Examination Report

April 2014 Part 2 FRCOphth Oral Examination

The ROYAL COLLEGE of OPHTHALMOLOGISTS

Contents:

1. Summary

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%. Candidates in OST are more likely to pass than those not in training posts (65% vs. 16%). This provides evidence that the examination is a valid assessment of achievement of the competencies described in the curriculum for OST.

The organisation and planning of the oral examination is a considerable challenge for the Examination Department and the host eye departments. Three teams of examiners were required to accommodate 104 candidates in the time available. It can be difficult to ensure that this number of consultants is released from clinical duties. The host eye department has to recruit a large number of patients. The increased number of examiners and patients can make it more difficult to standardise conditions for candidates.

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

This is the third oral examination that assessed candidates who had been successful in the new written examination, which now consists of just a single MCQ paper. The correlation between performance in the MCQ and the oral examination is acceptable (0.32). The MCQ paper does not act as a significant barrier to progression to the oral examination.

Candidate's performance was significantly better if they were in OST, received their primary medical qualification in the UK or had English as their first language. There was no statistically significant difference in the performance of candidates based upon gender or stated ethnicity.

There were some exceptionally good performances in the oral examination with the highest mark in each part over 90%.

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

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The oral parts of the twelfth sitting of the Part 2 FRCOphth examination were held in York from Monday 28 April to Thursday 2 May.

2. Candidates

105 candidates were eligible to sit the oral examination having successfully completed the written papers in February. 104 candidates presented themselves for the examination.

Oral examinations (Structured Viva and OSCE)

3. The Structured Vivas

There were five structured vivas, which were held on Monday 28 and Tuesday 29 April 2014 in the National Science Learning Centre, University of York. 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	Biometry
Tuesday AM	Humphreys visual field interpretation
Tuesday PM	Topography
Station 2:	**Patient management 1**
Monday PM	Diabetic PRP
Tuesday AM	Ushers syndrome
Tuesday PM	Diabetes and pregnancy
Station 3:	**Patient management 2**
Monday PM	Idiopathic intracranial hypertension
Tuesday AM	Paediatric cataract
Tuesday PM	Normal tension glaucoma
Station 4:	**Attitudes, Ethics and Responsibilities.**
Monday PM	Driving Standards and Non-Accidental Injury (5 mins each)
Tuesday AM	Social media interaction
Tuesday PM	Problem doctors and revalidation
Station 5:	**Audit, Research and EBM (5 minutes)**
Monday PM	Lattice degeneration
Tuesday AM	Lucentis v Avastin
Tuesday PM	Guidelines for treatment of amblyopia
	Health Promotion and Disease Prevention (5 minutes)
Monday PM	Tobacco Alcohol amblyopia
Tuesday AM	Endophthalmitis outbreak
Tuesday PM	AREDS
Station 6:	**Communication Skills**
Monday PM	Retinitis pigmentosa
Tuesday AM	Primary open angle glaucoma
Tuesday PM	Cataract AMD

The vivas were held in one large lecture hall separated by screens. The communication skills stations were each housed in separate rooms around 45 seconds walk from the main hall. There were three teams of examiners (red, blue and green teams). The examination was conducted in six rounds (two on Monday and four on Tuesday).

3a) Results:

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

Pass mark (using borderline candidate method):	62 (52%)
Mean score:	81 (67.5%)
Median score:	82 (68%)
Range:	37-116 (31%-97%)
Reliability: (Cronbach alpha)	0.8
SEM:	6
Final adjusted pass mark (+ 1 SEM)	**68 (57%)**
Pass rate before adjustment (pass mark 62/120)	95/104 (91%)
Pass rate after adjustment (pass mark 68/120)	**89/104 (86%)**

Table 1 Distribution of scores

Score	Distribution	Total
21-30		
31-40	//	2
41-50	//	2
51-60	///	3
61-70	///// ////// ///	13
71-80	///// ///// ///// ///// ///// ////	29
81-90	///// ///// ///// ///// ///// //	27
91-100	///// ///// ///// ////	19
101-110	///// //	7
111-120	//	2
Total		104

Table 2 Results for each station

Station		Mean score	Median score	Range
1	PI	17.7	18	5-24
2	PM	16.4	17	5-24
3	PM	16.9	18	5-24
4	AER	15.8	16	3-24
5	HPDP/EBM	14.2	15	2-24

Table 3 Correlation between examiner's marks at each station

Team	Station 1	Station 2	Station 3	Station 4	Station 5
	PI	PM	PM	AER	HPDP/EBM
	0.9	0.9	0.9	0.8	0.8

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
	0.8	0.9	0.9	0.8	0.8

Table 5 Correlation between viva stations

		Station 1	Station 2	Station 3	Station 4
		PI	PM	PM	AER
Station 2	PM	0.19			
Station 3	PM	0.28	0.30		
Station 4	AER	0.34	0.26	0.43	
Station 5	HPDP/EBM	0.27	0.19	0.19	0.21

3b) Standard setting for the structured vivas

Table 6

	1		*2*		*3*		*4*		*5*		*Total*
Number of borderline candidates	*25*	*29*	*28*	*24*	*17*	*13*	*23*	*25*	*28*	*37*	
Median borderline candidate mark	*7*	*6*	*7*	*6*	*6*	*6*	*6*	*6*	*6*	*6*	*62*

The pass mark for the structured viva was increased by 1 SEM from 62/120 (52%) to 68/120 (57%).

4. The OSCE

There were seven OSCE stations in all. The six clinical stations were held on Wednesday 30 April and Thursday 1 May 2014 at York District Hospital. The communication OSCE was conducted with the vivas. There were three teams of examiners (red team, blue team and green team) and six rounds (three on Wednesday and three 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.

Details of the patients who made themselves available for the examination are provided in appendix 2.

