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FROM THE EXAMINATIONS DEPARTMENT

## Public Report on the Part 2 FRCOphth Oral Examination April 2012

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The oral parts of the eight sitting of the Part 2 FRCOphth examination were held in Liverpool from 23<sup>rd</sup> to 26<sup>th</sup> April 2012

## **1. Candidates**

Sixty-eight candidates were invited to sit the oral examination having successfully completed the written papers in February. Sixty-seven candidates presented themselves for the examination. One candidate withdrew from the examination having passed the Fellowship Assessment.

To satisfy the requirements to proceed to the oral examination, candidates must achieve the following:

1. Obtain a combined mark from both written papers, which equals or exceeds the combined pass mark from both papers and
2. Obtain a mark in each written paper that equals or exceeds the pass mark in that paper after it has been reduced by 1 SEM

In total, 68/105 candidates passed the written papers and were invited to attend the oral examination.

**This represents a pass rate for the written papers of 65%.**

## **Oral examinations (Structured Viva and OSCE)**

### **2. The Structured Vivas**

There were five structured vivas, which were held on Monday 23 April and Tuesday 24 April in the Hilton Hotel, Liverpool. The communication skills OSCE station was conducted as one of the viva stations, making six stations in all. Each viva lasted 10 minutes. The stations were:

#### **Station 1. Patient investigations and data interpretation**

Monday PM Investigation of anisocoria

Tuesday AM Hess chart and assessment of diplopia

Tuesday PM OCT and Fluorescein angiography

#### **Station 2. Patient management 1**

Monday PM Vertical diplopia

Tuesday AM Papilloedema

Tuesday PM Lens dislocation

#### **Station 3. Patient management 2**

Monday PM Macular hole

Tuesday AM Central retinal vein occlusion

Tuesday PM Strabismus and diplopia

#### **Station 4. Attitudes, ethics and responsibilities.**

Monday PM Non-accidental injury

Tuesday AM Patient confidentiality

Tuesday PM Clinical supervision of trainees

#### **Station 5.**

##### **Audit, research and evidence based practice (5 minutes)**

Monday PM Diabetic retinopathy

Tuesday AM Steroid induced osteoporosis

Tuesday PM Laser safety

## Health promotion and disease prevention (5 minutes)

Monday PM Juvenile idiopathic arthritis

Tuesday AM Retinopathy of prematurity

Tuesday PM NICE guidance for glaucoma

The vivas were held in 2 large rooms, with stations partitioned by screens. There were 2 teams of examiners (red and blue teams). The examination was conducted in 6 rounds (2 on Monday and 4 on Tuesday).

### 2a) Results:

Maximum mark (5 stations, 10 examiners, 12 marks per station): 120

Pass mark (using borderline candidate method): 68/120

Mean score: 86/120 (72%)

Median score: 86/120 (72%)

Range: 52 -116

Reliability: (Cronbach alpha) 0.84

SEM: 6

Adjusted pass mark (+ 1 SEM) 74/120

Pass rate before adjustment (pass mark 68/120) 57/67 (85%)

Pass rate after adjustment (pass mark 74/120) 49/67 (73%)

Two candidates received a red flag, of whom 1 failed and 1 passed the viva examination. Two candidates received 2 red flags, of whom 1 failed and 1 passed the viva examination.

**Table 1 Distribution of scores**

Score	Distribution	Total
51-60	//	2
61-70	//// // /	11
71-80	//// // /	11
81-90	//// // //	15
91-100	//// // //	12
101-110	//// // //	14
111-120	//	2
Total		67

**Table 2 Results for each station**

Station		Mean score	Median score	Range
1	PI	9	9.5	3.5-12
2	PM	9.5	9.5	4-12
3	PM	8.5	9	3-12
4	AER	8	8.5	1.5-12
5	HPDP/EBM	8.5	8	3-12

**Table 3 Correlation between examiner's marks at each station**

Station 1	Station 2	Station 3	Station 4	Station 5
PI	PM	PM	AER	HPDP/EBM
0.85	0.74	0.86	0.76	0.83

**Table 4 Correlation between examiner's global judgements at each station**

Station 1	Station 2	Station 3	Station 4	Station 5
PI	PM	PM	AER	HPDP/EBM
0.79	0.64	0.75	0.69	0.79

**Table 5 Correlation between viva stations**

		Station 2	Station 3	Station 4	Station 5
		PM	PM	AER	HPDP/EBM
Station 1	PI	0.21	0.20	0.40	0.58
Station 2	PM		0.28	0.20	0.19
Station 3	PM			0.37	0.34
Station 4	AER				0.42

**2b) Standard setting for the structured vivas**

	1		2		3		4		5		Total
Number of borderline candidates	21	17	6	12	12	18	14	13	15	22	
Median borderline candidate mark	8	7	7	7	7	7	5.5	6	7	6.5	68

The pass mark for the structured viva was increased by 1 SEM to 74/120 (62%)

### 3. The OSCE

There were seven OSCE stations in all. The six clinical stations were held on Wednesday 25 and Thursday 26 April 2012 in the St Paul's Eye Department at the Royal Liverpool Hospital. The communication OSCE was conducted with the vivas. There were 2 teams of examiners (red team and blue team) and 6 rounds (3 on Wednesday and 3 on Thursday). Four of the OSCE stations lasted 15 minutes. The medicine and neurology stations ran as a double station and lasted 30 minutes. The communication OSCE lasted 10 minutes. There were two examiners at each station. In the communication OSCE, one examiner was a trained lay examiner.

Patient with the following conditions made themselves available for the examination:

#### **Wednesday Morning**

##### **Station 1 – Cataract & Anterior Segment**

- R. Lattice dystrophy w/central corneal opacity. L penetrating keratoplasty
- Oculocutaneous albinism, keratoplasty
- Myopia
- Mucous membrane pemphigoid
- Graft vs. host. Ocular surface disease secondary KCS
- Posterior polymorphous corneal dystrophy
- Bilateral Ascher rings
- Decompensating exophoria ectropion
- Fuchs endothelial dystrophy L. DSAEK
- Pseudophakia bullous keratopathy IOL dislocation

##### **Station 2 – Glaucoma & Lid**

- Oculocutaneous pemphigoid keratinisation
- R. Previous CRVO pseudoexfoliation
- Pigmentation dispersion glaucoma
- Pigment dispersion syndrome
- Glaucoma 360° posterior embryotoxon
- POAG
- Bilat advance glaucoma. Bilat pseudophakia
- High myope L. pseudophakic R. NS+
- High myope R. Aphakia L. PSCLO. R. failed rx Sx. L. Anterior uveitis – idiopathic
- Anterior segment dysgenesis. Complicated left cataract surgery. Left Ahmed valve. Lt Zonulohyaloid vitrectomy
- Glaucoma
- R. disc inf cupping – angle recession
- Ptosis
- Ectropion
- BCC
- R. disc early cupping – angle recession

##### **Station 3 – Posterior Segment**

- Birdshot retinopathy
- L. morning glory syndrome. L superior temporal chronic RD. Previous multiple RD repair w/heavy oil

- L. Microvascular ptosis. Diabetic maculopathy, L preprolif. DR.
- Refsum's disease – peripheral bone spicule pigmentation, Rt PSCP cat. Lt. PC IOL
- White w-out pressure both eyes
- Stargardt's disease. Fundus flavimaculatus exotropia
- Myopic MD, geographic atrophy
- Lt. background diabetic retinopathy, Rt. Previous macular oedema with exudates
- Bilateral macular telangiectasia
- Chronic anterior uveitis
- RP
- Bilateral OHN drusen + Rt. Peripapillary CNV
- Intermediate uveitis
- Rt. Toxoplasma scar
- Pseudoxanthoma elasticum, angioid streaks
- BDUMP

