



Public Report on the Part 2 FRCOphth Oral Examination April 2013

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1. Summary and recommendations

The Part 2 FRCOphth examination is a substantial challenge for candidates and a high level of competence is required to achieve a pass. The pass rate for the examination is around 50% and candidates in OST are more likely to pass than those outside. This provides evidence that the examination is a valid assessment of achievement of the competencies described in the curriculum for OST.

All three parts of the examination meet GMC standards for reliability (0.8).

Candidates performance was significantly better if they were in OST, had English as their first language and if they graduated in the UK. Statistically significant differences in performance based upon an analysis of stated ethnicity were not present for trainees in OST or who had graduated in the UK. Although the examination is available to all candidates with a medical qualification who have passed the Part 1 FRCOphth and the Refraction Certificate, the success of non-trainees is much less than those in training (20% vs. 56%).

There were some exceptionally good performances in the oral examination with the highest mark in each part of 94%.

The correlation between different stations is acceptable and provides further evidence of the validity of the examination.

There is no statistically significant difference between the performances of candidates in each stage of training (although statistical analysis is difficult for anything other than ST5 and ST6 as numbers are low for ST3, 4 and 7). It is, however, useful to note that the median total mark for ST4 candidates exceeded ST7 candidates by 19 (5%). The best performance in the oral examination was by trainees in ST6, ST5 in the OSCE and ST4 in the SV and MCQ. The pass rate was highest for trainees in ST5.

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The oral parts of the tenth sitting of the Part 2 FRCOphth examination were held in Brighton from 22 to 25 April 2013.

1. Candidates

93 candidates were eligible to sit the oral examination having successfully completed the written papers in September. 91 candidates presented themselves for the examination.

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, 93 candidates passed the written papers and were invited to attend the oral examination.

This represents a pass rate for the written papers of 85%

Oral examinations (Structured Viva and OSCE)

2. The Structured Vivas

There were five structured vivas, which were held on Monday 22 and Tuesday 23 April in the Audrey Emerton Building in Brighton. 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 Hess Chart
Tuesday AM Ocular ischaemic syndrome
Tuesday PM Corneal Topography

Station 2. Patient management 1

Monday PM Aqueous Misdirection
Tuesday AM Strabismus
Tuesday PM Non Ischaemic CRVO becoming Ischaemic

Station 3. Patient management 2

Monday PM Floppy Iris Syndrome
Tuesday AM Endothelium in Cataract Surgery
Tuesday PM Endophthalmitis

Station 4. Attitudes, ethics and responsibilities.

Monday PM Mental Capacity Act.doc
Tuesday AM Appraisal and revalidation
Tuesday PM Non-Accidental Injury

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

Monday PM Avastin

Tuesday AM Ozurdex for RVO

Tuesday PM ARMD

Health promotion and disease prevention (5 minutes)

Monday PM Infection control

Tuesday AM Overnight Contact Lens Wear

Tuesday PM Child screening check

The vivas were held in multiple rooms, with a number of these rooms partitioned by screens. The communication skills stations were each housed in separate rooms. There were three teams of examiners (red, blue and green teams). The examination was conducted in five rounds (two on Monday and three on Tuesday).

2a) Results:

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

Pass mark (using borderline candidate method):	65 (54%)
Mean score:	84 (70%)
Median score:	84 (70%)
Range:	53-118 (44-98%)
Reliability: (Cronbach alpha)	0.8
SEM:	6.5 (5.4%)
Adjusted pass mark (+ 1 SEM)	72 (60%)

Pass rate before adjustment (pass mark 65/120) 83/91 (91%)

Pass rate after adjustment (pass mark 72/120) 73/91 (80%)

Table 1 Distribution of scores

Score	Distribution	Total
41-50		0
51-60	////	4
61-70	//// //	13
71-80	//// // // // //	22
81-90	//// // // // // /	21
91-100	//// // // // //	17
101-110	//// // //	12
111-120	//	2
Total		91

Table 2 Results for each station

Station		Mean score	Median score	Range
1	PI	15.8	16	4-24
2	PM	16.2	16	6-24
3	PM	17.7	19	8-24
4	AER	17.8	19	3-24
5	HPDP/EBM	16.5	19	9-24

Table 3 Correlation between examiners' marks at each station

Team	Station 1	Station 2	Station 3	Station 4	Station 5
	PI	PM	PM	AER	HPDP/EBM
All	0.91	0.78	0.81	0.77	0.8
Blue	0.89	0.92	0.72	0.82	0.75
Red	0.91	0.82	0.85	0.74	0.72
Green	0.93	0.57	0.90	0.80	0.91

Table 4 Correlation between examiners' global judgements at each station

	Station 1	Station 2	Station 3	Station 4	Station 5
	PI	PM	PM	AER	HPDP/EBM
All	0.82	0.81	0.72	0.83	0.70
Blue	0.81	0.93	0.69	0.91	0.77
Red	0.86	0.87	0.70	0.76	0.26
Green	0.76	0.65	0.80	0.85	0.86

Table 5 Correlation between viva stations

		Station 2	Station 3	Station 4	Station 5
		PM	PM	AER	HPDP/EBM
Station 1	PI	0.22	0.22	0.17	0.17
Station 2	PM		0.38	0.25	0.08
Station 3	PM			0.26	0.22
Station 4	AER				0.30

2b) Standard setting for the structured vivas:**Table 6**

	1		2		3		4		5		Total
<i>Number of borderline candidates</i>	25	30	29	27	23	17	16	15	27	27	
<i>Median borderline candidate mark</i>	6	6	7	6	8	7	6	6	7	6	65

The pass mark for the structured viva was increased by 1 SEM from 65/120 (54%) to 72/120 (60%).

3. The OSCE

There were seven OSCE stations in all. The six clinical stations were held on Wednesday 24 and Thursday 25 April 2013 at the Sussex Eye Hospital. The communication OSCE was conducted with the vivas. There were three teams of examiners (red, blue and green teams) and five rounds (three on Wednesday and two 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.

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

Wednesday Morning

Station 1 - Anterior Segment

- Keratoconus
- Unnamed corneal dystrophy
- RE Penetrating keratoplasty LE fuchs dystrophy
- Corneal ectasia sec to LASIK
- Lt DSAEK R Fuchs dystrophy
- R. IOL dislocation
- R. DSAEK for decompensated cornea, Bilat pseudophakia, Bilat glaucoma with cupped discs
- Radial keratotomy BE, LE LASIK x2, Cataracts, LE RD macular off, vitrectomy
- Cataracts, LASIK, RP
- Rt. Keratoconus Lt. PK
- L. graft failure
- Lipid keratopathy
- Black IOL pseudophakia for intractable diplopia
- Corneal fuchs dystrophy
- L. corneal graft, R&L cataract surgery, R bootlace prolene suturing
- R bullous keratopathy, previous cataract surgery
- Bilateral LASIK, L pseudophakia, r. cataract
- RE heterchromic cyclitis, 3 trabeculectomies,