4a) 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)	87/156 (56%)
Mean score:	99/156 (63%)
Median score:	99/156 (63%)
Range:	46-144 (29%-92%)
Reliability (Cronbach alpha):	0.8
SEM:	8
Final adjusted pass mark (+1 SEM)	**95/156 (61%)**
Pass rate before adjustment (pass mark 87/156)	79/104 (76%)
Pass rate after adjustment (pass mark 95/156)	**64/104 (62%)**

Table 7 Distribution of scores

Score	Distribution	Total
31-40		
41-50	/	1
51-60	///	3
61-70	////	4
71-80	///// ///	8
81-90	///// ///// ///// ///	18
91-100	///// //// ///// ///// /	21
101-110	///// ///// /////	15
111-120	///// ///// ///// ///// ///	23
121-130	///// /////	10
131-140		0
141-150	/	1
Total		

Table 8 Station marks (before weighting)

Station		Maximum possible	Mean (%)	Median	Min	Max
1	Anterior segment & cataract	36	24 (67%)	24	8	36
2	Glaucoma & lid	36	23 (64%)	23	10	36
3	Posterior segment	36	26 (72%)	27	13	36
4	Paediatric & strabismus	24	13 (54%)	13	2	24
5/6	Medicine and neurology	48	29 (60%)	29	7	44
7	Communication	18	11 (61%)	11	0	18

Table 9 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	0.8	0.8	0.9	0.9	0.9

Table 10 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.
	0.8	0.9	0.9	0.9	0.9	0.8

Table 11 Correlation between station scores (combined marks 2 examiners)

		Station 1	Station 2	Station 3	Station 4	Station 5/6
		Cat/AS	Glauc/lid	Posterior	Orbit/Strab	Med/neuro
Station 2	Glauc/lid	0.35				
Station 3	Posterior	0.35	0.13			
Station 4	Orbit/Strab	0.35	0.33	0.15		
Station 5/6	Med/neuro	0.35	0.25	0.30	0.21	
Station 7	Comm	0.15	0.23	0.16	0.33	0.39

4b) Standard setting for the OSCE

Table 12

Station	*1*		*2*		*3*		*4*		*5 & 6*		*7*	
No. of borderline candidates	29	27	26	28	18	21	37	33	24	25	36	33
Median borderline candidate weighted score	6.7	6.7	6.7	6.7	7.7	7.3	6	6	14	13	3.3	3.3
Median borderline candidate raw score	10	10	10	10	11.5	11	6	6	14	13	5	5

The pass mark for the OSCE was increased by 1 SEM from 87/156 (56%) to 95/156 (61%)

5. Overall results for the oral examination

5a. Results

Pass mark	163/276	(59%)
Mean	180/276	(65%)
Median	181.5/276	(66%)
Range	88-243 (32%-88%)	

To pass the oral examination candidates must achieve 163/276 overall, 62/120 in the viva and 95/156 in the OSCE.

80 candidates achieved 163/276, but only 60 met all three requirements in order to pass the examination overall.

Pass rate for the oral examination	60/104 (58%)
Pass rate for the entire examination	60/117 (51%)

Table 13 Distribution of scores

Score	Distribution	Total
61-70		
71-80		
81-90	/	1
91-100	/	1
101-110	/	1
111-120		0
121-130	///	3
131-140	/////	5
141-150	/////	5
151-160	///// /	6
161-170	///// ///// ///// ////	19
171-180	///// /////	10
181-190	///// /////	10
191-200	///// ///// /////	15
201-210	///// ///// //	12
211-220	///// /////	10
221-230	////	4
231-240	/	1
241-250	/	1
251-260		0
Total		

Table 14 Correlation between scores in each part of examination

	VIVA	*OSCE*	Oral examination
MCQ	0.20	0.35	0.32
VIVA		0.56	

5b) Breakdown of Oral Examination

Table 15 Breakdown of results by training

	Failed	Passed (%)	Total
In OST	25	55 (69%)	80
Not in OST	19	5 (21%)	24
Total	44	60 (58%)	104

These differences are statistically significant (p = 0.00004)

Pass rate for the oral examination for candidates in OST 69%
Pass rate for the Part 2 examination for candidates in OST 65%

Table 16 Breakdown of results by gender

	Failed	Passed (%)	Total
Female	14	22	36
Male	30	38	38
Total	44	60	104

These differences are not statistically significant (p = 0.38)

Table 17 Breakdown of results by deanery

	Failed	Passed	Total
East Midlands	2	3	5
East of England	3	3	6
East Scotland	0	1	1
London	4	14	18
Mersey	0	4	4
North Scotland	0	0	0
North Western	2	3	5
Northern	1	3	4
Northern Ireland	0	1	1
Oxford	0	2	2
Peninsula	1	0	1
South East Scotland	1	1	2
West Scotland	1	4	5
Severn	1	0	1
Wales	1	2	3
Wessex	1	2	3
West Midlands	2	5	7
Yorkshire	5	7	12
	25	55	80

Table 18 Breakdown of results by level of training

	Failed	Passed	Total
ST3	0	0	0
ST4	2	9	11
ST5	9	24	33
ST6	6	19	25
ST7	4	2	6
Total	21	54	75

* Level unknown for 5 candidates in OST

Table 19 Breakdown of results by country of qualification

	Failed	Passed	Total
UK	14	41 (75%)	55
Outside UK	30	19 (39%)	49
Total	44	60 (58%)	104

These differences are statistically significant (p = 0.0003)

Table 20 Breakdown of results by first language

	Failed	Passed (%)	Total
English	15	43 (74%)	58
Other	24	15 (38%)	39
Total	39	58	97

*First language unknown for 7 candidates

These differences are statistically significant (p = 0.0007)

Table 21 Breakdown of results by ethnicity

	Failed	Passed	Total
White	10	21 (68%)	31
Non-white	29	35 (55%)	64
Total	39	56 (59%)	95

* Ethnicity undeclared by 9 candidates

These differences are not statistically significant for white/non-white (p = 0.27)

Table 22 Ethnicity of candidates in OST

Ethnicity	In OST	Not in OST	Total
White	28	3	31
Non-white	48	16	64
	76	19	95

* Ethnicity undeclared by 9 candidates

Table 23 Breakdown for candidates in OST by ethnicity

Ethnicity	Fail	Pass	Total
White	8	20 (71%)	28
Non-white	16	32 (67%)	48
	24	52 (68%)	76

* Ethnicity undeclared by 4 candidates

These differences are not statistically significant for white/non-white in training (P = 0.8)

Table 24 Breakdown of results by number of previous attempts

Attempts	Failed	Passed (%)	Total
1 (First)	25	43 (63%)	68
2	10	8 (44%)	18
3	3	6 (67%)	9
4	0	2 (100%)	2
5	1	1 (50%)	2
6	4	0	4
7	0	0	0
8	1	0	1
Any resit	19	17 (47%)	36