#### **Station 4 – Strabismus & Orbit**

- Duane's syndrome
- Occl. On R lens to elevate Dip. TED.
- Rt. Superior oblique under-reaction w/Rt. Inferior oblique over-reaction
- R. upper lid retractions R+L lower lid refractions. R. mild exophthalmos
- Limitations post buckle
- Bilateral ptosis, external ophthalmoplegia
- Graves' disease
- R. Decompensated esotropia – controlled by glasses
- Esotropia, hypermetropia, anisometropia, Sjogrens syndrome
- TED N 4 XP
- R. EXotropia worse w-out spectacle correction
- Exotropia monocular double vision 6/6 Rt Amblyopic Lt.
- Convergence spasm and R SO under action
- Lt. Inferior rectus followed by weakening of both medial recti
- Thyroid eye disease
- Ptosis + anophthalmic socket
- IR myositis

#### **Medicine & Neurology – Station 5 and 6**

- Sticklers syndrome
- CPEO – ptosis & strabismus, surgery before diagnosis made
- RA
- Metallic AVR
- Parkinson's/tremor
- Renal transplant/fistula
- Peripheral neuropathy/tremor
- Graves' disease
- Type 2 DM, R toe amputation, healed ulcers, reduced lower leg sensation. L. Charcot joint but in plaster cast. Bilate pre-proliferative DR and maculopathy.
- Autoimmune retinopathy on IVIG infusions
- Spondyloarthritis L. anterior uveitis R. posterior synechiae
- Type 1 DM, R. scleritis

- Wegner's granulomatosis, Saddle nose w/nasal mass enlargement. Hear valve replacement due to CUG
- Type 1 DM
- Acromegaly
- Other pituitary Cushings
- Other pituitary
- RA with swan neck, hand surgery, nodules
- Uveitis ocular and systemic sarcoidosis
- R. Incomplete III nerve palsy 2° acute midbrain infarct
- Lattice corneal dystrophy. Previous CVA. Lt. Hemiparesis – speech impaired.
- Rt. Homonymous hemianopia secondary to stroke
- Left VI nerve palsy acute onset, vascular origin
- Medical – Guttata asymptomatic
- Has RA with signs, also dry eye

### **Wednesday Afternoon**

#### **Station 1 – Cataract & Anterior Segment**

- R. Lattice dystrophy w/central corneal opacity. L penetrating keratoplasty
- Oculocutaneous albinism, keratoplasty
- Mucous membrane pemphigoid
- Graft vs host. Ocular surface disease secondary KCS
- Herpes simplex keratitis
- Bilateral Ascher rings
- Oculocutaneous albinism 3/60 VA R+L
- Exotropia, Aphakia, astigmatism
- Myasthenia Gravis Rt. HSK. Rt. Corneal melt (PUK)
- Fuchs endothelial dystrophy L. DSAEK
- Cataracts – Fuchs endothelial dystrophy
- Pseudophakia bullous keratopathy IOL dislocation

#### **Station 2 – Glaucoma & Lid**

- Oculocutaneous pemphigoid keratinisation
- R. Previous CRVO pseudoexfoliation
- R. Glaucoma R. CRVO
- Glaucoma, R. repaired RD
- Pigment dispersion glaucoma
- Pigmat dispersion syndrome
- POAG
- Rt. Fuch's heterochromic cyclitis
- Bilat advance glaucoma. Bilat pseudophakia
- High myope R. Aphakia L. PSCLO. R. failed rx Sx. L. Anterior uveitis – idiopathic
- Glaucoma
- R. disc inf cupping – angle recession
- Glaucoma surgery R+L. DS and Trab.
- Ptosis
- R. disc early cupping – angle recession

### **Station 3 – Posterior Segment**

- Birdshot retinopathy
- L. morning glory syndrome. L superior temporal chronic RD. Previous multiple RD repair w/heavy oil
- L. Microvascular ptosis. Diabetic maculopathy, L preprolif. DR.
- Refsum's disease – peripheral bone spicule pigmentation, Rt PSCO cat.
- White w-out pressure both eyes
- Bilat Retinoschisis R>L inferotemporal
- Stargardt's disease. Fundus flavimaculatus exotropia
- L. optic nerve head drusen. R. Old RD surgery/macular scar + inferior retinectomy
- Bilateral macular telangiectasia
- Chronic anterior uveitis
- RP
- Rt. Toxoplasma scar

### **Station 4 – Strabismus & Orbit**

- Duane's syndrome
- Rt. Superior oblique under-reaction w/Rt. Inferior oblique over-reaction
- Limitations post buckle
- Lacrimal mucocele
- Bilateral ptosis with down gaze palsy
- Consecutive LXT with LHT with left amblyopia
- 5 previous squint operations, consecutive XT with RHT and DVD.
- Vertical deviation under action of inferior rectus
- R. Decompensated esotropia – controlled by glasses
- TED N 4 XP
- R. EXotropia worse w-out spectacle correction
- Exotropia monocular double vision 6/6 Rt Amblyopic Lt.
- Convergence spasm and R SO under action
- Lt. Inferior rectus followed by weakening of both medial recti
- Thyroid eye disease

### **Medicine & Neurology – Station 5 and 6**

- Sticklers syndrome
- R III palsy. Ocular myasthenia (treated)
- CPEO – ptosis & strabismus surgery before diagnosis made
- Lt. background diabetic retinopathy. Rt. Previous macular oedema with exudates
- TED fitted w/12o base up L. lens
- Small R. ptosis. Dilated L pupil. Complete L. ptosis
- Juvenile idiopathic arthritis
- R. upper lid retractions, R+L lower lid retractions. R. mild exophthalmos
- Parkinson's
- Metallic AVR
- Parkinson's/tremor
- Renal transplant/fistula
- Peripheral neuropathy/tremor
- Graves' disease



- Thyroid eye disease
- Type 2 DM, R toe amputation, healed ulcers, reduced lower leg sensation. L. Charcot joint but in plaster cast. Bilate pre-proliferative DR and maculopathy.
- Lipodystrophy 2o HIV medication/HIV
- Autoimmune retinopathy on IVIG infusions
- Wegner's granulomatosis, Saddle nose w/nasal mass enlargement. Hear valve replacement due to CUG
- Type II DM (insulin) L. hemiplegia
- Acromegaly
- Other pituitary Cushings
- Other pituitary
- RA with swan neck, hand surgery, nodules
- Uveitis ocular and systemic sarcoidosis
- R. Incomplete III nerve palsy 2° acute midbrain infarct
- Lattice corneal dystrophy. Previous CVA. Lt. Hemiparesis – speech impaired
- Left VI nerve palsy acute onset, vascular origin
- Rt. Facial nerve palsy
- Goodpastures disease
- Diabetic with autonomic neuropathy

### **Thursday Morning**

#### **Station 1 – Cataract & Anterior Segment**

- R. Lattice dystrophy w/central corneal opacity. L penetrating keratoplasty
- Oculocutaneous albinism, keratoplasty
- Mucous membrane pemphigoid
- Graft vs host. Ocular surface disease secondary KCS
- Posterior polymorphous corneal dystrophy
- Bilateral Ascher rings
- Keratoconus. Recent R. INTACS inserted.
- Rt. Corneal melt (PUK) pressured polymyalgia rheumatic
- Lattice dystrophy (recurrence in graft)
- Cataracts – Fuchs endothelial dystrophy