Station 2 - Glaucoma and Lid

- Ptosis ectropion blocked tear duct
- Pigment dispersion syndrome
- Normal tension glaucoma
- Ectropion, R HSK + anaesthetic cornea
- POAG
- Ptosis
- Ptosis, aponeurotic dehiscence
- Primary angle closure
- Pigment dispersion syndrome left eye
- R. eye blunt trauma from squash ball ► cataract (now pseudophakic) 2° glaucoma
- Ptosis lax LCT
- L. mac hole ► vitrectomy ► uncontrolled IOP ► Baerveldt tube
- Bilat Band keratopathy, bilat pseudophakia, Glaucoma
- rubeosis slow flow ischaemic, has had baerveldt tube
- Lid - upper lid entropion Retina - prolif DR
- Normal tension glaucoma
- Advanced POAG, Previous R. RD
- R. RD, R, subluxed IOL ► removal ► R. AC IOL ► 2° glaucoma

Station 3 - Posterior Segment

- Bilat ARMD
- Prolif diabetic retinopathy R&L
- L. BRVO - ischaemic, NV, PRP

- R. RD (mac off) March 2012, Re-detachment ► S.oil/encicle + phaco May 2012
- L. CRVO/papillophlebitis
- Trauma/bilat cat surgery/L. IOL displaced, L RD encircled/vity chronic RD
- Prolif DR very ischaemic New vessel R disc Previous vity/delam Avastin/Lucentis for dmo
- R. hemiretinal vein occlusion with PRH + NVE
- R. hemireitnal vein occlusion (inf)
- Bilat diabetic maculopathy ► resistant to treatment, Bilat PRP laser
- R. vit haem secondary to eccentric disciform, Bilat dry AMD, pseudophakia
- Peripheral retinal closure with neovascularisation Eales disease
- R eye trauma (firework) 5/11/11 - severe retinal trauma
- L. epi-retinal membrane, L retinal break lasered in 2007
- R. atypical central vein occlusion
- Diabetic maculopathy
- L retinal breaks treated with 360° indirect laser retinopexy April 2011
- Adult vitelliform

Station 4 - Strabismus and Orbit

- Longstanding r. superior oblique palsy
- Exotropia, R. homonymous hemianopia
- Thyroid eye disease
- Arnold chiari malformation with torsional nystagmus
- L orbital mass ? Lymphoma
- Thyroid eye disease. L. artificial eye
- L. IV palsy or SO palsy ? Related to RD surgey
- Oculopharyngeal muscular dystrophy
- RIR u/a ► r. hypertropia with diplopia, AHPChin depression ▼ to gain single vision
- R. Duane's Type A
- Thyroid eye disease
- L. sphenoid wing meningioma (extensive) ► proptosis, complete brow & lid ptosis
- Consecutive R. exotropia
- L hypotropic 2° thyroid

Medicine and Neurology Station 5 and Station 6

- MS resolving R. 6th nerve palsy
- Sero+ RA, secondary Sjogren's syndrome
- Ocular myasthenia
- L. optic atrophy secondary to arterial occlusion, echo - mild valve disease ▲ cholesterol
- MS
- Drusens of disc,
- RA for 45 yrs, never had DMARDS (she wont have them), lovely RA hands, no nodules
- L. optic nerve coloboma
- Senior-Loken syndrome Type 5
- R. Illrd - R. ptosis -resolving L Illrd myasthenia gravis
- Large pituitary adenoma drained 2012
- Meningioma and reduced VA left

- R. RAPD R. morning glory type disc also MRIs
- Holmes Adie pupil
- Ehlers Danlos + PXE
- Myasthenia gravis MuSK +
- R. III nerve palsy - partial
- L. optic neuropathy secondary to GCA
- Probable ? NAION AF heart surgery
- Extraocular ophthalmoplegia tremor
- Pituitary macroadenoma
- L. disc anomaly. EOM Right SR under action, left IO Overaction
- ankylosing spondylitis, also had iritis 8 years ago, currently well
- Rheumatoid arthritis
- R. complete 3rd nerve palsy, pupil involvement, Glaucoma, 2x repair RUL old ptosis
- Intermediate uveitis (presumed TINU) R+L, R. myelinated RNFL
- Marfan/IOL dropped had sutured PC IOL
- Primary toxoplasma retinitis
- Guillain Barre Partial III nerve
- Behcet's vasculitis

Wednesday Afternoon

Station 1 - Anterior Segment

- KC
- Lattice dystrophy
- Lt DSAEK R Fuchs dystrophy
- L INTACS + keratoconus
- Fuchs dystrophy RE, endothelial graft LE
- R. decompensated cornea, Bilat. Pseudophakia
- keratoconus, congenital cataract
- Fuchs dystrophy + Cataracts
- Corneal guttae, L ERM
- Subluxated lens both eyes
- Bilat corneal grafts, cataracts
- Axenfeld syndrome, glaucoma
- BE lattice dystrophy, BE penetrating corneal frags
- L. herpes simplex keratouveitis
- R. ocular melanosis
- R. DSAEK for decompensated cornea, Bilat pseudophakia, Bilat glaucoma with cupped discs
- Basement membrane dystrophy, complex cat. Surgery LE, diabetic retinopathy
- R bullous keratopathy, previous cataract surgery
- Rt. Keratoconus Lt. PK
- R <L Fuchs with guttata, L. pseudophakia, small Yag capsulotomy
- Marfan syndrome Glaucoma subluxed lens

Station 2 - Glaucoma and Lid

- Floppy lid syndrome, possible Ehlers Danlos syndrome
- Lentigo maligna, ectropion, pseudophakia
- R. Fuchs heterochromic cyclitis with 2° glaucoma, R. Trab

- PXF / OHT
- Pigment dispersion syndrome
- R pseudophakia, L. Aphakia, Glaucoma
- Levator detachment frontalis overaction
- Pseudoexfoliation
- Medial ectropion
- POAG, Bilat Trab, L. baerveldt tube, L. globe trauma/rupture
- RE pigment dispersion syndrome with secondary glaucoma
- Ptosis and retinopathy
- L. lower lid entropion
- Diab. Retinopathy R. PRP, R. rub. glaucoma - bilat. Tubes, L. POAG, Bilat pseudophakia, R herp keratopathy
- Glaucoma encapsulated trab blebs
- R. aphakic, L. corneal decompensation, blind phthical eye Moltino tube
- Bilateral OCP SYMBLEPHARON
- ROP R.cat surgery marked inflammatory response 360° post synechiae iris bombe & secondary glaucoma

Station 3 - Posterior Segment

- L. retinal paramac telangiectasia
- Bilat dry ARMD with soft drusen
- Choroidal melanoma inactive for 3 years. Sub retinal haemorrhage recently
- R. PED/Drusen L. BRVO (chronic)
- CSR L >>R OCT fluid + FFA
- PDR R. vit delam 2009 L. occ vit haem
- Prolif DR, maculopathy, keratopathy
- Branch vein occlusion L, lasered Nov 2012
- R. bear tracking
- Old R CRVO with mac exudates
- Implantable contact lenses rd
- L. optic nerve melanocytoma
- Retinal telangiectasia + exudate
- L. diabetic retinopathy (R2) pseudophakia with AC IOL
- R. inferior RD and barrier laser, R. optic disc notch
- R. peripapillary angioma (hamatoma) with maculopathy
- Diabetic maculopathy / prolifer. Disease, L. macroaneurysm ? Old RD
- Confluent drusen 6/6 R&L
- R. CRVO
- Coats disease
- RP pseudophakia