5d) Table 25 Comparison to previous examinations

Date	April 10	Oct 10	April 11	Nov 11	April 12	Oct 12	April 13	Nov 13	April 13
Candidates	21	26	46	77	104	95	109	103	104
MCQ pass mark	66%	65%	65%	58%	58%	55%	61%	59%	58%
Reliability	0.8	0.8	0.7	0.7	0.7	0.7	0.8	0.8	0.8
EMQ pass mark	65%	64%	65%	59%	58%	59%	NA	NA	NA
Reliability	0.9	0.8	0.7	0.7	0.7	0.8	NA	NA	NA
Viva pass mark	57%	56%	63%	60%	62%	58%	60%	58%	57%
Reliability	0.90	0.8	0.8	0.8	0.8	0.8	0.8	0.9	0.8
OSCE pass mark	61%	62%	63%	65%	62%	62%	63%	61%	61%
Reliability	0.8	0.9	0.9	0.8	0.8	0.8	0.8	0.8	0.8
Written pass rate	48%	58%	46%	68%	65%	81%	85%	93%	90%
Oral pass rate	50%	73%	71%	54%	57%	63%	57%	58%	58%
Overall pass rate	24%	58%	33%	35%	37%	51%	48%	53%	51%
Overall pass rate in OST	NA	NA	43%	46%	43%	63%	56%	64%	65%

Table 26 Cumulative results by deanery (September 2010 to date)

Deanery	Number of passes	Number of candidates	Pass rate %
East Scotland	3	3	100
Oxford	16	20	80
Northern Ireland	8	11	73
Severn	12	17	71
North Scotland	4	6	67
London KSS	78	119	66
Mersey	17	26	65
Northern	13	20	65
South East Scotland	7	11	64
East Midlands	12	21	57
West Scotland	9	16	56
Peninsula	10	19	53
Wales	14	28	50
West Midlands	21	44	48
Yorkshire	23	51	45
North Western	15	36	42
East of England	6	15	40
Wessex	4	11	36
TOTAL	272	474	58

Appendix 1: Candidate evaluation

The following feedback is from 20 candidates who took part in the structured vivas/comms skills out of 104 (19% response)

Viva Station 1 Patient Investigations & Data Interpretation

Were you treated in a courteous manner by the examiners in this station?
Yes 100% No 0%

No comments

Were the questions appropriate for the station?
Yes 85% No 15%

Comments

- The examiners seemed to be a little restricted in the questions they could ask. I could tell they wanted to ask other questions or rephrase the ones they had been given, but struggled to do so.
- Some questions were basic sciences related more than clinical e.g. how does none contact biometry measure axial length. I think this was inappropriate.
- I felt that there were too many questions on the theme of Medical Retina whilst there were so many areas which were totally untouched. The communication skills station was on Wet AMD; The patient management station was based on Medical Retina (pregnancy in diabetes and wet AMD), Health promotion disease management asked questions on AREDS. So basically 2 stations out of 5 station was devoted to Medical Retina which is unjustified and the judgment of a candidate is somewhat skewed. I feel that the VIVA should be a realistic snapshot of the entire syllabus which cannot be covered in the OSCE and therefore it is best to remove any such bias.
- On the whole but a question at the end in particular wasn't understood and the examiner persisted in the same line of questioning without clarification
- The quality of the pentacam print out was poor as it was very difficult to read the numbers, the layout of the printout was different to what I had been familiar with and therefore difficult to answer specific questions about the average K readings for example.
- I felt the questions about trend analysis and VFI were slightly inappropriate as they are not clinical indices we use in our practice. Particularly, we do not usually interpret this data from a fields test.

Were the questions of an appropriate standard for an exit examination?
Yes 95% No 5%

Comments

- VF tests were very sub-specialised for glaucoma, not general ophthalmologists. I found this difficult despite doing glaucoma for the past 10 months.

Viva station 2 Patient Management 1

Were you treated in a courteous manner by the examiners in this station?
Yes 95% No 5%

Comments

- The examiners were rather stand off-ish

- Some question asked about pathophysiology of a disease, these are part one FRCOphth questions not for exit exam. Also, the quality of photos is poor and certainly must be changed
- Excellent examiners, allowed me adequate time to speak.

Were the questions appropriate for the station? Yes 95% No 5%

Comments

- Not really sure about this one. The printed photo of the optic disc I was shown was of a terrible quality. The whole station revolved around picking up signs of glaucoma from this photo, but I didn't feel it was appropriate to comment on the cup from this photo as I would be guessing. Consequently I feel the examiners assumed I missed the signs. It started the station off on completely the wrong foot and I subsequently struggled with questions that followed.
- Poor colour photograph of optic disc with new vessels
- The image quality was terrible, it really made me wonder if it was the finding or was it my imagination
- The fundus photograph shown was of poor quality

Were the questions of an appropriate standard for an exit examination?
Yes 100% No 0%

Comments

- I think the questions were at an appropriate level, but should have been worded differently. What is your differential for normal tension glaucoma? Did they mean other forms of glaucoma or other causes of optic neuropathy? Too broad a line of questioning.

Viva station 3 Patient Management 2

Were you treated in a courteous manner by the examiners in this station?
Yes 95% No 5%

Comments

- One of the examiners was quite harsh in his approach and attitude. I think examiners should keep in mind that an exam can stress some candidates considerably. An exam does not reflect their true behaviour and approach to real life in the clinic and this should be taken into consideration.
- In this station I ran out of time because examiners veered and focused into importance of examining pupil reflexes in congenital cataracts (this had nothing to do with the station and the examiner dwelled on this point unnecessarily). As a consequence I ran out of time discussing management.

Were the questions appropriate for the station? Yes 95% No 5%

Comments

- I understand this station was supposed to be an extremely complex situation and is supposed to test our management of unfamiliar situations
- I was asked detailed questions about a relatively rare condition (Usher's syndrome). I have always been told that this exam is to gauge if a candidate is safe to become a consultant. I do not believe that knowing such detail by heart makes you any safer in real life. At this day and age of information technology, such detailed information can be very easily found online (such as the OMIM website). I have seen consultants in the clinic (who are perfectly safe to see patients) looking up such information online. Therefore committing details on relatively rare conditions to memory is unnecessary.