#### **Station 2 – Glaucoma & Lid**

- Oculocutaneous pemphigoid keratinisation
- R. Previous CRVO pseudoexfoliation
- Molteno tube, glaucoma, stable treated diabetic retinopathy, L. maculopathy
- Glaucoma 360° posterior embryotoxon  
POAG
- Advanced POAG Lt.
- Bilat advance glaucoma. Bilat pseudophakia
- High myope L. pseudophakia R. NS+
- R. disc inf cupping – angle recession
- POAG with damaged discs and OAG fields
- L+R old deep sclerectomies and Lt. Phaco
- Alkali injury Lt. eye – ptosis opaque cornea
- Anterior segment dysgenesis. Complicated left cataract surgery. Left Ahmed valve. Lt. Zonulohyaloid vitrectomy.
- Rt. Corneal melt (PUK) previous polymyalgia rheumatica
- Ptosis

### **Station 3 – Posterior Segment**

- Birdshot retinopathy
- L. morning glory syndrome. L superior temporal chronic RD. Previous multiple RD repair w/heavy oil
- L. Microvascular ptosis. Diabetic maculopathy, L preprolif. DR.
- Refsum's disease – peripheral bone spicule pigmentation, Rt PSCP cat. Lt. PC IOL
- Refsum's disease – peripheral bone spicule pigmentation, Rt. PSCO cat.
- White w-out pressure both eyes
- Stargardt's disease. Fundus flavimaculatus exotropia
- Lt. background diabetic retinopathy, Rt. Previous macular oedema with exudates
- Pic BE L. old treated CNVM
- L. optic nerve head drusen. R. old RD surgery/macular scar + inferior retinectomy
- Chronic anterior uveitis
- 2 previous operations DVD w/LHT
- Radiation retinopathy
- Bilateral OHN drusen + Rt. Peripapillary CNV
- Intermediate uveitis
- Optic nerve drusen

### **Station 4 – Strabismus & Orbit**

- Thyroid eye disease
- Duane's syndrome
- Occl on R. lens to elevate Dip TED
- R. upper lid retractions R+L lower lid refractions. R. mild exophthalmos
- Down gaze palsy
- 25 PD exophoria breaking down to be manifest for near.
- Graves' disease
- Consecutive alternating exotropia w/alternating height, has had 1 previous operation
- Rt VI nerve, RIII nerve weakness and left amblyopia
- TED N 4 XP
- R. Exotropia worse w-out spectacle correction
- Decomp. Esophoria
- Thyroid Eye Disease
- Rt. Inferior rectus weakness of 6mm
- Lt. Hypotropia w/intermittent dip

### **Medicine & Neurology – Station 5 and 6**

- Lattice degeneration, bilateral PK
- CPEO – ptosis & strabismus, surgery before diagnosis made
- Pseudoxanthoma elasticum. Angioid streaks L. end stage CNV. R. Stable CNV.
- Psoriatic arthritis
- RA
- Parkinson's/tremor
- Peripheral neuropathy/tremor
- MS. R. Optic atrophy Pis. Old R. granulomatous uveitis

- Spondyloarthritis L. anterior uveitis, R. posterior synechiae
- Type I DM, R. scleritis
- Type I DM
- Acromegaly
- Other pituitary Cushings
- Rt. Facial nerve palsy
- Psoriatic arthritis
- Parkinson's – progressive supranuclear palsy
- Type I DM L. Hemiparesis Pump
- Stroke & mitral stenosis

### **Thursday Afternoon**

#### **Station 1 – Cataract & Anterior Segment**

- Lattice degeneration bilateral PK
- R. Lattice dystrophy w/central corneal opacity. L. penetrating keratoplasty.
- Oculocutaneous albinism, keratoplasty
- Mucous membrane pemphigoid
- Graft vs host. Ocular surface disease secondary KCS
- L. Herpes simplex keratitis
- Right HSK
- Keratoconus. Recent R INTACS inserted
- Oculocutaneous albinism 3/60 VA R+L
- Bilateral pseudophakic. High myopia, L HSV keratitis
- Exotropia, aphakia, astigmatism
- Myasthenia Gravis Rt. HSK Rt. Corneal melt (PUK)
- Lattice dystrophy (recurrence in graft)
- Cataracts – Fuchs endothelial dystrophy

#### **Station 2 – Glaucoma & Lid**

- Oculocutaneous pemphigoid keratinisation
- R. Previous CRVO pseudoexfoliation
- R. Glaucoma, R. CRVO
- Molteno tube, glaucoma, stable treated diabetic retinopathy, L. maculopathy
- POAG
- Rt. Previous uveitis. Fuchs HC but PS+++
- Rt. Corneal melt (PUK) pressured polymyalgia rheumatica
- Advanced POAG Lt.
- Bilat advance glaucoma. Bilat pseudophakia
- R disc inf cupping – angle recession
- Glaucoma surgery R+L DS and Trab
- POAG with damaged discs and OAG fields
- Entropion
- Alkali injury Lt eye – ptosis opaque cornea
- Ptosis

#### **Station 3 – Posterior Segment**

- Birdshot retinopathy
- L. morning glory syndrome. L superior temporal chronic RD. Previous multiple RD repair w/heavy oil

- L. Microvascular ptosis. Diabetic maculopathy, L preprolif DR
- Refsum's disease – peripheral bone spicule pigmentation, Rt PSCO cat
- White w-out pressure both eyes
- Stargardt's disease. Fundus flavimaculatus exotropia
- Lt. background diabetic retinopathy. Rt. Previous macular oedema with exudates
- Pic BE L. old treated CNVM
- L optic nerve head drusen R. old RD surgery/macular scar+inferior retinectomy
- Preprolif diabetic retinopathy NIR Type 2
- Chronic anterior uveitis
- Bilateral retinal/iris coloboma
- Radiation retinopathy
- Optic nerve drusen

#### **Station 4 – Strabismus & Orbit**

- Thyroid Eye Disease
- Duane's Syndrome
- Rt superior oblique under-reaction w/Rt inferior oblique over-reaction
- R upper lid retractions R+L lower lid retractions R mild exophthalmos
- Lacrimal mucocele
- Grave's disease
- Consecutive alternation exotropia w/alternating height, one previous operation
- Rt. Vin, RIII weakness and left amblyopia
- 2 previous operation with DVD w/LHT
- Rt. Acute onset sixth nerve palsy
- Right hypertropia
- Esotropia w/manifest latent nystagmus
- TED N 4 XP
- R. exotropia worse w-out spectacle correction
- Decomp. Esophoria
- Thyroid eye disease
- Rt. Inferior rectus weakness of 6mm
- Orbital schwannoma
- Exotropia 'V' pattern. Bimedial recti under action

#### **Medicine & Neurology – Station 5 and 6**

- Sticklers syndrome
- R III palsy. Ocular myasthenia (treated)
- CPEO-ptosis & strabismus, surgery before diagnosis made
- Pseudoxanthoma elasticum, Angioid streaks L. end stage CNV R. stable CNV
- TES fitted w.12o base up L lens
- Small R ptosis. Dilated L pupil. Complete L ptosis
- Parkinson's
- Psoriatic arthritis
- Parkinson's/tremor
- Bilateral Vin weakness L.R. Diplopia controlled with prism.
- Parkinson's
- MS. R. optic atrophy Pis. R. Granulomatous uveitis
- Thyroid eye disease
- Lipodystrophy 2o HIV medication/HIV

- Type II DM (insulin) L. hemiplegia
- Acromegaly
- Other Pituitary Cushings
- Goodpasture's disease
- 6<sup>th</sup> w/previous transposition (eye muscle surgery) and homonymous hemianopia – RTA causation
- Diabetic with autonomic neuropathy

### 3a) Results

Candidates examine three patients in stations 1-3, two patients in station 4, four patients in station 5 and one patient in station 6. Each patient is worth a maximum of 12 marks (2 examiners x 3 marks x 2 criteria). To balance the contribution to a candidate's mark from each station, the mark from each of stations 1-3 and 7 is weighted by 0.666. The relative contribution from each station in the OSCE is thus 2,2,2,2,4,1.

