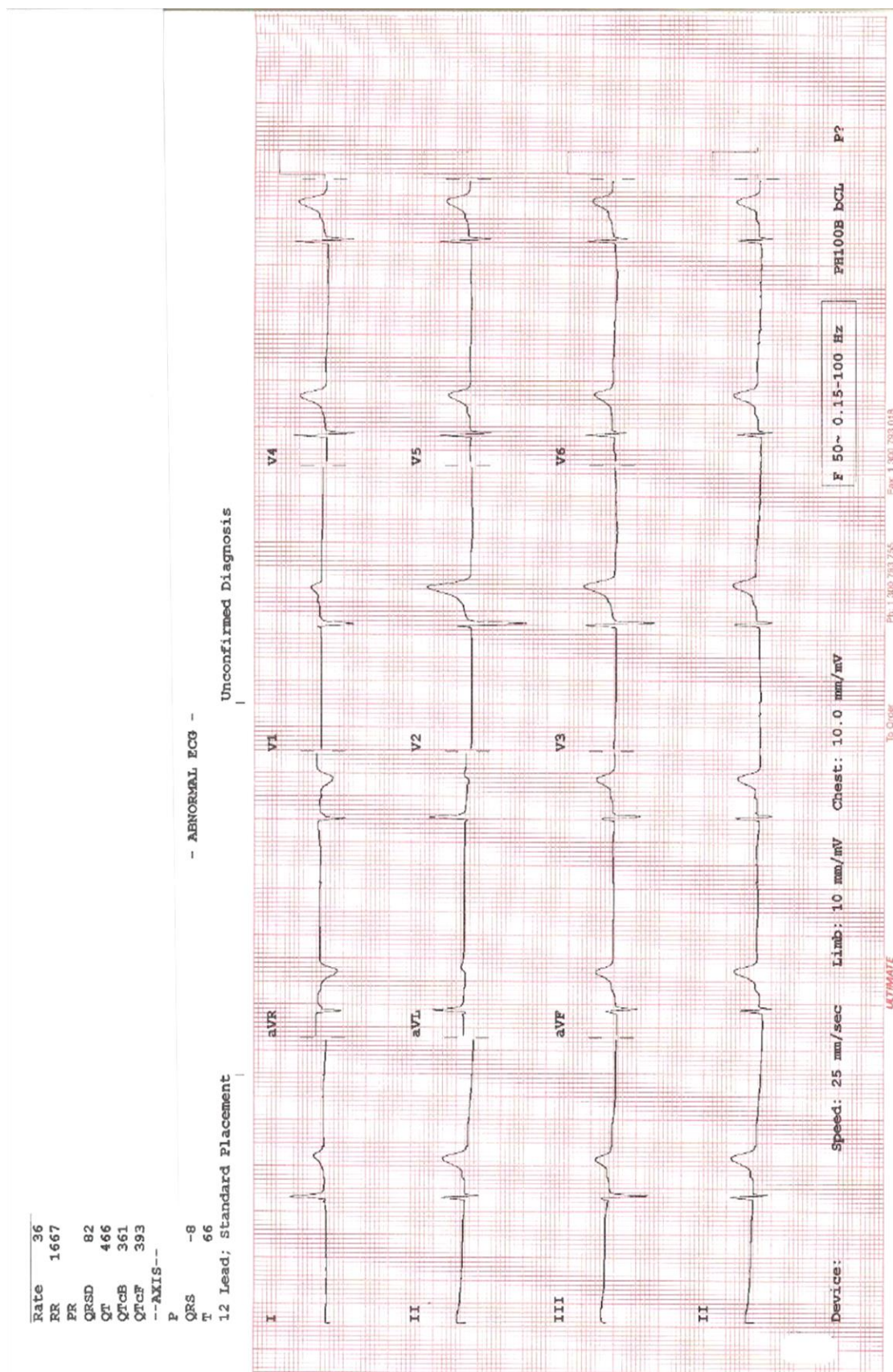
This is his ECG. (Candidate will be handed an ECG to interpret – see next page for example)

- What is your analysis and interpretation of this ECG?
- What is your treatment plan now and for the next hour? Please provide details and reasoning.
- If the patient does not respond to your treatment plan, how would you escalate your treatment?

Part 3

Another hour has passed. The patient is still not stable and remains bradycardic and hypotensive despite your treatment plan.

- What are your key concerns now?
- What are your management priorities and plans now? Please provide details and reasoning.



Candidate Expectations

Candidates would be expected to cover the following responses in each of the relevant domains:

- **Medical Expertise**

Part 1: Initial Management

- Identify this is a potentially life-threatening verapamil toxicity
- Commence decontamination with both charcoal/whole bowel irrigation
- Perform pre-emptive intubation to facilitate decontamination
- Provide details on other initial supportive treatment

Part 2: Specific/Further Management

- Provide a structured analysis of the ECG including confirmation of features of toxicity
- Commence an appropriate escalating treatment plan to support patient's haemodynamic status
- Provide details of treatment plan modalities likely to succeed:
 - Intravenous calcium in adequate doses
 - A trial of intravenous fluids
 - Progression to high dose insulin therapy if the above measures fail
 - Consideration of mechanical haemodynamic support
- Avoid treatment modalities unlikely to be of initial value:
 - Atropine
 - Inotropes with primarily vasoconstrictive properties

- **Prioritisation and decision-making**

- Explain why this overdose is potentially lethal
- Explain the specific benefits and risks of decontamination
- Justify early decontamination, including why benefits outweigh potential risks
- Discuss the issues regarding decontamination against the patient's will
- Justify decision to intubate to facilitate decontamination
- Explain and justify an appropriate order treatment including escalation
- Prioritise urgent transfer to a tertiary ICU which can deliver 3rd line care