Were the questions of an appropriate standard for an exit examination?
Yes 95% No 5%

No comments

Viva station 4 Attitude, Ethics and Responsibilities

Were you treated in a courteous manner by the examiners in this station?
Yes 90% No 10%

Comments

- No eye contact was given at all. Both the examiners were writing when I was answering. There was lack of clarity regarding the questions asked which made me give a wrong answer in the beginning but I clarified the question again and gave the correct answer
- One of the examiners seemed irritated. This shouldn't be the behaviour of an examiner in an exam.

Were the questions appropriate for the station? Yes 80% No 20%

Comments

- Candidates have been asked in too much detail about driving standards. I challenge any of the consultants to remember these details in real life practice e.g. driving standards for patients with diplopia and eye patches and also long standing field defect. Not appropriate for this exam.
- I found the whole scenario presented to me to be completely ridiculous. This station didn't not either test my knowledge of GMC guidance with respect to attitude, ethics and responsibilities, nor did it test how I would apply this knowledge to a real situation.
- Not sure…may be in the current world of face book and SMS texts…
- Questions about social media and doctors were interesting, it would have been more appropriate for a discussion rather than an examination station.
- The question was about a scenario regarding "Facebook". I DO NOT have Facebook and do not intend to have one. I do not know how it works and am not interested to know. Again, this exam is to show if a candidate is safe to be a consultant. Knowing how Facebook works is not relevant to Ophthalmology. I do not think that knowing what the GMC has said by heart makes you any safer. As long as you know the gist of what the GMC said should suffice. Also, when the examiner moved on to a different scenario, it wasn't clear that he actually moved on to something completely different and it took me a while to realise this. I think that there are many more important ethical issues that could have been discussed in this station rather than social media and Facebook. Social media is not used by everybody (including myself); therefore I am sure that I am safe in this regard because I do not have one.
- The Facebook question assumes that we are all Facebook users. I do not use Facebook and think it is inappropriate to assume we all know how it functions. It was clear that even the examiners were bemused that we were being asked about Facebook. I clearly stated that I would not use any technology that would jeopardise patient confidential information. I also mentioned Caldicott guidelines. I do not think the Facebook question should have been included in the exam. I am not familiar with the security features of Facebook such as how many people have access to the information. Is it like a telephone conversation I would have with a colleague over a BT telephone line? Unless a person understands how Facebook actually works including security and privacy functions, this is a difficult question to answer, and I think an unfair question to ask in a Fellowship exam.

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

Yes 85% No 15%

Comments

- An enjoyable and thought-provoking line of questioning

Viva station 5 Audit, research and evidence based medicine

Were you treated in a courteous manner by the examiners in this station?
Yes 95% No 5%

Comments

- A very fair station with adequate opportunity to speak about the CATT study

Were the questions appropriate for the station? Yes 75% No 25%

Comments

- This station did feel like another patient management station rather than research and EBM. The questions on toxic optic atrophy did not relate to any well known research that I was aware of.
- This station was completely out of context. Entering into this station candidates are mentally prepared for questions on audit, clinical trials and clinical governance. Surprisingly, we are asked on definition of lattice degeneration, and its pathophysiology (again part 1 stuff). Then the second examiner discusses a case with toxic neuropathy. The station felt like a third patient management station and had no relevance to audit and research what so ever. In addition, candidates on a different day were asked in deep details about CATT study. I do not see how this was relevant to practice.
- Appropriate level of questions but one half of this station ran like patient management station rather than evidence, research, and audit.
- Lattice degeneration: Questions were asked in an unclear way and repeated in such a way as to make the candidate doubt their answers
- The question on incidences of lattice asked specifically about numbers. This is not a Landmark study. It is not appropriate to ask this when other candidates were asked about NTG, CATT, IVAN studies.
- Questions seemed more on clinical management rather than the above
- The questions about retinal tear were not appropriate. It required too much figures. The questions about DVLA were fine.

Were the questions of an appropriate standard for an exit examination?
Yes 80% No 20%

Comments

- The follow up questions to the toxic optic atrophy case required an in-depth general medical knowledge. I was asked to name the contents of pabrinex which seemed a little off topic for an ophthalmology exam
- For an exit exam we are expected to know about the trials and their outcomes in reasonable depth and understand their relevance to our clinical practice. The question in this station were either completely irrelevant or were asked in too much detail. I think candidates should be compensated for the mental shock they have experienced in this station.
- I found the suggested level of knowledge required by the examiners for these studies to be too high. These were not ‘landmark’ papers and as such we cannot be expected to remember all equivalent studies, across all sub-specialties, to this level

OSCE station Communication Skills

Were you treated in a courteous manner by the examiners in this station?
Yes 100% No 0%

No comments

Was the clinical scenario explained clearly? Yes 85% No 15%

Comments

- I really think we should have been given time prompts for the station. I was led by the patient's line of questioning and didn't have time to summarise the encounter or to ask if they had any further questions etc at the end. I think the examiners should have interrupted and said "in the last two minutes, can you sum up please? Especially if there were marks allocated for these points
- I did not understand what was required of me in this station. Was I to register the patient as SI/SSI? Was I to discuss driving? It seemed strange that a patient with a corneal abrasion should have kinetic perimetry in casualty. I tried to cover everything but I felt the scenario was not true to life.
- It felt like a typical day-to-day scenario which was good. However, I felt like I spent the whole station worrying about if I am missing a hidden agenda because the scenario was so straight forward.
- I had a large table placed between myself and the actor. This is not how we are taught to set up a room for effective communication. The other room apparently did not have a table between the candidate and the actor. Consistency is so important.
- But, could have been good to give 2 minute warning so as to wrap up the communication
- A warning bell given a minute earlier than the conclusion would have been appreciated otherwise communication skills can go on forever and the termination of the skills station may appear abrupt.
- Although it wasn't made clear in the written description and the examiners advised what to focus on
- I felt the instructions were not overly clear. I was not given an indication as to whether it would be a station with sequential questions or the whole scenario entailed breaking the bad news (I realised it was the later after I was asked to leave the room early)

Was the clinical scenario appropriate for an exit examination?
Yes 95% No 5%

Comments

- Perhaps the clinical scenario was a little simple
- It was difficult to explain both the diagnosis (of Glaucoma and explain DVLA) and DVLA. Regulations in such a short time. It wouldn't be appropriate to rush the patient through such a life changing diagnosis. I would in my practice allow few minutes for the patient to understand his/her diagnosis and then talk through the implications. Felt a bit rushed to cram everything in (like bombarding the patient with info)…and also as no 2 minute warning given, couldn't summarise either.
- This station is 10 minutes long. I was asked to counsel a patient on 2 different things – explain the diagnosis, treatment and prognosis of glaucoma to a newly diagnosed glaucoma patient; and also to inform her that she is not fit for driving. I do not think that 10 minutes is enough to do that properly. Moreover, we weren't given a signal to alert us that time is running out. Unfortunately I think that in real life, if you are counseling a patient on such important issues, and you start looking at your watch because time is

running out, is a particularly rude and dismissive attitude. Therefore more time should be allocated if you are given 2 things to deal with rather than one!