Maximum mark after weighting: 156

Stations 1-3: 2 criteria scored 0-3 for 3 patients by 2 examiners x 0.666 = 24

Station 4: 2 criteria scored 0-3 for 2 patients by 2 examiners = 24

Station 5: 2 criteria scored 0-3 for 4 patients by 2 examiners = 48

Station 6: 3 criteria scored 0-3 for 1 patient/actor by 2 examiners x 0.666 = 12

Pass mark (using borderline candidate method):	87/156
Mean score:	99/156
Median score:	100/156
Range:	58-142
SD	20.76
Reliability (Cronbach alpha):	0.80
SEM:	9
Adjusted pass mark (+1 SEM)	96/156 (62%)

Pass rate before adjustment (pass mark 87/156)	49/67 (73%)
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Pass rate after adjustment (pass mark 96/156)	38/67 (56%)
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**Table 6 Distribution of scores**

Score	Distribution	Total
51-60	/	1
61-70	////	5
71-80	//// III	8
81-90	//// III	8
91-100	//// IIII II	12
101-110	//// IIII I	11
111-120	//// IIII	10
121-130	//// III	8
131-140	//	2
141-150	//	2
Total		67

**Table 7 Station marks (before weighting)**

Station		Maximum possible	Mean	Median	Min	Max
1	Anterior segment & cataract	36	25	25	7	36
2	Glaucoma & lid	36	26	27	13	36
3	Posterior segment	36	25	25	12	36
4	Paediatric & strabismus	24	14	13	1	24
5/6	Medicine and neurology	48	28	29	11	47
7	Communication	18	11	12	1	18

**Table 8 Correlation between examiner's marks at each station**

Station 1	Station 2	Station 3	Station 4	Station 5/6	Station 7
Cat/AS	Glauc/lid	Posterior	Orbit/Strab	Med/neuro	Comm.
0.9	0.63	0.65	0.91	0.64	0.65

**Table 9 Correlation between examiner's global judgements at each station**

Station 1	Station 2	Station 3	Station 4	Station 5/6	Station 7
Cat/AS	Glauc/lid	Posterior	Orbit/Strab	Med/neuro	Comm.
0.83	0.64	0.75	0.87	0.61	0.64

**Table 10 Correlation between station scores (combined marks 2 examiners)**

		Station 2	Station 3	Station 4	Station 5/6	Station 7
		Glauc/lid	Posterior	Orbit/Strab	Med/neuro	Comm.
Station 1	Cat/AS	0.41	0.15	0.15	0.3	0.06
Station 2	Glauc/lid		0.06	0.25	0.39	0.2
Station 3	Posterior			0.25	0.36	0.09
Station 4	Orbit/Strab				0.38	0.22
Station 5	Med/neuro					0.3

**3b) Standard setting for the OSCE**

Station	1		2		3		4		5 & 6		7	
No. of borderline candidates	22	23	22	18	24	22	17	20	17	21	18	21
Median borderline candidate score	6.7	7.3	7.3	6.7	6.7	8.3	7	6	14	12	3	2.7

The pass mark for the OSCE was increased by 1 SEM from 87/156 to 96/156 (62%).

**4a) Overall results for the oral examination**

Pass mark	170/276
Mean	185.5/276
Median	189/256
Range	123-251

To pass the oral examination candidates must achieve 170/276 overall, 68/120 in the viva and 96/156 in the OSCE)

Pass rate for the oral examination	38/67 (57%)
Pass rate for the entire examination	38/104 (37%)

**Table 11 Distribution of scores**

Score	Distribution	Total
121-130	///	3
131-140	//// /	6
141-150	///	3
151-160	//// /	6
161-170	//// /	5
171-180	//// /	5
181-190	//// //	7
191-200	//// ////	10
201-210	///	4
211-220	//// /	6
221-230	////	5
231-240	////	5
241-250	/	1
251-260	/	1
Total		

**Table 12 Correlation between scores in each part of examination**

	EMQ	VIVA	OSCE
MCQ	0.25	0.25	0.27
EMQ		0.34	0.21
VIVA			0.75

Correlation between written and oral examinations 0.36

#### 4b) Breakdown of Oral Examination

**Table 13 Breakdown of results by training**

	Failed	Passed	Total
In OST	21	36	57
Not in OST	8	2	10
Total	29	38	67

**These differences are statistically significant (p = 0.016)**

Pass rate for the oral examination for candidates in OST 36/57 (63%)  
 Pass rate for the Part 2 examination for candidates in OST 36/85 (42%)

**Table 14 Breakdown of results by gender**

	Failed	Passed	Total
Female	5	12	17
Male	24	26	50
Total	29	38	67

These differences are not statistically significant (p = 0.26)

**Table 15 Breakdown of results by deanery**

	Failed	Passed	Total
East Midlands	1	1	2
East of England	1	2	3
London	3	14	17
Mersey	1	1	2
North Western	3	3	6
Northern	1	2	3
Northern Ireland	1	2	3
Oxford	1	2	3
Peninsula	1	1	2
Scotland West	1	0	1
Severn	1	2	3
Wales	2	3	5
Wessex	1	1	2
West Midlands	0	1	1
Yorkshire	2	1	3

**Table 16 Breakdown of results by level of training**

	Failed	Passed	Total
ST3	1	0	1
ST4	1	2	3
ST5	4	15	19
ST6	4	9	13
ST7	4	4	8
Total	14	30	44

**Table 17 Breakdown of results by country of qualification**

	Failed	Passed	Total
UK	10	30	40
Outside UK (Inc Republic of Ireland)	19	8	27
Total	29	38	67

**These differences are statistically significant (p = 0.0004)**

**Table 18 Breakdown of results by first language**

	Failed	Passed	Total
English	16	31	47
Other	12	5	17
Total	28	36	64

**These differences are statistically significant (p = 0.012)**

**Table 19 Breakdown of results by ethnicity**

	Failed	Passed	Total
White	6	12	18
Non-white	23	25	48
Total	29	37	66

These differences are not statistically significant for white/non-white (p = 0.40)



**Table 20 Ethnicity of candidates in OST**

Ethnicity	In OST	Not in OST	Total
White	17	1	18
Non-white	40	10	50
	57	11	68

**Table 21 Breakdown for candidates in OST by ethnicity**

Ethnicity	Fail	Pass	Total
White	4	12	16
Non-white	17	23	40
	21	35	56

These differences are not statistically significant for white/non-white in training  
(P = 0.36)

**Table 22 Breakdown of results by number of previous attempts**

Attempts	Failed	Passed	Total
1 (First)	15	27 (64%)	42
2	10	8 (44%)	18
3	3	1 (25%)	4
4	1	1 (50%)	2
5	0	0 (0%)	0
6	0	1 (100%)	1
Any resit	14	11 (44%)	25