Station 4 - Strabismus and Orbit

- Limited abduction mild ptosis
- L. ICA aneurysm
- Arnold chiari malformation with torsional nystagmus
- Thyroid eye disease. L. artificial eye
- R. hypotropic for near
- Longstanding r. superior oblique palsy
- L IV n palsy improving
- DVD, Hx of squint surgery
- L. sphenoid wing meningioma (extensive) ► proptosis, complete brow & lid

- ptosis
- TED
- Oculopharyngeal muscular dystrophy
- Manifest latent nystagmus with DVID (R>L)
- Distance left eso
- Adenoid cystic carcinoma
- Esotropia
- Thyroid eye disease
- Alternating esotropia
- 3rd r/l

Medicine and Neurology Station 5 and Station 6

- III nerve palsy craniopharyngioma
- MS resolving R. 6th nerve palsy
- Sero+ RA, secondary Sjogren's syndrome
- Sero negative arthritis and chronic AU R+L
- R. Adie's pupil = main sign
- L. Horner's syndrome
- Exotropia, bitemporal hemianopia
- Bilateral disc drusen
- RA for 45 yrs, never had DMARDS (she wont have them), lovely RA hands, no nodules
- L. optic nerve coloboma
- Ant uveitis + ank. Spondylitis
- Pituitary macroadenoma - surgical resection and radiotherapy
- Optic atrophy, reitnal pigmentation
- MS
- Scleritis, Rh athritis on ward ehh patient
- Myasthenia gravis RIO u/a
- Old multifocal choroiditis, L. otpic atrophy MS ie old uveits
- Optic chiasm glioma previous radiotherapy
- R. optic atrophy secondary neurobehcets
- R. III nerve palsy - partial
- L. optic neuropathy secondary to GCA
- Myasthenia gravis MuSK +
- Left INO ? Ischaemic cause
- Acromegaly - hands, brow, no field defect scans
- Occiptal meningioma
- Pituitary Glaucoma
- R. Bell's palsy, Bilat pseudophakia, Primary Open Angle Glaucoma
- Toxoplasma retinitis R. eye
- Mechanical mit vale replacement 1999, mixed aortic vale disease, atrial fibrillation
- Wegeners granulomatosis
- L. chronic AU
- Marfans/IOL dropped had sutured PC IOL
- Guillan barrie Partial III nerve
- Vith nerve palsy

Thursday Morning

Station 1 - Anterior Segment

- KC
- Corneal ectasia sec to LASIK
- Lt DSAEK R Fuchs dystrophy
- Bilat epithelial basement membrane dystrophy
- R. traumatic corneal laceration & traumatic cataract
- Fuchs dystrophy
- R+L guttata (Fuchs) L. incarcerated iris post phaco, R+L dry ARMD
- Lipid keratopathy
- Fuchs', cataract
- R. pseudophakia, L. 3rd penetrating corneal graft
- R. DSAEK for decompensated cornea, Bilat pseudophakia, Bilat glaucoma with cupped discs
- Radial keratotomy BE, LE LASIK x2, Cataracts, LE RD macular off, vitrectomy
- R. partial LASIK flap melt
- R. pseudoexfoliation syndrome
- Corneal fuchs dystrophy
- R. pseudophakia, R. PXF
- R < L Fuchs with guttata, L. pseudophakia, small Yag capsulotomy
- Bilateral LASIK, L pseudophakia, r. cataract
- L. corneal graft, R&L cataract surgery, R bootlace prolene suturing
- Corneal perforation, L patch graft, L contact lens

Station 2 - Glaucoma and Lid

- Pigment dispersion syndrome left eye
- Rubeosis left glaucoma laser avastin diode diabetes
- Ptosis lax LCT
- L. upper lid port wine stain/haemangioma, L. secondary glaucoma
- POAG
- Glaucoma
- PXF Glaucoma
- Pigment dispersion syndrome
- L. herpetic keratouveitis, L. Baerveldt tube, L. pseudophakia, L. 2nd glaucoma
- Advanced POAG
- Rd oil glaucoma
- Glaucoma, Pis, cupped discs,
- Spastic entropion
- Glaucoma R > L
- POAG
- Pigment dispersion syndrome
- Rubeosis slow flow ischaemic, has had baerveldt tube
- R. Trab, R. pseudophaia, L+R glaucoma on drops, dilated R. pupil

Station 3 - Posterior Segment

- L. choroidal rupture
- Prolif diabetic retinopathy R&L
- Hereditary dystrophy ? Stargardts
- Von Hippel Lindau

- Turners keratoconus RD oil aphakia
- R. choroidal folds
- L. epi-retinal membrane, L retinal break lasered in 2007
- Fuchs endothelial dystrophy + wet AMD
- R. mac off RD repair 2008 (vity), L RD mac off repiar vity then re-detachment ► encircling
- Diabetic Maculopathy with oedema ++ refractory to treatment, PRP laser
- ?R. giant cell arteritis ► R. central reitnal artery occlusion ► rubeosis ► blinde eye
- Peripheral retinopathy ? Cause
- Sickle cell
- R. bear tracking
- R. RD ► surgery ► retinal fold
- R. chorioretinal scar, L. inferior retinal schisis, Bilat corneal radial keratomies
- Peripheral retinal closure with neovascularisation Eales disease
- R. diabetic mild exudates + cortical lens
- FEVR
- R. Coats disease (supertemporal retina, R. vitrectomy & membrane peel R. peripheral retinal telangiectasia, subtle SRF, macular: signs of previous membrane peel

Station 4 - Strabismus and Orbit

- Longstanding r. superior oblique palsy
- THYROID
- Squint
- Squint
- L. CVS
- R. hypertropia, prisms RA Browns ?
- L VI palsy
- RIR u/a ► r. hypertropia with diplopia, AHPChin depression ▼ to gain single vision
- Thyroid eye disease
- Residual exotropia
- Residual congenital alternating esotropia, high myope
- Thyroid eye disease, squint surgery
- L Duanes
- Duanes retraction syndrome
- L. convergent squint
- Esophoria/esotropia
- R. hyoptropic for near
- Consecutive exotropia with A pattern, prev squint surgery to all horizontal recti + poss surgery to bilat los
- Thyroid eye disease proptosis diplopia
- Thyroid eye disease

Medicine and Neurology Station 5 and Station 6

- Optic atrophy, reitnal pigmentation
- Bilat optic atrophy, likely to be autosomal dominant optic atrophy
- Guillan barrie Partial III nerve
- Bilateral Vith nerve palsies (longstanding)
- Holmes Adie pupil