The Structured Viva – Overall Feedback

Was the structured viva examination well organised?
Yes 95% No 5%

Comments

- A late start was quite frustrating
- Time prompts from the examiners or invigilators (a buzzer for two minute warning perhaps) would have been useful
- Patient investigations and audit research station have compromised the standard and quality of the viva exam. The communication skills station was on a different floor causing a slight distress; However, I guess this is related to the venue rather than the structure of the exam.
- Too much time between stations
- Room was crowded and could hear other people talking in nearby stations
- Well organised despite a small venue
- The rest time was quite long to begin with as it was longer than the actual stations. Once the flow was improved by having candidates wait outside the next station the rest stations were better timed.

Were you given clear instructions about the structured viva examination?
Yes 95% No 5%

Comments

- Sometimes, I wasn't quite sure which station I was going into until I was sitting down in front of the examiners. Preparing your mind a little bit ahead, helps a lot in an exam.

Did you feel that the structured viva examination was a fair assessment of your knowledge?
Yes 85% No 15%

Comments

- I felt it could have covered a better breadth of knowledge
- But cannot comment on how fair the system is in the sense that different group got different set of questions. Some candidates were texting questions to their friends!
- 2 out of the 6 stations could have been much better organised; this would have improved my performance
- Not enough clinical scenarios; more ethics/communications than I expected

In your opinion should the structured viva examination be included in the exit examination?
Yes 100% No 0%

Comments

- It is important tool of assessing candidates providing that the correct questions are asked. This is an exam to assess the clinical and practical knowledge and safety of candidates at a consultant level and not to challenge their knowledge of basic sciences. This is a stage they have already been assessed on and passed in part 1 and 2 FRCOphth.

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

- Overall, a very fair exam

- Very well organised fair exam
- Good location and well planned. However would prefer if there were separate rooms for the examiners and candidates instead of partition of cubicles as it can be noisy or difficult to listen to questions or answer with the background noise. For comms skills it would be good to give a two minute warning so the candidate can summarise.
- A very fair examination
- I think the lattice question should not be counted.

OSCE

OSCE station 1 Cataract and Anterior Segment

Were you treated in a courteous manner by the examiners in this station?
Yes 100% No 0%

Comments

- Excellent cases and extremely pleasant examiners
- Reasonably so. One examiner was very courteous; the other examiner was very abrupt at times.
- I felt that the examiners were telling me to keep examining the patients despite I telling them that I had completed the same. They did not start asking questions till a long time. It resulted in the time getting over before all the questions could be asked. I knew the answers but in all the three patients, ran out of time since questions were not asked from me till long. I request you to kindly look into this and the examiners should start asking the questions as soon as the candidate feels he has completed the clinical examination.

Were the patients you were asked to examine appropriate for the station?
Yes 100% No 0%

Comments

- Although I was questioned about my technique to assess TI defects – "I have never seen it being done like that before". The management questions were being asked as the patients were switching rooms and this I found off-putting especially as I had to move whilst this happened.

Were the questions of an appropriate standard for an exit examination?
Yes 100% No 0%

No comments

OSCE station 2 Glaucoma and eyelid

Were you treated in a courteous manner by the examiners in this station?
Yes 100% No 0%

Comments

- Very nice examiners and fair station
- There were extra people in my room and I was not informed who they were. He was not a patient and he did not ask me questions.

Were the patients you were asked to examine appropriate for the station?
Yes 95% No 5%

Comments

- None of the glaucoma patients had been dilated adequately. I had to examine the posterior segment in undilated eyes and the examiners only realised at the end that their questions were inappropriate given the undilated eyes.

Were the questions of an appropriate standard for an exit examination?
Yes 90% No 10%

Comments

- There was no pen torch available for measuring MRD
- Sometimes the questions were a bit vague; but overall I was quite happy with how that station went.
- Inappropriate to ask questions regarding patients who require dilated pupils.

OSCE station 3 Posterior Segment

Were you treated in a courteous manner by the examiners in this station?
Yes 85% No 15%

Comments

- One of the examiners was quite rough in his approach
- Extremely abrupt examiner
- I felt one of the examiners was overly difficult. I felt some of my answers were mocked – "you tell me the vessels are non-branching yet you diagnose shunts. Which is it? You can't have it both ways". I felt rushed in my exam, I was not given enough time to examine. I was told to say what I could see and move on, as a consequence I missed a haemorrhage in the macula. I was asked to give one diagnosis, even though I explained it was difficult to piece together macular haemorrhages and pigment looking like RP (hence I had to plump for old laser scars)

Were the patients you were asked to examine appropriate for the station?
Yes 95% No 5%

Comments

- Was asked to perform indirect ophthalmoscopy with patient in sitting up position. Specifically asked the examiner whether I could lie the patient down and the answer was no. I could see the lesion with patient sitting up. But felt a bit embarrassed as I had to bend down in an awkward position.
- One patient for indirect ophthalmoscopy had a peripheral pigmented retinal lesion which was difficult to see
- The examiner did not allow for a full and proper examination of the patient who needed an indirect ophthalmoscopy examination. He did not allow me to examine the patient lying down nor was there a chair for me to sit on to examine the patient at eye level. I was expected to examine the patient standing up while the patient was sat down in a chair. Also one of the slit lamp fundus examination patients had not been dilated properly and I was expected to examine the whole fundus. This is inappropriate.
- I had to continually ask for the light to be switched off. The macro-aneurysm patient was not dilated and difficult to examine. The indirect ophthalmoscope was very old and stuck to the wall. This made examination of the left eye very difficult.