#### **4c) Breakdown of both parts of the examination (written and oral)**

**Table 23 Breakdown of results by training**

	Failed	Passed	Total
In OST	48	36	84
Not in OST	17	2	19
Total	65	38	103

**These differences are statistically significant (p = 0.008)**

**Table 24 Breakdown of results by gender**

	Failed	Passed	Total
Female	15	12	27
Male	50	26	76
Total	65	38	103

These differences are not statistically significant (p = 0.36)

**Table 25 Breakdown of results by deanery**

	Failed	Passed	Total
East Midlands	1	1	2
East of England	1	2	4
London	10	14	24
Mersey	2	1	3
North Western	7	3	10
Northern	3	2	5
Northern Ireland	1	2	3
Oxford	1	2	3
Peninsula	3	1	4
Scotland North	1	0	1
Scotland South East	1	0	1
Scotland West	2	0	2
Severn	2	2	4
Wales	3	3	6
Wessex	2	1	3
West Midlands	3	1	4
Yorkshire	4	1	5

**Table 26 Breakdown of results by level of training**

	Failed	Passed	Total
ST3	1	0	1
ST4	4	2	6
ST5	11	15	26
ST6	12	9	21
ST7	10	4	14
Total	38	30	68

**Table 27 Breakdown of results by country of qualification**

	Failed	Passed	Total
UK	27	30	57
Outside UK (Inc Republic of Ireland)	38	8	46
Total	65	38	103

**These differences are statistically significant (p = 0.0004)**

**Table 28 Breakdown of results by first language**

	Failed	Passed	Total
English	39	31	70
Other	26	5	31
Total	65	36	101

**These differences are statistically significant (p = 0.007)**

**Table 29 Breakdown of results by ethnicity**

	Failed	Passed	Total
White	18	12	30
Non-white	47	25	72
Total	65	37	102

These differences are not statistically significant for white/non-white (p = 0.66)

**Table 30 Breakdown for candidates in OST by ethnicity for the examination overall (written and oral parts)**

Ethnicity	Fail	Pass	Total
White	13	12	25
Non-white	35	23	58
	48	35	83

These differences are not statistically significant for white/non-white candidates in ophthalmic specialist training (p = 0.62)

**4d) Table 31 Comparison to previous examinations**

Date	Oct 08	April 09	Sept 09	April 10	Oct 10	April 11	Nov 11	April 12
Candidates	7	15	16	21	26	46	77	104
MCQ pass mark	61%	64%	64%	66%	65%	65%	58%	58%
Reliability	0.55	0.81	0.77	0.83	0.77	0.70	0.70	0.70
EMQ pass mark	64%	64%	66%	65%	64%	65%	59%	58%
Reliability	0.82	0.90	0.83	0.86	0.81	0.7	0.7	0.72
Viva pass mark	59%	59%	64%	57%	56%	63%	60%	62%
Reliability	0.88	0.80	0.84	0.90	0.79	0.79	0.81	0.84
OSCE pass mark	65%	60%	63%	61%	62%	63%	65%	62%
Reliability	0.85	0.82	0.94	0.80	0.87	0.85	0.83	0.80
Written pass rate	86%	53%	38%	48%	58%	46%	68%	65%
Oral pass rate	50%	50%	33%	50%	73%	71%	54%	57%
Overall pass rate	29%	27%	13%	24%	58%	33%	35%	37%

**Table 32 Cumulative results by deanery (September 2010 to date)**

Deanery	Number of passes	Candidates	Pass rate %
Northern Ireland	3	4	75
Mersey	5	7	71
East of England	2	3	67
Severn	8	12	67
Oxford	7	11	64
London	29	48	60
East Midlands	4	8	50
Northern	3	6	50
Scotland North	1	2	50
Scotland South East	2	4	50
Peninsula	2	5	40
Wales	3	10	30
West Midlands	5	17	29
North Western	3	11	27
Yorkshire	5	20	25
Wessex	1	5	20
Scotland West	0	3	0

## 5) Summary

The Part 2 FRCOphth examination is now attracting significantly more candidates, with 104 candidates sitting the examination in February/April 2012. The pass rate for the written papers was 65%, of whom 57% went on to pass the oral examination. The overall pass rate was low with only a 37% pass rate.

The two written papers have a less than optimal reliability, probably caused by the relatively limited number of questions in each paper on its own. Planned changes to the written examination from 2013 should address this. The oral examinations have an acceptable reliability above 0.8.

There is a good correlation between the performance of candidates in the 2 parts of the oral examination.

Candidates who are not in OST, those who graduated outside the UK and those who do not have English as their first language perform less well in the examination.

Michael Nelson BSc (Hons) FRCOphth MAEd  
**Education Adviser**

June 2012

## **Appendix 1: Candidate evaluation**

### **Structured viva**

#### **Viva Station 1 Patient Investigations & Data Interpretation**

##### **Were you treated in a courteous manner by the examiners?**

Yes 94%  
No 6%

- Opening question was very indirect and non-specific. Could not provide differentials from just one sign – more information requested but difficult to extract.
- Given scenario, asked clarification and referred back to scenario – good (Horner's pupil)
- Very nice, put me at ease and made sure questions were clear.
- Second guessing the answers the examiners were trying to extract was difficult: on several occasions they 'dug' for an answer I had already given – and I suppose my answer wasn't noted.
- Nice examiners
- Friendly examiners, clear questions

##### **Were the questions appropriate for the station?**

Yes 94%  
No 6%

- The questions could have been better structured with less of an emphasis on the physiological basis of a test but rather its clinical interpretation and relevance to a patient.
- Asked about other scenarios (after finishing the main scenario) – good
- They weren't really data interpretation related.
- The ptosis in the picture was not very convincing
- Appropriate questions on pupil examination.

##### **Were the questions of an appropriate standard for an exit examination?**

Yes 100%  
No 0

- I did not feel this scenario reflected an exit level assessment but this may have been more to do with how it was delivered rather than the content.
- Had 1 minute to spare

#### **Viva station 2 Patient Management 1**

##### **Were you treated in a courteous manner by the examiners?**

Yes 100%  
No 0

- Very clear and concise instructions with delivery of information in a timely method to allow a discussion to take place (compare this to previous station – PI)
- Given scenario, questioned about initial differentials (thoughts)
- Both very nice, but I found one examiner a bit unclear as to the questions he was asking (which may well be a reflection of my lack of knowledge rather than poor examining technique!)
- Examiners very kind and understanding. They smiled and made it easier to think.
- Friendly examiners, clear questions
- Being my first station it was nice to see that the examiners made an effort to put me at ease.

### **Were the questions appropriate for the station?**

Yes 100%  
No 0

- Well-structured and clear questions.
- Once I got lost with the manner the question was framed but understood once it was reframed (TED)
- They looked for an answer of anti-VEGF for CSR. Digging for an inappropriate treatment is a little silly.
- Good range of questions assessing different areas of knowledge
- Appropriate questions on thyroid eye disease.

### **Were the questions of an appropriate standard for an exit examination?**

Yes 100%  
No 0

- Good station and scenario
- Friendly examiners
- A little 'trick' to try and fool you. But part of the fun of an exam.

### **Viva station 3 Patient Management 2**

#### **Were you treated in a courteous manner by the examiners?**

Yes 100%  
No 0

- Well-structured station, Good lead into topic and elaboration of topic. Well-spoken and clear examiners.
- Very relaxed atmosphere (Macular hole)
- One examiner in particular was very friendly and put me at ease.