- Primary toxoplasma retinitis
- Senior-Loken syndrome Type 5
- Meningioma
- Extreme ROP Born at 23 weeks
- VI nerve palsy
- Vein occlusion, previous endarterectomy, vascular disease, heart murmur
- R. Horner's syndrome Brainstem CVA Torsional nystagmus
- R. RAPD R. morning glory type disc also MRIs
- Disc fullness but other intracranial pathology + IHH
- R diabetic papillitis, mac ERM
- Sphenoid meningioma
- RP/alpha methyl CoA Deficiency Refsums, Charcot Marie Tooth, peripheral neuropathy
- Bells VI myopia disc pallor
- L.uveitis, 2° cataract, 2° glaucoma, arthritis L eye disc cupping, failed trab.arthritis hand
- Pituitary adenoma ► bilat optic atrophy L >> R, retinoschisis bilat (myopic)
- Ischaemic retinal vasculitis L. AION
- L. optic disc pit
- MS resolving R. 6th nerve palsy
- IHH
- L. optic neuropathy secondary to GCA
- Angioid streaks peau d'orange ? PXE Ehlers Danlos
- L. optic nerve coloboma
- Rheumatoid arthritis
- Leber's hereditary optic neuropathy
- Adies tonic pupil

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 5/6: 2 criteria scored 0-3 for 4 patients by 2 examiners = 48

Station 7: 3 criteria scored 0-3 for 1 patient/actor by 2 examiners x 0.666 = 12

Pass mark (using borderline candidate method)	89	(57%)
Mean score:	103.5	(66%)
Median score:	102	(65%)
Range:	68-146	(44-94%)
Reliability (Cronbach alpha):	0.8	
SEM:	9	(6%)
Adjusted pass mark (+1 SEM)	98/156	(63%)
Pass rate before adjustment (pass mark 89/156)	66/91	(73%)
Pass rate after adjustment (pass mark 98/156)	54/91	(59%)

Table 7 Distribution of scores

Score	Distribution	Total
61-70	//	2
71-80	//// //	9
81-90	//// //// ////	15
91-100	//// //// // /	16
101-110	//// //// //// //	17
111-120	//// // /	11
121-130	//// //	8
131-140	//// ////	10
141-150	///	3
Total		91

Table 8 Station marks (before weighting)

Station		Maximum possible	Mean	Median	Min	Max
1	Anterior segment & cataract	36	25.2	26	6	36
2	Glaucoma & lid	36	23.9	24	6	36
3	Posterior segment	36	26.4	27	8	36
4	Paediatric & strabismus	24	15.7	16	4	24
5/6	Medicine and neurology	48	30.1	29	8	48
7	Communication	18	11.3	11	0	18

Table 9 Correlation between examiners' 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.
<i>All</i>	0.71	0.78	0.82	0.86	0.86	0.82
<i>Blue</i>	0.86	0.82	0.93	0.91	0.87	0.84
<i>Red</i>	0.52	0.66	0.82	0.91	0.85	0.76
<i>Green</i>	0.77	0.84	0.76	0.76	0.83	0.85

Table 10 Correlation between examiners' 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.
<i>All</i>	0.68	0.65	0.84	0.83	0.75	0.76
<i>Blue</i>	0.80	0.64	0.91	0.87	0.76	0.77
<i>Red</i>	0.44	0.43	0.88	0.84	0.80	0.70
<i>Green</i>	0.75	0.77	0.78	0.77	0.70	0.72

Table 11 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	0.29	0.27	0.13	0.34	0.15
Station 2	Glauc/lid		0.23	0.40	0.15	0.40
Station 3	Posterior			0.07	0.23	0.06
Station 4	Orbit/Strab				0.25	0.36
Station 5	Med/neuro					0.27

3b) Standard setting for the OSCE

Table 12

Station	1		2		3		4		5 & 6		7	
No. of borderline candidates	21	28	29	23	31	30	26	31	34	36	30	24
Median borderline candidate weighted score	7	8	7	7	7	8	6	7	12	13.5	3	3

The pass mark for the OSCE was increased by 1 SEM from 89/156 (57%) to 98/156 (63%)

4. The overall examination (oral and written papers)

4a) Overall results for the oral examination

Pass mark	170/276	(62%)
Mean	187.5	(68%)
Median	185	(67%)
Range	122-260	(44-94%)

To pass the oral examination candidates must achieve 170/276 overall, 65/120 in the viva and 98/156 in the OSCE.

Pass rate for the oral examination	52/91	(57%)
Pass rate for the entire examination	52/109	(48%)

Table 13 Distribution of scores

Score	Distribution	Total
121-130	/	1
131-140	//	2
141-150	//// /	6
151-160	//// ////	10
161-170	//// //	9
171-180	//// //// //	12
181-190	//// //// //	12
191-200	//// ////	9
201-210	//// ////	10
211-220	//// /	6
221-230	////	4
231-240	//// /	6
241-250	//	2
251-260	//	2
Total		91

Table 14 Correlation between scores in each part of examination

	VIVA	OSCE	Oral examination
MCQ	0.43	0.38	0.45
VIVA		0.51	

4b) Breakdown of Oral Examination

Table 15 Breakdown of results by training

	Failed	Passed	Total
In OST	27	47	74
Not in OST	12	5	17
Total	39	52	91

These differences are statistically significant ($p = 0.01$)

Pass rate for the oral examination for candidates in OST 47/74 (64%)

Pass rate for the Part 2 examination for candidates in OST 47/83 (57%)

Table 16 Breakdown of results by gender

	Failed	Passed	Total
Female	12	10	22
Male	27	42	69
Total	39	52	91

These differences are not statistically significant ($p = 0.15$)

Table 17 Breakdown of results by deanery

	Failed	Passed	Total
East Midlands	1	1	2
East of England	1	0	1
East Scotland	0	2	2
London	9	13	22
Mersey	2	4	6
North Scotland	0	2	2
North Western	2	2	4
Northern	2	1	3
Northern Ireland	0	0	0
Oxford	0	0	0
Peninsula	3	2	5
South East Scotland	1	1	2
Scotland West	2	3	5
Severn	0	2	2
Wales	1	5	6
Wessex	0	0	0
West Midlands	2	4	6
Yorkshire	1	5	6
	27	47	74

Table 18 Breakdown of results by level of training

	Failed	Passed	Total
ST3	2	0	2
ST4	2	1	3
ST5	11	25	36
ST6	9	17	26
ST7	3	3	6
Total	27	46	73

* Level unknown for 1 candidate in OST

Table 19 Breakdown of results by country of qualification

	Failed	Passed	Total
UK	18	40	58
Outside UK	21	12	33
Total	39	52	91

These differences are statistically significant ($p = 0.002$)

Table 20 Breakdown of results by first language

	Failed	Passed	Total
English	16	38	54
Other	15	11	26
Total	31	49	80

*First language unknown for 11 candidates

These differences are statistically significant ($p = 0.015$)

Table 21 Breakdown of results by ethnicity

	Failed	Passed	Total
White	5	19	24
Non-white	33	32	65
Total	38	51	89

* Ethnicity undeclared by 2 candidates

These differences are statistically significant for white/non-white ($p = 0.01$)

However there is no significant difference in the performance based upon ethnicity for candidates who attended a UK medical school.