Were the questions of an appropriate standard for an exit examination?
Yes 95% No 5%

Comments

- The quality of the optics in the indirect ophthalmoscope was awful. Even the clarity of the slip lamps in many stations were not right. This may have been alright for a person used to that kind of a museum piece of equipment- but it is quite difficult for someone who is used to much better instruments especially when one has to diagnose and give a verdict within minutes.
- It was a shame that the indirect ophthalmoscope was of a poor quality. It was extremely loose on my head and kept falling off. I pointed this to the examiner who tried to adjust it, but was unable to do so as well. I was told that it was broken and they would change it after my station. Despite this I was told to carry on. I pointed that I was not getting a binocular view and was told to hold the indirect with one hand and one of the examiners was holding the cable , so I wasn't able to do the examination in all positions as did not have a hand free to lift the lid. The examiners did say that it would not have a bearing on my performance but I felt it really unnerved me to the extent that I became very shaky for the next station which was squint/ orbit and as a result it affected my performance tremendously for that station. I have never had problem with adjusting an indirect over my head and was told that my head size was small! I can only say that the equipment for this exam should meet a certain standard which should be decided by the college and met by the hospitals hosting the exam. There is already a lot of pressure on the candidates to perform well without these things affecting that further.

OSCE station 4 Strabismus and Orbit

Were you treated in a courteous manner by the examiners in this station?
Yes 90% No 10%

Comments

- I felt like I was being instructed too much – I would have come to the clinical findings in less time if I had been allowed to follow my own practiced examination routine. The order I was asked to do things was not intuitive for me and would not have shown my ability at its best.
- Courteous yes, but myself and other candidates were somewhat put off by the examiner's tendency to laugh between themselves during the exam. It seems to have been a theme with these two examiners.
- Lovely examiners – given time to examine and explain findings as well as discuss management without interruption.
- Very unprofessional behaviour from both examiners. They were laughing and joking throughout the examination from the moment I entered the room. This was extremely off-putting for both myself and the patients. I believe I may have lost valuable marks due to the cavalier approach of the examiners

Were the patients you were asked to examine appropriate for the station?
Yes 80% No 20%

Comments

- I was given a IV palsy, which although tough, is fair and allows assessment of the candidate performing a Parks 3 step test. My second patient was very tricky and I did not get the diagnosis.
- Myopic heavy globe (if that's what it was) is sub-specialist knowledge. You would expect a general ophthalmologist to pick up the signs, but would they all get the diagnosis?
- The patients were quite complex and had already had Botox or other surgical procedures which makes the signs quite complex and difficult to interpret unless one knows the history
- The fourth nerve palsy patient had no vertical deviation in the primary position and an esotropia so was very difficult to examine

- My patients were relatively more complex compared to what some of the other candidates got.
- Some patients were confusing and rare. The findings were not fitting into particular patterns.
- I was asked to examine a lady with changing nystagmus in different gaze positions. I was unable to fully examine the patient due to the constant banter and laughter in the background. This disrupted the patient's attention as well. This inappropriate and off-putting behaviour was also noted by my fellow candidates. The patients were not adequate because the examiners were unable to identify if the patients were orbit or strabismus cases, When I asked the examiners they refused to tell me which meant I lost valuable marks in my examination sequence.

Were the questions of an appropriate standard for an exit examination?
Yes 100% No 0%

Comments
- Seemed to be a lack of questions on 'how would you manage this patient?'

OSCE station 5 Medicine and Neurology

Were you treated in a courteous manner by the examiners in this station?
Yes 95% No 5%

Comments
- This was my first station, the examiners were very friendly and made me feel at ease
- I felt harshly treated by the examiners. One kept interrupting everything I said and questioned the validity of my choice of investigation i.e. I was asked what investigations I would do for choroidal folds. Before I went on to image the orbits I mentioned FFA. I justified it as there was concurrent macular oedema; however the examiner wanted more explanation and then proceeded to say this was useless in this situation. I had told him I would start off with a history earlier in the case scenario and later on he suggested I should start off with history taking! I felt he was not listening to me. In the management of swollen discs, I wanted to sequentially discuss the aetiology of swollen discs and relevant investigations. But I was continually stopped after each point and asked to explain why this would not be pertinent in this case; although this was not the question I was asked! I was told how would one investigate swollen discs (not 'how would you investigate this patient'). He then moved me on without me mentioning imaging to assess papilloedema!

Were the patients you were asked to examine appropriate for the station?
Yes 90% No 10%

Comments
- It was interesting having a Parkinson disease patient but as they have so few ophthalmic features it seems more of an academic exercise than a true test of an ophthalmologist's clinical skills
- I had a gentleman with Parkinson's and no ophthalmic sings, he had little systemic findings on examination bar rigidity in his upper limbs, I suspect he had taken his treatment that day and so there was little to examine.

Were the questions of an appropriate standard for an exit examination?
Yes 80% No 20%

Comments

- As much as I love general medicine, it is difficult to justify some of the cases that come up in this station
- I felt like the whole station was contrived. These were definitely interesting cases, but the way that they were used in the exam didn't allow me to demonstrate myself as a clinician in terms of assessing their problem(s) and formulating a management plan. It was more of a 'show and tell' than a useful clinical scenario. I also felt that the verbal scenarios that I was given were too long and I therefore forgot salient points and I began to mix the 4 patients up. A written summary of the clinical context would have helped a lot.
- I felt that the case mix was quite good and we were not asked anything funny by the medicine/neurology consultant unlike other years wherein candidates were expected to be as slick and proficient as a neurology trainee. Also, the cases had some neurology and ophthalmology associations and not merely purely neurology.
- The neurology station's line of question was odd. One example I could remember was when a summary of the symptoms of one patient was given from13 years ago and I was asked what her diagnosis could have been from that without even being allowed to examine the patient.
- The gait and examine the patients face was a very tricky assessment for an ophthalmologist and I felt overall this question was unfair.

The OSCE overall

Was the OSCE well organised?
Yes 95% No 5%

Comments

- Amazingly well organised – thank you
- Very good venue of the OSCE and viva but would have preferred better instruments (slit lamp) and indirect ophthalmoscope
- Very well organised
- Too many unprepared patients whom were not well dilated. Unprofessional behaviour from the strabismus and orbit station examiners.