#### **Were the questions appropriate for the station?**

Yes 100%  
No 0

- Detailed discussion about the entire subject
- I found the line of questioning in this station very oblique. Very open questions such as “tell me about posturing” (which I was asked) are a bad idea in time-pressured, ten-minute stations because if the candidate goes down one path (e.g. talks mostly about the evidence, or mechanism, or patient experience etc) then the examiners have lost time to check the candidate knows what they’re really asking about. Better to ask focused questions such as “what does a patient need to know about posturing?” or “how does posturing work?” which then doesn’t waste time.

**Were the questions of an appropriate standard for an exit examination?**

Yes 100%  
No 0

- Guided to discuss evidence behind management strategies, which is what is expected at this level.
- Had 1 minute to spare, asked 1 question but was told not a part of the exam! – Friendly examiner.

**Viva station 4 Attitude, Ethics and Responsibilities**

**Were you treated in a courteous manner by the examiners?**

Yes 94%  
No 6%

- Clear scenario and questions by examiners, concise and allowed discussion.
- Examiner offered to shake-hand, felt at ease (NH)
- Very much so.

**Were the questions appropriate for the station?**

Yes 94%  
No 6%

- Last part suddenly switched to ‘new scenario’, not much time to discuss (possibly domestic violence)
- Clear questions asked by examiners
- One examiner could have been a bit more specific with this question
- Questions did not cover a broad range of ethical dilemmas but only focused on one aspect of ethics not adequately assessing my knowledge.
- Question towards the end of adult woman presenting with same injury as a baby – difficult to know what examiners were getting at – their questions became even more open such as “now what do you think?” to which there could be hundreds of answers, all appropriate. Need to ask more focused questions, like in the other stations.

**Were the questions of an appropriate standard for an exit examination?**

Yes 94%  
No 6%



## **Viva station 5      Audit, research and evidence based medicine**

### **Were you treated in a courteous manner by the examiners?**

Yes 88%  
No 12%

- Examiners not helpful
- Nice examiners
- Examiners smiled and put me at ease!
- Friendly examiners, clear questions

### **Were the questions appropriate for the station?**

Yes 88%  
No 12%

- The picture was of PDR (in pregnancy), discussion on that – asked about follows up guidelines (NICE). Switched to diabetic, not yet pregnant, in the middle. Managed to get myself confused with regards to which follow up: PDR or early BDR in pregnancy.
- Laser safety nurse? Not in my hospital. It was clearly something the examiners were looking for.
- One of the questions is how does the patient take bisphosphonates which is not routinely prescribed by ophthalmologist in clinical practice
- The photo of diabetic retinopathy in pregnancy was not totally clear – it was not clear if there was neovascularisation at the disc and there was no way to establish if there had been a vitreous haemorrhage since this information was not provided and not available from the photo
- The fundus photos were in a plastic envelope, which caused light reflection and made them difficult to see! Also we were asked to grade the diabetic retinopathy despite the fact that only the posterior pole (and nothing nasal to the disc) was visible – not really what you do in real life where you need to see all 4 quadrants before you can examine.
- Management of diabetic retinopathy in pregnancy is a poor topic that has multiple potential answers.

### **Were the questions of an appropriate standard for an exit examination?**

Yes 94%  
No 6%

- Some questions seemed obscure to daily clinical practice (e.g. how often does one look at a patient's T score) but nevertheless the importance of evidence-based practice is appreciated.

## **Overall Feedback on the Structured Vivas**

### **Was the structured viva well organised?**

Yes 94%  
No 6%

- Excellent venue
- Congrats to all the staff for being friendly, clear and running a tight ship. Thank you.
- Exceptionally well organized.
- Well run Viva
- Well organised, ran smoothly.

### **Were you given clear instructions about the structured viva examination?**

Yes 100%  
No 0

- Examination college staff giving helpful instructions in between stations
- The Instructions to Candidates manual stated that we would be given a 5-minute notice during the Communications section, which I never received. Therefore, a lot of points that I would have like to discuss were left untouched.
- Apart from the note-taking issue with Communication Skills mentioned previously.

### **Did you feel that the structured viva examination was a fair assessment of your knowledge?**

Yes 94%  
No 6%

- There are a few factors which I feel could be improved.
- Though this depends on how it is marked! Hopefully some consideration is taken that this is a very artificial environment, and when discussing what you would do it is different to if a patient is there in front of you!
- But non-focused questioning always wasted time.

### **In your opinion should the structured viva examination be included in the exit examination?**

Yes 94%  
No 6%

- This remains an excellent method to test a candidate's ability to assimilate and communicate effectively but is dependent on the delivery of station by examiners.
- Definitely
- It is a much fairer reflection of clinical acumen than the written.

## General comments on structured vivas

- The room was secluded, away from other distractions. Candidates had enough 'space' to concentrate. Sometimes could overhear candidate from adjacent station, but not too bad.
- In general it's a good and fair way of assessing different topics relevant to the exit exam. The examination structure seems sensible and should not need changing.
- Different examiners will have different examining styles, but the main problem with the structured viva is that some examiners seem to default to very open questions. This is fine for a half-hour viva, but not for a ten-minute station in which several key points need to be covered. The reason is that examiners often have in mind one particular aspect of a topic, despite asking a very open question, and there is a lot of time-wastage while the candidate tries to figure out what the examiner wants to know. For example, after describing a clinical presentation, rather than "what do you think?" how about "what is the differential diagnosis?" or "what is the most likely diagnosis". Subsequently. Rather than "what would you do?" how about "how would you investigate?" or "how would you manage/treat?"
- In general I felt that in those stations where the examiners stuck to clear, direct questions, I had finished before time and was asked to leave the station early; in those stations where the examiners were mostly asking very open or oblique questions we always seemed to run out of time and I felt I had not been able to adequately demonstrate my knowledge in the area, because it took so much time to clarify what the questions actually were.
- I was very impressed by how well the viva was organised. A real credit to all involved. Really it is hard to fault the standard of questions and topics used – I would not have expected any less from an exit exam. My only concern relates not to the college or exam but my realisation that colleagues I have met from some European countries are able to get onto the specialist register having been through a training program and exam structure that is really not up to the same standard as the RCOPHTH exams and don't cover the same domains as our curriculum. It worries me that that if all goes well and I get through and eventually get on the specialist register we will essentially be treated the same. I cannot see how this can be fair.

## OSCE

### OSCE station 1    Cataract and Anterior Segment

#### **Were you treated in a courteous manner by the examiners in this station?**

Yes    72%  
No     18%

- Very professional, considerate clear examiners
- Pleasant examiners
- Very friendly
- Very much so – absolute gentlemen.
- Unfortunately, this station was the only one in which I felt that, at times, my knowledge was not being tested and the only one I found unpleasant and unnecessarily stressful. At times, the examiners appeared to have questions in mind, which they wanted me to answer, but they never actually verbalized those questions and reacted negatively when I answered what I thought they were asking. I then asked what they were actually asking me but they just moved on so I never got a chance to answer.
- Interrupted by the examiners constantly, very difficult to establish a train of thought.
- This station really stood out from the other stations for me. The examiners seemed rushed and hassled. I accept that this is a final professional exam and being put under pressure is part of it but the examiners felt quite confrontational, for example often following my answers with “Oh really”; “is that what you think”; “That’s an answer I expect from a nurse” (I hadn’t quite finished my answer yet). I also accept that I probably did not give the answers expected of me but is it really necessary to be so adversarial? Maybe they were pushing to help me but compared to all the other stations the tactics/methods used seemed really out of place. Please do not take this as a criticism towards the individual examiners who I appreciate are trying to do their best in the short time allocated at each station.