Table 22 Ethnicity of candidates in OST

Ethnicity	In OST	Not in OST	Total
White	21	3	24
Non-white	52	13	65
	73	16	89

* Ethnicity undeclared by 2 candidates

Table 23 Breakdown for candidates in OST by ethnicity

Ethnicity	Fail	Pass	Total
White	5	16	21
Non-white	22	30	52
	27	46	73

* Ethnicity undeclared by 1 candidate

These differences are NOT statistically significant for white/non-white in training ($P = 0.11$)

Table 24 Breakdown of results by number of previous attempts

Attempts	Failed	Passed	Total
1 (First)	24	32	56
2	8	15	23
3	6	5	11
4	0	0	0
5	1	0	1
Any resit	15	20	35

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

* 2 candidates who passed the written examination did not sit the oral examination

Table 25 Breakdown of results by training

	Failed	Passed	Total
In OST	36	47	83
Not in OST	19	5	24
Total	55	52	107

These differences are statistically significant ($p = 0.002$)

Table 26 Breakdown of results by gender

	Failed	Passed	Total
Female	14	10	24
Male	41	42	83
Total	55	52	107

These differences are not statistically significant ($p = 0.30$)

Table 27 Breakdown of results by deanery

Deanery	Failed	Passed	Total
East Midlands	1	1	2
East of England	3	0	3
East Scotland	0	2	2
London	10	13	23
Mersey	2	4	6
North Scotland	0	2	2
North Western	2	2	4
Northern	2	1	3
Northern Ireland	0	0	0
Oxford	0	0	0
Peninsula	3	2	5
Scotland South East	1	1	2
Scotland West	3	3	6
Severn	0	2	2
Wales	1	5	6
Wessex	1	0	1
West Midlands	5	4	9
Yorkshire	2	5	7
	36	47	83

Table 28 Breakdown of results by level of training

	Failed	Passed	Total
ST2	1	0	1
ST3	2	0	2
ST4	4	1 (20%)	5
ST5	12	25 (68%)	37
ST6	14	17 (55%)	31
ST7	3	3 (50%)	6
Total	36	46	82

Table 29 Breakdown of results by country of qualification

	Failed	Passed	Total
UK	25	40	65
Outside UK (Inc Republic of Ireland)	29	12	41
Total	54	52	106

Country of qualification unknown for 1 candidate

These differences are statistically significant ($p = 0.001$)

Table 30 Breakdown of results by first language

	Failed	Passed	Total
English	22	38	60
Other	23	11	34
Total	45	49	94

These differences are statistically significant ($p = 0.005$)

Table 31 Breakdown of results by ethnicity

	Failed	Passed	Total
White	6	19	25
Non-white	45	32	77
Total	51	51	102

These differences are statistically significant for white/non-white ($p = 0.005$)

Table 32 Breakdown for candidates in OST by ethnicity for the examination overall (written and oral parts)

Ethnicity	Fail	Pass	Total
White	6	16	22
Non-white	29	30	59
	35	46	81

These differences are NOT statistically significant for white/non-white candidates in ophthalmic specialist training ($p = 0.08$)

4d) Table 33 Comparison to previous examinations

Date	Sept 09	April 10	Oct 10	April 11	Nov 11	April 12	Oct 12	April 13
Candidates	16	21	26	46	77	104	95	109
MCQ pass mark	64%	66%	65%	65%	58%	58%	55%	61%
Reliability	0.8	0.8	0.8	0.7	0.7	0.7	0.7	0.8
EMQ pass mark	66%	65%	64%	65%	59%	58%	59%	NA
Reliability	0.8	0.9	0.8	0.7	0.7	0.7	0.8	NA
Viva pass mark	64%	57%	56%	63%	60%	62%	58%	60%
Reliability	0.8	0.9	0.8	0.8	0.8	0.8	0.8	0.8
OSCE pass mark	63%	61%	62%	63%	65%	62%	62%	63%
Reliability	0.9	0.8	0.9	0.9	0.8	0.8	0.8	0.8
Written pass rate	38%	48%	58%	46%	68%	65%	81%	85%
Oral pass rate	33%	50%	73%	71%	54%	57%	63%	57%
Overall pass rate	13%	24%	58%	33%	35%	37%	51%	48%
Overall pass rate in OST	NA	NA	NA	43%	46%	43%	63%	56%

Table 34 Cumulative results by deanery (September 2010 to date)

Deanery	Number of passes	Number of candidates	Pass rate %
East Scotland	2	2	100
Severn	12	16	75
Oxford	11	15	73
Northern Ireland	5	7	71
North Scotland	4	6	67
Scotland South East	5	8	63
London	53	86	62
Mersey	9	16	56
Northern	7	13	54
Scotland West	3	6	50
Wales	11	22	50
East Midlands	5	11	45
Yorkshire	15	34	44
West Midlands	12	30	40
Peninsula	5	13	38
North Western	10	28	36
East of England	2	7	29
Wessex	2	8	25
TOTAL	173	328	53

Appendix 1: Candidate evaluation

Structured Viva

Viva Station 1 Patient Investigations & Data Interpretation

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

Yes: 95% No: 5%

Comments

- The examiners were borderline bored
- Lovely examiners
- Very polite and I felt they tried to put me at ease

Were the questions appropriate for the station?

Yes: 91% No: 9%

Comments

- I think the examiners should use recognized UK terminology, as I was initially confused at the question about viscoelastics as the terminology used was American terminology – it was referred to as “ocular viscoelastic device”. I think I answered the question well, but may have appeared a little confused as to what was being sought after in the last stem of the question as I was somewhat confused by the American terminology.
- Bigger pictures of FFA would be helpful, especially since the transit time was the basis of further questions in the station.
- Pic of cornea very blurred, pupil sl. Oval also. I thought the question regarding the chemical make-up of Viscoat/Healon and BSS plus was more of a part 1 question and not really clinically relevant. Relevant to know their uses in surgery and differences i.e. cohesive/dispersive but not chemical constituents.
- Only one Investigation and the rest of the station is comment on it, management etc so not Investigation station per se. If few different Investigations are presented it would improve the reliability of the test (in my humble opinion).
- Very poor quality FFA images and OCT. The least college could do is have good quality Heidelberg images, or images on a screen (or iPad- cost less than half of a candidate’s fees) that can be enlarged or simply clearer printouts. Simple macular oedema was very difficult to see on the poor quality printout.

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

Yes: 95% No: 5%

Comments

- I think that most of the questions were pitched at a the level that was appropriate (i.e. not at the level of someone who has specialized in that sub-specialty)

Viva station 2 Patient Management 1

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

Yes: 91% No: 9%

Comments

- The FFA picture quality was poor (even considering the condition). At the beginning I attempted to clarify if one area was an artefact from the photo or

not so that I did not waste time discussing something inappropriate. – I had the curt reply “you will just have to answer just as all the other candidates will have to do too. I was so taken aback by the tone used by the examiner to my left that it really threw me. I did not answer the question nearly as well as I could have which is a shame, as I knew enough about the condition to do so. Exam conditions are stressful enough without such abruptness.

- First examiner very pleasant and had clear questions. Second examiner very brief-not a clear examiner. Kept asking me questions after buzzer and I was unsure if I should carry on or walk away as instructed to do.

Were the questions appropriate for the station?

Yes: 100% No: 0%

Comments

- Question on surgical assisted device unclear. I know the indications and uses for cohesives and dispersives but this question was not clear.