Were you given clear instructions about the OSCE?
Yes 100% No 0%

No comments

Did you feel that the OSCE was a fair assessment of your knowledge?
Yes 90% No 10%

Comments

- It depends on how the marks are attributed. With a close marking system and no knowledge of how the marks are given / taken away it is impossible for me to say whether the knowledge I displayed was fairly assessed.
- It only captures a few topics and pathology. It doesn't have the capacity to assess my knowledge or clinical experience accurately but is the most accurate tool available.
- Too many times I was interrupted and unable to continue to divulge my knowledge.

In your opinion should the OSCE be included in the exit examination?
Yes 95% No 5%

Comments

- It is an artificial environment to diagnose / manage patients which is quite different to how we practice in our daily clinics etc. It is not a proper fair assessment of any candidate's knowledge.

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

- A very well organised and fair exam
- A very fair exam
- Very well thought out and organised exam. There were a large number of rare and esoteric cases. This is fine as long as there are marks to be had for a safe and comprehensive approach to the patient assessment. In this situation if all the marks are on the final diagnosis it renders the exam a rather hit and miss, pot-luck exercise rather than a good assessment of the competence of the ophthalmologist.
- Good location. Well planned and organised. Good selection of patients.

Appendix 2

	OSCE	Area		Dilate
neurofibromatosis ET	AS	B		No
Keratoconus PKP 1986. Aborted rejection episode. L eraly	AS	C		No
pemphigold mycophenolate	AS	C		No
ocular melanosis pseudopapilloedema	AS	C		No
HSK x	AS	D		No
HSK x	AS	D		No
esotropia	AS	B	changed	No
Post polymorphous	AS	B	pm	No
Anirida x	AS	D		No
corneal scars	AS	B		No
rubeoisis	AS	D		No
irido-dialysis x	AS	C		No
iris lisch nodules x	AS	D		No
osteogenesis arcus senilis	AS	D		No
iris melancytic lesion x	AS	B		No
iris naevus x	AS	D		No
corneal granular dystrophy x	AS	D		No
interstitial keratitis	AS	C		No
posterior polymorphous corneal dystrophy resolved left	AS	C	changed	No
Fuchs's	AS	B		No
anterior segment dysgenisis, Salzmanns.	AS	C		No
HSK x	AS	C		No
osteogenesis arcus senilis	AS	C		No
Left inferior pigmented iris lesion	AS	B		No
blepharitis x	AS	D	AM	No
keratoconus	AS	B		No
anterior chamber lens x	AS	B		No
pigment dispersion syndrome x	AS	B	PM	No
keratoconus	AS	B		No
pigment dispersion syndrome x	AS	D	PM	No
Left inferior pigmented iris lesion	AS	C		No
anterior chamber lens x	AS	D		No
RD plomb Left	AS	D	Not	No
BCC LLL adj to punctum, BCC nose	Gl L	D		No
BCC LLL	Gl L	D		No
Congenital Ptosis	Glc L	B		No
rubeotic glaucoma x	GnL	B		No
basal cell C x Gorlins syndrome	GnL	D		No
Fuchs's Hetero L trab and cat L molteno and diode. CMO	GnL	B		No
glaucoma bil pan uveitis, old chorioretinitis. PAS L Moteno	GnL	C		No
rubeotic glaucoma x	GnL	D		Maybe
glaucoma disc right	GnL	B		Maybe
glaucoma disc right	GnL	B		Maybe
lid intradermal naevi x	GnL	B		No
lid intradermal naevi x	GnL	C		No
L CRVO PRP, residual neovasc cupped disc	GnL	C		Left
L CRVO PRP, residual neovasc cupped disc	GnL	D		Left
glaucoma ECCE Failed deep slerectomy, L Trab. Trauma	GnL	B		No
glaucoma ECCE Failed deep slerectomy, L Trab. Trauma	GnL	C		No
R Trauma ICCE 1985 Aphakic glaucoma Right HZO	GnL	C		No
axenfelds syndrome x	GnL	C	pm newMoved	No
glaucoma IOLs asymmetrical cups	GnL	C		Maybe
Glaucoma Myopic degen Trabs	GnL	D		Maybe

	OSCE	Area			Dilate
glaucoma/cupped discs/retintis pigmentosa	GnL		B		Both
levator aponeurosis x	GnL	C			No
levator aponeurosis x	GnL		B		No
glaucoma Trabs	GnL	B			No
glaucoma Trabs	GnL		C		No
pseudo-exfoliation/glaucoma x	GnL	D			No
Fuch's Heterchromia	GnL		D		No
congenital glaucoma	GnL	D PM			No
chronic open angle glaucoma x	GnL	D			No
chronic open angle glaucoma x	GnL		C		No
Schisis and bilateral ptosis ? levator	GnL		C	changed	Maybe
LUL intradermal naevus, LLL BCC listed for Tenzel for	GnL		D PM		No
BCC RLL	GnL	D			No
toxaplasma R LHZO, ant evieits. Disc drusen	MnN	C			Maybe
toxaplasma R LHZO, ant evieits. Disc drusen	MnN		B		Maybe
R blind APD treated melanoma ruthenium plaque	MnN		D		No
optic disc pit associated field loss	MnN		B	changed	Maybe
SAH L Hemianopia L Optic atrophy x	MnN		C		No
Left hypertropia MS	MnN		D		No
Parkinsons convergence weakness x	MnN	D			No
Parkinsons convergence weakness x	MnN		C		No
MELAS, mitochondrial, deaf, prox muscle weakness DM,	MnN	B			Maybe
MELAS, mitochondrial, deaf, prox muscle weakness DM,	MnN		C		Maybe
bilateral ptosis 06/5067	MnN		C		No
anaesthetic cornea x	MnN	C pm			No
syringomyelia Bil VI n, Downbeat A Chiari. L Rc Rs 2012	MnN		D		No
Sens XT LAPD no obvious cause	MnN	D			No
Sens XT LAPD no obvious cause	MnN		B		No
Adies's pupil	MnN		B		No
loss horizontal pursuits x	MnN	C			No
myotonic dystrophy x	MnN				No
3rd Nerve 20 yr hx secondary to brain stem meningioma	MnN	C am			No
C-ANCA positive CRAO APD	MnN	C			No
Horners	MnN	B			No
myotonic dystrophy x	MnN	B			No
optic nerve head drusen, ACLO. REtinal flecks	MnN	B			Both
MG	MnN		C		No
idiopathic cerebella degeneration down beat	MnN	C			No
6th nerve x	MnN				No
intracranial meningioma, ODD, right nasal field loss	MnN	D AM			No
superior quadrantanopia	MnN	B			No
Right Hemianopia	MnN		D		No
Junctional APD	MnN	D			No
Junctional APD	MnN		B		No
IIIRd n treated Rc Rs LR BTX	MnN	D			No
Horner's x	MnN	B			No
Syrinx, weak left side, nystagmus (down and torsional),	MnN	C			No
optic disc drusen	MnN	B			No
quadrantanopia x	MnN	B			No
L OA mild APD left field loss more superiorly presumed	MnN		C		No
RA hands	MnN		B		No
Glc sup field loss to conf hypotropia high axial myopia	MnN	D			No
optic atrophy x	MnN	C			No