#### **Were the patients you were asked to examine appropriate for the station?**

Yes    100%  
No     0

- Relevant cases and questions
- 1 case was ‘rare’, never seen before (cornea = stromal ring like deposit -? drug toxicity)
- Good cases. Last one very challenging.
- Although all 3 had corneal changes only. I thought perhaps the station might cover other features of anterior segment and cataract.

#### **Were the questions of an appropriate standard for an exit examination?**

Yes    100%  
No     0

- When I was unable to answer a question the examiner gave me his expected answer – which was incorrect but I didn’t argue.

- I was asked about torque vs anti-torque suturing of a penetrating graft, which I felt was a little too subspecialist for a general exit exam. I've worked for 4 corneal consultants and have never heard of these terms!
- Again another aspect that stood out was the style of questioning compared to the other stations. Quite often I felt I was being asked quite general questions (e.g. on management) but the examiners appeared to be looking for very specific answers.
- Wanted me to answer "anterior segment OCT" for all patients. When I stated that we do not have one at my department, the reply was "change department".

## **OSCE station 2    Glaucoma and eyelid**

**Were you treated in a courteous manner by the examiners in this station?**

Yes    100%  
No      0

- Although some questions were not clear and one had to double check what the examiners meant
- Felt a bit rushed with couple of questions (maybe because of time constraints)
- Nice examiners
- These examiners were very friendly; this made it very easy to have a clinical discussion with them
- Extremely so. I actually enjoyed this station!
- Friendly examiners

**Were the patients you were asked to examine appropriate for the station?**

Yes    100%  
No      0

- Quite a few of the questions were obscure and unclear – I felt some of the questions could have been more relevant to practical management of these patients rather than asking about slit-lamp techniques.
- Good cases
- The 90D provided was really smudged!

**Were the questions of an appropriate standard for an exit examination?**

Yes    100%  
No      0

## **OSCE station 3    Posterior Segment**

**Were you treated in a courteous manner by the examiners in this station?**

Yes    88%  
No      12%

- Unfortunately, I felt the attitude of both examiners in the station was particularly unfriendly and unhelpful
- Friendly

- I'm afraid one of the examiners made two obviously sarcastic comments to me, as follows:
  - (i) After I'd finished examining a lady's fundus with the indirect ophthalmoscope, as I removed the instrument from my head he said "well I'm going to assume that you saw nothing because you didn't say anything while you were examining"  
(*Solution: standardise expectations so that candidates know whether to present as they examine, or afterwards – for all stations*)
  - (ii) After I mentioned that the lady had a pigmentary retinopathy, he said, "what would you do?" (An inappropriately open question with 60 seconds remaining) and after I answered with which investigations I'd do (as I knew I had about 60 seconds left) he said "well how about starting with a history?" (I would like to think that no candidate would order Electroretinography without taking a history)  
(*Solution: discourage examiners from asking such open questions with so little time remaining and instead have focussed ones e.g. "what would you look for in the history?"*)

### **Were the patients you were asked to examine appropriate for the station?**

Yes 94%  
No 6%

- 2 out of the 3 patients were relevant but for the last patient, I was advised that a clinical sign was not there that I had described even though I was clearly seeing it. I felt the closed nature of their response was particularly disheartening.
- Missed one sign, which was different from the main diagnosis, allowed to have a second look.
- Hard cases though! Maybe one straightforward case out of the 3 would have been nice, ha ha! Wish I could find out what the diagnosis of one of them was!!
- Good variety of patients
- Doing indirect ophthalmoscopy on a patient sitting down is not always easy for a short ophthalmologist. I was asked to examine the inferior retina of a tall man with a prominent brow while he was sitting and this was not possible. IDO should be done with a patient lying down so that all areas of the retina may be viewed easily.
- However it would have been preferable to be able to examine the patient lying down for the indirect part of the examination rather than sitting up, as I couldn't reach.
- Two patients were not cooperative in examination i.e. closing their eyes in spite of lowering the intensity of slit lamp light while examining which made them difficult to examine under exam conditions
- Sectoral retinitis pigmentosa is rare.

### **Were the questions of an appropriate standard for an exit examination?**

Yes 94%  
No 6%

- Obscure questions with no relevance to clinical assessment, management and thought processes.
- Challenging, but as long as the marking is appropriately pragmatic, I think it is fair.

## **OSCE station 4    Strabismus and Orbit**

**Were you treated in a courteous manner by the examiners in this station?**

Yes 94%  
No 6%

- Although examiners were courteous, there was a tendency to interrupt during the motility examination, which would break the flow of the exam. May be better to let candidates finish their examination and then summarise findings.
- Very friendly
- Very much so.
- Polite, relaxed and engaging. It felt like a discussion rather than an interrogation.
- Whilst struggling with examining a patient the examiner barked me at.

**Were the patients you were asked to examine appropriate for the station?**

Yes 88%  
No 12%

- Asked to talk through findings (which helped in ocular motility)!
- The orbit patient was not cooperative to give detailed history of her medical condition.
- I had two thyroid eye disease patients, which are known to be difficult to examine. Therefore I could not show I knew how to examine motility/orbit.

**Were the questions of an appropriate standard for an exit examination?**

Yes 100%  
No 0

- Good questions asked by the examiners

## **OSCE station 5    Medicine and Neurology**

**Were you treated in a courteous manner by the examiners in this station?**

Yes 94%  
No 6%

- Examiners differed in their conduct of the station but generally satisfactory (one particularly clear and helpful, the other less so).
- Started off well, relaxed.
- Very much so.
- Very courteous examiners. It was easy to think and answer answers with these examiners
- Very reassuring and calm.
- Asking questions about very rare conditions not commonly seen in routine practice like a disease causing bilateral optic atrophy treated with Immunoglobulin? What is the drug that causes Lipodystrophy? Asking about the facial appearance of a patient who has Lipodystrophy, which is a rare condition.

### Were the patients you were asked to examine appropriate for the station?

Yes 88%

No 12%

- 4<sup>th</sup> patient disappeared! Examiners were reassuring before found 'another case'. Got stressed a bit – but I guess it is an exam!
- I'm not convinced purely neurological cases, with no ophthalmological significance, are necessary to determine if someone will be a good ophthalmology consultant. Having said that, the examiner was friendly and encouraging, and I enjoyed the challenge.
- A variety of patients with good signs
- I had to do a cardiovascular exam with the patient still fully clothed. I couldn't tell if the murmur was real or just her jumper rubbing on my stethoscope!
- Patients are not very cooperative

### Were the questions of an appropriate standard for an exit examination?

Yes 88%

No 12%

- Lipodystrophy – unfair for an ophthalmology exam
- In my opinion 2 cases were not a common diseases that help in good assessment of exit examination
- I wasn't allowed to examine patients with a slit lamp or indirect ophthalmoscope. All ophthalmic findings had to be ascertained from an ophthalmoscope, which whilst not unreasonable, doesn't reflect practice. No other candidates that I spoke to were asked to use an ophthalmoscope.
- Neurologist wanted to keep talking about mitochondrial inheritance

### OSCE station      Communication Skills

#### Were you treated in a courteous manner by the examiners?

Yes 100%

No 0

- Indifferent, I guess because the 'patient actor' was the main focus.