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

Yes: 100% No: 0%

Comments

- Yes but whole station about IFIS. Wished you asked me on more subjects. We prepared a lot of this exam and would have liked to be asked on more breadth of knowledge.

Viva station 3 Patient Management 2

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

Yes: 95% No: 5%

Comments

- Although courteous I found the examiners intimidating and it really put me off.
- Being asked if I had “done this before” because I became a little muddled when explaining a procedure is quite off-putting.

Were the questions appropriate for the station?

Yes: 95% No: 5%

Comments

- The questions were slightly confusing- we kept going backwards and forwards and there was no clear direction of the questions
- The photograph showed a shallow anterior chamber and corneal oedema. The questions were on the oedema. The shallow anterior chamber was a red herring as was not questioned. (However I started by giving the causes of anterior chamber shallowing post cataract surgery). In future a photograph with only corneal oedema would be better.
- In my experience, a child has Orthoptic assessment and refraction by time they come to see the Dr at which point ocular motility and fundus is seen. The style of questioning and format of answer required slightly unrealistic. Examiner looked very disappointed when I stated this is what would be done in this order-as this is what is done in a practical NHS clinic.

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

Yes: 95% No: 5%

Comments

- However some of the questions (‘endothelial cell count of a 70 year old’, or ‘what is in BSS Plus?’) were more like MCQ questions. These two questions were not such a useful test of clinical management. However the other questions were good.
- Please make the anterior segment photo bigger and with higher resolution

Viva station 4 Attitude, Ethics and Responsibilities

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

Yes: 100% No: 0%

Comments

- I have to say I had difficulty understanding one of the examiners questions due to a strong accent.

Were the questions appropriate for the station?

Yes: 95% No: 5%

Comments

- But the phrasing of questions could have been better to make clearer the angle/expected answers
- In contrast to other stations, the questions of the two parts in this station were very similar if not identical. This was confusing and reassurance was needed from the examiners to ensure that I was on the right track.
- I did not understand one part of the question. The examiner did not rephrase the question just repeated it. I was not clear whether the question was related to the patient that we had just discussed or to another situation.

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

Yes: 100% No: 0%

Comments

- Sometimes it is very difficult to understand the questions. What is needed. The examiners looked as if they were under strict instruction to be vague and would not give you a clue if you are on the right track

Viva station 5 Audit, research and evidence based medicine

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

Yes: 100% No: 0%

Comments

- Examiners very pleasant.

Were the questions appropriate for the station?

Yes: 82% No: 18%

Comments

- Question not clear and misleading. Some of it not relevant to ophthalmology at all.
- NICE guidelines are not used in Scotland. I felt it would have been better to ask about RCOphth guidelines or specific studies instead. The question re: types of contact lens solutions available I thought was very strange.
- Broad question. College guidance on vein occlusion. Do I talk about CRVO or BRVO?
- Some of the questions on this station could have been presented in a different manner. Instead of what are the risk factors for CL keratitis it could have been changed to who is at risk of CL keratitis? Examiners wanted to know about age and sex!

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

Yes: 86% No: 14%

Comments

- Some questions had no relevance to ophthalmology

- One of the questions asked “What cleaning agent would you clean a room infected with C. difficile”. As an ophthalmologist I would be contacting the consultant microbiologist and hospital infection control team for advice. I don’t think it’s essential for an ophthalmologist to know the name of the cleaning agent as I would not be the person cleaning the room.

The Structured Viva – Overall Feedback

Was the structured viva examination well organized?

Yes: 95% No: 5%

Comments

- Too much was packed in each station – there was barely enough time and I heard one of the examiners saying the same to one of his colleague.
- Very well organized, team made us feel comfortable with clear instructions regarding where to go and what to do in between stations.

Were you given clear instructions about the structured viva examination?

Yes: 100% No: 0%

Comments

- The instructions were rather unclear in the glaucoma management station where glaucoma post trabeculectomy complications were discussed.

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

Yes: 91% No: 9%

Comments

- The structured viva is limited by the structured nature of it and the fact the examiners were after very specific answers that were on their mark sheets but were unable to ask any direct questions. The repeat question of ‘is there anything else’ is extremely frustrating when anything else could essentially be everything else when the question is so vague. It is a more accurate assessment of the candidate’s ability to read the examiners mind than an assessment of the candidate’s knowledge.
- On the whole it is a fair assessment of a candidate’s knowledge. However, I do think it is important that all the examiners ask the same question of **each candidate in the same way**. For example, in the FFA ocular ischaemic syndrome station, the parallel circuits asked the question in very different ways. One examiner was very abrupt and rude, which was off putting at the very beginning when I wanted to check if something was an artefact as the quality of the image was poor, whereas a colleague on the other parallel circuit running at the same time as mine was asked to look at the times for the FFA which gave the diagnosis away. This is a leading question, which is fine only if all the candidates are asked this in the same way.
- Very directed and particular. Despite good breadth of knowledge it is very easy to do badly in this exam due to the format
- It’s a ‘snap shot’ of sections your knowledge rather than an overall assessment

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

Yes: 91% No: 9%

Comments

- I think the scenarios need to be more rigorously tested prior to utilizing them in real exams. Given the time constraints, there needs to be either a more

general marking scheme or more direct questioning. It is unfair to expect candidates to come out with exactly what is on the examiners sheet and then mark them down for needing lots of prompting.

- A good reflection of knowledge
- Good as it allows assessment of things that cannot be assessed in a clinical scenario
- I think a viva similar to the old exit with one set of examiners and not moving around all the time may be more appropriate as they can more gauge the level of the candidate. It also will give a good candidate more of an opportunity to shine.

Please write any other comments you have about the structured viva examination below.

- The section with 4 stations in was a bit noisy and more difficult to hear in comparison to the other rooms.
- Sometimes because examiners appear to be looking for key words it may restrict some candidates' ability to score according to their marking scheme
- Overall, fair exam with very pleasant examiner and a good set up
- It seems a pity that the mark from the theory test counts nothing in the final score. Compared to the viva, it has as much breadth in testing knowledge and understanding. I am not too sure on the value of the viva as questions are limited many are vague and highly weighted. Felt depend on the luck of the moment rather than wide knowledge. May be better to add it to the MCQ mark as many who had high marks in the MCQ feel it not fairly counted compared to those who just about passed the MCQ.
- This was extremely difficult and stressful. I can see the advantage of the old style exit when a candidate talks in depth about common topics This would judge a candidates safety and knowledge in a much more in depth manner
- I do not understand why the College is not able to provide investigation print-outs (such as FFA) at an appropriate size. In most units you would be asked to look at a FFA on a large monitor (e.g.: 20+ inches), yet for the exam (for the second year running), poor quality images smaller than a 6x4 inch photo are still provided. Why can't the College invest in a couple of portable tablet computers (e.g.: Apple iPad or Google Nexus 10) for exam purposes to at least show images in higher quality and at a more appropriate size.

OSCE

OSCE station 1 Cataract and Anterior Segment

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

Yes: 90% No: 10%

Comments

- Very pleasant
- I found these examiners abrupt. They were not forthcoming in helping with technical issues such as the use of an unfamiliar slit lamp.
- The examiners said hello, but were very cold with very little feedback and no guidance.