	OSCE	Area			Dilate
L Blind OA R Inf field Map dot	MnN		D		No
dysmetric saccades	MnN		B		No
inf field loss NAION right x	MnN	C			No
inf field loss NAION right x	MnN		B		No
Myasthenia Gravis reduced abdctn	MnN	D			No
Sarcoid Uveitis L VII nerve (in 2005)	MnN	D			Maybe
hemianopia	MnN		D		No
optic neuritis LAPD	MnN		C		No
quadrantanopia	MnN				No
Right hemianopia	MnN	D			No
Right hemianopia	MnN		C		No
trigem swannoma anaesthtic cornea, 2007 left corneal	MnN	D			No
Post op LAPD L inflamm optic neuropathy. INS	MnN	B			No
Post op LAPD L inflamm optic neuropathy. INS	MnN		C		No
Full disc Hypermetropia Chroidal folds	MnN	B			No
Full disc Hypermetropia Chroidal folds	MnN		C		No
Failed RD right and sympathetic left	MnN	B			Both
Failed RD right and sympathetic left	MnN		C		Both
Lupus, Reynauds, On hydroxychlorquine, PSCLO.	MnN	C new		Change	no
Lupus, Reynauds, On hydroxychlorquine, PSCLO.	MnN		B	changed	no
Sarcoid affecting liver, Pan uveitis, Glaucoma extensive	MnN	C new		Change	No
Sarcoid affecting liver, Pan uveitis, Glaucoma extensive	MnN		B		No
Rheumatoid Arthritis	MnN	B new		Change	No
	MnN		D		No
TED Post IR MRc ET and Ltd elevation	MnO	D			No
Bil ptosis Myotonic dystrophy	MnO		D		No
pigmented lesion	Rta		D		Maybe
retinal pigmentation x	Rta	B			Both
Choiroidal hamangioma x	Rta		B		Left
CRAO	Rta	D			Right
CRAO	Rta		B		Right
inferior schisis, outer leaf break, Old focal superotemporal	Rta		B		Right
Hyaloid artery remnant x	Rta	C			Left
PIC choroidal neovascularasation 20 yrs ago	Rta	D pm			Both
Right melanocytic lesion. Left small pigmented lesion	Rta	C AM			Right
retinoschisis	Rta	C			Left
collateral vessels bilateral non ischaemic CRVO 2004	Rta	B			Both
collateral vessels bilateral non ischaemic CRVO 2004	Rta		C		Both
Pseudo elasticum Angiod streaks Right net	Rta		B		Right
retinal necrosis x	Rta	D			Right
retinal necrosis x	Rta		C		Right
amelanotic naevus	Rta		D		Right
pseudoxanthoma elasticum x	Rta		C		Both
retinitis pigmentosa x	Rta		C		Both
severe non prilifertive DR x	Rta	C			Both
inferior macroaneurysm x	Rta	B			Right
MAc pucker with pseudo hole and floating operculum	Rta	D			Left
retinitis pigmentosa x	Rta	D			Both
retinitis pigmentosa x	Rta		B		Both
DR Laserd CMO	Rta		D		Both
retinitis pigmetosa	Rta	B			Both
choroidal naevus x	Rta	B			Left
RP	Rta		D AM		Both

	OSCE	Area		Dilate
retinal tear retinopexy 2008	Rta	C		Left
ARMD x	Rta	D am		Both
mac holes RD sx epi retinal	Rta	B		Both
retinoschisis	Rta	D		Right
retinoschisis	Rta		C	Right
choroidal malignant melanoma x	Rta		D pm	Left
retinoschisis x	Rta		D	Both
Adult Bests?	Rta		B	Maybe
choroidal malignant melanoma x	Rta	C PM		Left
retinoschisis	Rta		D	Left
Poss Toxocara Retinal Fold Sensory XT Sx 2/9/2013	Rta	C		Left
Poss Toxocara Retinal Fold Sensory XT Sx 2/9/2013	Rta		D	Left
ION R IV AMD	SnO	B		No
Thyroid eye disease x	SnO		D	No
Excimer x	SnO	C		No
Bleph plasty Limited elevation	SnO	D		No
Myeloma R VI n Brain stem CVA 2010 Reduced	SnO	C		No
Myeloma R VI n Brain stem CVA 2010 Reduced	SnO		D	No
6th nerve palsy 1997	SnO	D pm		No
Post op sup myokymia	SnO	D		No
Post op sup myokymia	SnO		C	No
seonsory exotropia	SnO		?	No
Chronic prgressive external ophthalmoplegia	SnO	B		No
decompensating esophoria post BTX MR	SnO		B changed	No
lipodermoid	SnO	B		No
lipodermoid	SnO		C	No
Duanes/LN x	SnO	B PM		No
LSOP	SnO		D	No
Limited add abd os myopia post op	SnO		B	No
Exotropia	SnO	B		No
Large ET good fixation ou	SnO		D	No
Thyroid x	SnO	C pm		No
Thyroid x	SnO		B pm	No
ependymona	SnO	C		No
ependymona	SnO		B	No
XT post p ET from head inj prob decomp ET	SnO	D		No
XT post p ET from head inj prob decomp ET	SnO		C	No
Craniofrontal dysplasia, bilateral ptosis, left hypotropia and	SnO	D11	newMoved	no
TED L hypoT and ET, Ltd elevation abduction os	SnO	C	?	No