#### Was the clinical scenario explained clearly?

Yes 88%

No 12%

- Given time to think about
- But, I wish we could have taken the scenario in with us. We were allowed to make notes, but I didn't take down the patient's name as it didn't cross my mind before (such an artificial situation). I don't see why we couldn't take all the printed information with us.
- The patient mainly complained of decreased vision for reading. In the clinical scenario, only her distance vision was mentioned which made it difficult to give very clear advice. It would have been useful to know her near vision as well.
- 1. I had a misunderstanding with the invigilator, who I thought had told me that the paper provided was for note taking *during* the interview. Consequently I left it blank outside the interview room, and just before entering the room the



invigilator commented to me that I hadn't taken any notes. It was then that I realised that we had had the opportunity of taking notes, but I hadn't done so, and unfortunately this put me in totally the wrong frame of mind for the interview, in which I feel I subsequently underperformed.

2. The scenario said that we had operated on the wrong eye, but did not specify which operation. If the recess-resect had been executed to still move the eyes away from each other, then the wrong-eye operation might still have cured the squint. But if, thinking that we were operating on the other eye, the MR/LR procedures had been unaltered, and then the child would have had a worse squint and would need another operation. This would obviously alter how we counselled the mother, and should have been explained more clearly – the confusion as to which operation we'd actually done on the wrong eye (which in real life you'd know, having just done it) made it difficult to give confident answers to the mother. Also I was unsure if taking one particular route (e.g., that the eyes had still been moved away from each other and there was hence a chance that the child wouldn't need further surgery) would cause me to be marked down. Also, it didn't mention whether we were the consultant, trainee, etc. so we had to make up answers to the mother's questions as we went along, which felt very artificial.

- Wrong eye surgery on child squint; no information given as to what type of squint and how child was after surgery therefore difficult to counsel patient's mother.

### **Was the clinical scenario appropriate for an exit examination?**

Yes 88%  
No 12%

- Although a clear scenario, I would like to state two important points:
  - 1) There was no warning before the end of the station as was expected from the exam information from the College.
  - 2) If the actor in the station becomes emotional, it can be difficult to stick to the time period and make all the points necessary. It may be necessary to advise actors to limit this during the scenario.
- Actor was a 'strong actor' in the setting of a 'complete scenario'
- Good scenario
- Not particularly challenging really?
- Not sure how much this contributed to the exam. Candidates were not expected to say a great deal. Actor did most of the talking.
- I realize that the whole point of this station was to test communication skills in a stressful situation however the actress (who was excellent and very convincing) reacted so vehemently and so quickly to every sentence (interrupting each sentence) that I never actually got to speak as that would have involved interrupting her. In a real life situation then there would be more time and more resources to go over all the necessary information (i.e. low visual aids, AREDS supplements, support from social services, driving) indeed I'd probably have brought her back another time with her husband for example, rather than try and cover all of it in 10 minutes, but, in the exam, I was aware that all of that needed to be covered (as I'm sure we were marked on whether we gave that information) and I felt I wasn't given the chance (and it felt inappropriate to raise some of the issues during this initial "consultation"). I felt that her reaction was a little too over the top and therefore the station felt very artificial and, in my opinion, didn't actually test my real life communication skills.

- Very good actors, although from speaking to other candidates, the degree to which the actors gave them a hard time varied considerably from one actor (very quickly pacified) to another (crying, constantly aggressive)!
- The actress was very aggressive and confrontational (realistic!) but speaking to other groups, their actress was much more subdued so they were able to explain issues better, I hope this is taken into consideration.

## **The OSCE overall**

### **Was the OSCE well organised?**

**Yes** 88%  
**No** 12%

- However, I noted an irregular and sometimes long waiting time between the stations
- Bit cluttered having to wait outside room with patients all around – little distracting.
- Very much so – thanks!
- Well run OSCE
- Excellent mix of patients and very well run
- The team were highly efficient and supportive
- Time is not very well managed by examiners
- But it started very late so we had to wait for almost an hour after we'd arrived

### **Were you given clear instructions about the OSCE?**

**Yes** 94%  
**No** 6%

- I feel this could have been better done and at a slower pace. It seemed rushed.
- Some examiners wanted us to talk through our findings while examining patients; others were happy to let us examine and present our findings at the end – but often the instructions were not clear. In my first (strabismus) station I was allowed to examine and then present later. But in my second station, I received a sarcastic comment for not having talked through my findings while I examined. Perhaps all candidates and examiners could be given clear instructions as to how to approach the presentation of findings and perhaps this could be standardised across all examiners, and all stations. In view of the time pressure, I'd suggest that all candidates are instructed to present their findings as they examine (which admittedly feels unusual as it's not done in normal clinical practice), and that this is made clear to all patients and examiners.

### **Did you feel that the OSCE was a fair assessment of your knowledge?**

**Yes** 69%  
**No** 31%

- Certain stations did not test me to the best of my abilities e.g. the posterior segment station, which I found very jumbled and disjointed.
- Well, impossible to fairly assess anyone's knowledge in a short period of time. But I think a reasonable way of ranking candidates.

- A wide variety of patients used across all sub-specialties
- Yes apart from the Cataract and Anterior Segment station
- In isolation, I do not think the OSCE allows you to demonstrate knowledge well, but when combined with the written and VIVA think it does so
- It's a very high pressure, stressful situation. It is difficult to know how best to present yourself, knowledge and understanding in this environment. Guidance from the college on what is expected from a candidate to pass each section would be helpful.

**In your opinion should the OSCE be included in the exit examination?**

**Yes** 94%  
**No** 6%

- Of course!
- Absolutely – this is what makes our system/exam stand out globally. It is essential a clinical component with patients remains, and it is something the college can be proud of. Others need to replicate to match the high standard set. Well worth all the effort.
- Clinical skills assessment is important in final FRCOphth exams
- Although it is perhaps better placed as it used to be at the start of specialist training.
- 1-In my opinion it is better to decrease number of patients and decrease number of questions to fit for the time allocated for each case  
 2- Medicine and neurology station needs to be more focused on ophthalmologically related medical and neurological conditions.

**Please write any other comments you have about the OSCE below.**

- The two components of the oral examination are excellent methods of assessment for an exit however they can be compromised by the quality of examiners and their experience of guiding candidates through an anxious experience. I hope that the feedback provided will improve the system for future candidates. Please note that the conduct of the examiners plays a big role in how well a station achieves its aims.
- Communication skills station is not a realistic demonstration of communication skills in actual practice as not normally being watched and assessed.
- Overall ALL examiners put me at ease despite me being very nervous and anxious. And felt like the examiners were trying to help me rather than fail me. Follow on questions were appropriate.
- The time in the OSCE is quite limited and the situation artificial since there is no history. I'm not sure how real it therefore reflects ability to deal with clinical signs. I do however think it is an important exam to combine with the written and VIVA.
- It was overall well organised and run, and the patients were great. The basic OSCE structure is a fair assessment and I don't think needs altering - but I did feel there was enormous time pressure in some stations and perhaps 15 minutes per station would be better. The examining styles of different examiners varied enormously, but I see no solution to this, other than perhaps extending each station to 15 minutes.  
 As with the viva, I felt that the use of open questions was counter-productive in such a time-pressured setting. Perhaps examiners could be encouraged to discard questions such as "what do you think?" and "what would you do?" (which invariably result in a wasted minute while the candidate clarifies the exact question being asked) in favour of questions where the candidate knows

exactly what they're being asked about e.g. "what is the differential diagnosis?" or "how would you investigate this patient?"

- Like the viva I was impressed on how well the OSCE's were organised. I appreciate how difficult it can be to get all the patients & examiners all ready and on time.
- My OSCE was due to start at 1130am-1300hrs. Due to delays from first group the OSCE was delayed by 30-40 minutes. This ran into and past lunchtime leaving me hypoglycaemic and therefore underperformed.