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

Yes: 95% No: 5%

Comments

- Slit lamp was not working properly at the beginning of anterior segment station – the examiners struggled also to get it working and told me I would get an extra 30 seconds at end to make up for lost time, which I didn't – so

I didn't really see much when I looked at the first patient and I explained this to the examiners – for the 2nd and 3rd patient I had worked out what the problem with the slit lamp was and could see clearly. 2 of my colleagues also struggled with the exact slit lamp and told me that the image was very blurred.

- One patient I was asked to examine the left eye only. Once patient had left room I was then questioned on both eyes.
- On the whole the cases were good but one case with miscellaneous corneal scarring could have been replaced. The examiners provided little/no prompting letting me guess what the diagnosis was and how I would manage the patient.

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

Yes: 100% No: 0%

OSCE station 2 Glaucoma and eyelid

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

Yes: 100% No: 0%

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

Yes: 100% No: 0%

Comments

- The case for lids (small pigmented area next to a surgical scar at crowfeet area) was difficult to spot especially since the same patient had obvious bilateral ectropion and I was instructed to use the slit-lamp to describe my findings. Only after a few hints and remove the slit-lamp then the focus of the station became apparent.

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

Yes: 100% No: 0%

Comments

- Some additional time in this station would have been valuable to discuss YAG in more detail.

OSCE station 3 Posterior Segment

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

Yes: 100% No: 0%

Comments

- However, the female examiner appeared rushed as though there was not enough time and thus I felt I was rushed through the second two patients although I actually had plenty of time.
- Very pleasant, helpful with regards to the use of equipment

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

Yes: 100% No: 0%

Comments

- Although using the indirect with the patient sat up was not ideal

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

Yes: 100% No: 0%

Comments

- I do feel that the examiner should decide in advance which instruments are to be used at this station, and all candidates should have to use these rather than being given a choice. Some candidates were asked to choose which instrument they would prefer to use the slit lamp vs. indirect vs. ophthalmoscope, whilst other candidates were told which instrument to

examine with.

OSCE station 4 Strabismus and Orbit

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

Yes: 100% No: 0%

Comments

- Very disarming. Made me feel more relaxed
- Very pleasant, helpful with handing equipment, understanding
- Extremely nice examiners who made me feel at ease for this difficult station.

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

Yes: 95% No: 5%

Comments

- In the so-called orbital case, I was asked to examine the lids! The cases seemed vague to me.

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

Yes: 95% No: 5%

OSCE station 5 Medicine and Neurology

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

Yes: 95% No: 5%

Comments

- But I felt intimidated by the physician. May it is their way of asking and giving comments. The Ophthalmologist was great and very calm.
- I felt that one of the two examiners in this station was aggressive in their style of questioning throughout the station. The way questions were asked made it difficult to understand what answers were being sought, or what examination was wanted of me. This is in complete contrast to the other examiner for the station, and in addition in contrast to the other examiners in all the other stations, which is why I felt it necessary to comment on this.
- Extremely nice examiners who made me feel at ease for this difficult station.

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

Yes: 81% No: 19%

Comments

- Patients had extremely complex neurological problems that would be far beyond the scope of a general ophthalmologist. It is unreasonable for an ophthalmologist to have the depth of knowledge of a neurologist.
- Even though I wasn't sure of one of the diagnoses, I still think their inclusion in the exam was important as there are such patients that we encounter in our work all the time. Assessing a candidate's ability to handle uncertainty is important
- My case mix was much more difficult than those of any other candidate I spoke to after the exam. It is not possible to compare a case of Wallenberg Syndrome to that of something like rheumatoid hands/ morning Glory discs/ Angioid streaks/ pituitary adenoma etc and it seems unfair to weight the cases in a similar way. Also, the neurology cases take much more time to examine, which means it is more likely a candidate will not be able to get through all 4 cases, which is what happened to me. Given the idea is to pick up as many points as possible it is critical to get through all the cases. Even the consultant neurologist who had helped me prepare for the neurology component had not seen a case of Wallenberg Syndrome so it seems somewhat unfair to expect an ophthalmologist to diagnose this especially with the short time allocated. I

would also like to mention that the patient was facing a bright window which made assessment of his Horner's much harder than it needed to be – it would have been much more appropriate and considerate to have the patient's back to the window so that the pupil was not still in bright light even when we dimmed the room lights. I was asked to examine a fundus where the dilating drops had worn off. I did mention this to the examiners at the time and thankfully drops were put in for the remaining candidates after me. After I left the room the patient actually approached me and said he was sorry that he did not mention to the examiners that his drops felt like they were wearing off. I reassured him it was not his fault, but it would have made things much easier if they were topped up.

- Three cases were appropriate (Angioid streaks, Myasthenia gravis, 3rd nerve palsy secondary to Subarachnoid haemorrhage). But the problem was with the lady whose visual field assessment was asked. She was finding it difficult to comprehend the test and was unsure what she was saying and repeatedly looking at examiners face, with everything I was doing. I am not sure, if the examiner (a neurologist) sitting behind me was saying something using sign language to her! I have always read and understood that the white hatpin is for peripheral VF and red one to plot the blind spot, central or centrocecal scotoma. The examiner however asked me to do the peripheral VF with red pin! Not sure, if he was asking for any quadrant desaturation. Moreover the instruction in this station was misleading. The examiner said, 'this lady had brain operation, her VF have improved and now she has residual VF defects, try to plot'. When I started examining her, she did not have any residual VF defect, she instead was having gross VF loss in all four quadrants. In addition, she was using what looked like varifocal glasses, I feel theoretically we have to do the VF testing in her both with and without glasses, which I started doing, but practically in such a station with such a short time, one should keep clear-cut cases, without any added confusion and just look for the method of examination. I literally ran out of time with her, she was however last case of my exam.
- Asked to give differentials for unilateral pupillary miosis. Went through the list. Asked for another cause. Again, I asked to confirm the examiners meant causes of UNILATERAL miosis – confirmed. Later told they were looking for causes of bilateral miosis. Unclear.
- One of the patients unintentionally misled to the wrong finding. I hope the examiners took this into consideration. (Not received the results yet!)
- Having a patient with just a peripheral ring of retinal laser scarring and expecting a candidate to identify it as *pan-retinal* photocoagulation is inappropriate. Trainees would likely be re-trained by their supervisor in laser application if they called such a peripheral ring of laser "PRP".
- I actually enjoyed the challenge of this station.

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

Yes: 86% No: 14%

Comments

- The trickiest station of the entire exam! Some of the cases were quite difficult and possibly beyond what is expected of an ophthalmologist
- I do not think that this station is fair in providing a uniform or representative case mix in terms of difficulty. There is far too much weighting allocated to this station given that it is meant to be an **ophthalmology exit exam**. In order to justify this weighting, the curriculum should also reflect this i.e. 1/3 of our training should be geared towards a firm in medicine/ neurology if 1/3 of an OSCE mark is to be allocated to medicine and neurology! I would like to think that I passed or failed my ophthalmology exit exam based on my ability in

ophthalmology rather than my ability to be a neurologist/ physician. It would be far more appropriate and realistic to expect a candidate to pick up signs and know when to refer a patient to the neurologist/ physician, as that would be what actually happens in real life in clinic. Furthermore, the alternative case - book option exit examination available to some candidates does not require candidates to perform in neurology/ medicine to a similar extent – this is inequitable.

- It makes little sense to ask what specific prognostic tests medical teams might do for conditions that medical specialties (and not ophthalmologists) would primarily manage. Trainees taking the MRCP or MRCPGP would not be asked what additional tests an ophthalmologist would do for a patient with a primarily ophthalmic problem, only what they would specifically do. The expected knowledge base (and therefore the questions asked) is not appropriate for an ophthalmic examination.

OSCE station Communication Skills

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

Yes: 100% No: 0%

Was the clinical scenario explained clearly?

Yes: 95% No: 5%

Comments

- However the scenario asked us to give the patient the diagnosis. In this scenario this was impossible to do as the diagnosis could only be confirmed following further tests.
- Difficult to know whether to concentrate wholly on patient and worries vs. the atypical presentation
- Very open statement. Unsure if it was a management scenario (Optic neuritis and bitemporal pallor) or counselling on tumour. Patient kept talking about MS so very difficult to know what the station required.

Was the clinical scenario appropriate for an exit examination?

Yes: 100% No: 0%

Comments

- We entered this station as a communications skill one and that was our direction of thinking. However we were then marked on clinical basis as well.
- I think it would be helpful to rename this station patient management & communication skills.
- This was very unrealistic as in real life you don't let a patient bully you to talk about a topic that is not relevant. Also one would have all the necessary information and tests

The OSCE overall

Was the OSCE well organized?

Yes: 100% No: 0%

Comments

- Very well organised
- Very well done. No stress during exam as was clearly told where to go next and had time to clear my head between stations
- Despite the logistical nightmare it must be, it was very well organized, flowed very well despite the tight corridors – I think Brighton need commending for their efforts and should be proud of what they achieved.

- The only drawback was the 30min rest station. Although I understand the logistics of the examination could be difficult, it would be better if candidates have their own area to rest and collect their thoughts for the later stations.
- The examiners need more training as well. Some examiners made sure that the candidate sees as many cases as possible and they guided the candidate through. While in couple of stations, the examiners were so neutral that the candidate felt lost with the instructions.
- Great effort.
- Well organized with sufficient time in between stations.
- It was well organized but there was no distance fixation target in the strabismus station.

Were you given clear instructions about the OSCE?

Yes: 95% No: 5%

Comments

- It would have been useful to know in the letter saying we'd progressed to the OSCE what equipment (if any) we would need to bring. If we don't need to bring any, say so – it was a small but surprising cause of stress in the days before travelling down.
- In most of the stations. The instructions were unclear in stations such as the one asking one to do the visual field assessment.], the one asking to do a lid examination. These instructions are okay when there are clear-cut clinical findings, but in cases where the findings are subtle, the candidate can be lost.

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

Yes: 95% No: 5%

Comments

- The questions were of an appropriate standard. I don't think any of the questions asked were unreasonable or unfair.
- It is a very artificial setup but this is part of the nature of this exam
- I did not feel that there was not enough time to examine patients and it all felt very rushed. I am worried that I missed things as I felt very rushed. I would be much more thorough in my clinical practice especially when faced with difficult cases such as rotatory nystagmus.
- On the whole, yes. However, the way questions were asked for the medicine/neurology station made it a lot harder to perform as optimally as possible
- Difficult, as cross section rather than overall assessment – as is necessary in exams!

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

Yes: 100% No: 0%

Comments

- I think passing the exam should be an overall mark for structured viva and OSCE i.e. you can marginally fail the OSCE and still pass if you pass the structured viva well enough.
- Given that we are after all clinicians, our clinical skills should be scrutinized by peers before being considered safe for independent practice.
- Very varied but realistic cases chosen. Overall, a good test.
- It allows the opportunity to assess trainees on examination skills/clinical management.

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

- The scoring system does not provide enough scope for marks. Even a slightly

larger range e.g. 0 – 4 may help better differentiate between candidates.

- Overall, very well constructed exam, the medicine and neurology station was quite difficult, but I have to say the examiners were fair. Not much to fault really, it is a bit tight for time especially if we have to see 3 patients who have to be moved around!
- Whilst I am totally aware of the close relationship between neurology and ophthalmology, I think that the medicine/ neurology station should not be given so much weighting in an ophthalmology exam. If it does remain 2/6 of the OSCE mark, the college should seriously consider adding a year onto our training dedicated to medicine/ neurology i.e. (7 years plus 1)1/8th of training time would be spent learning about medicine/ neurology – even with this extra year, the station would remain over represented in an ophthalmology exam (more than 2 years should be dedicated to medicine/ neurology to balance the representation allocated in the current exam format – currently 0 years are allocated to this). Also, MRCP should be made compulsory as the current set up clearly favours those who have done this in the past. The MRCOphth message board clearly reflects that many candidates feel the same about the medicine/ neurology station. On a humorous note, my father who is actually a physician could not understand why I spent every Sunday morning after the results came out for the written paper on a neurology ward, and couldn't understand why I was reading an MRCP short case book (Ryder) when he thought I was preparing for an ophthalmology exit exam. I hope my comments are taken in the spirit they are meant. I'd also like to say that I appreciate that there is a huge amount of work that goes into setting up this examination and I'm sure efforts are made to minimize any issues. Equally, a huge amount of time is spent preparing for the examination at the expense of family time by most by this stage. It would be reassuring to know that success was dependent on a true reflection of each candidate's ophthalmic ability.
- There was a certain sense of haste towards the end of the examination, especially the last station when I felt I was a bit rushed by the examiners. I was in the last rotation of the day and that might be the reason, but it would be better if each candidate could be taken through the station at usual pace throughout the exam.
- Having a 30-minute rest station in between was not ideal. Otherwise the organisers should be congratulated on their hard work for organising the VIVA and OSCE.
- Well organized. I enjoyed it.
- I hope you revise your decision of joining two stations in one. This is with regard to the medicine and neurology. My reasons are: Having 2 examiners instead of 4 will significantly impact on the reliability of the test. Furthermore if a candidate did not do well in the first case this will impact on 3 further cases both psychologically and through the subjective feeling of the examiners. In our exam there were 2 medical rooms for 2 candidates so can easily do 2 stations per candidate per room. It is well known between candidates now that this station is the ultimate decider of the WHOLE exam rather than an even distribution of weight.
- I am also not sure why a physician should be an examiner in an Ophthalmology exam. The level of knowledge and skill expected from us should be what is expected from an Ophthalmologist. Physicians have their own (higher) expectations from their candidates and as far as I know they don't ask an Ophthalmologist to examine in their ophthalmoscope OSCE.
- All the equipment provided should be in perfect working order. The indirect ophthalmoscope on the medicine/neurology station could not be tightened for fitting, so examination had to be done in such a way as to prevent the headwear from falling off the head. It is challenging enough to have to

examine patients in such an unrealistic manner (i.e.: no time for appropriate history taking, examine only specifically requested bits) without having equipment that does not function as it should.