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FROM THE EXAMINATIONS DEPARTMENT

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Public Report on the Part 2 FRCOphth Oral Examination November 2012

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The oral parts of the ninth sitting of the Part 2 FRCOphth examination were held in Sunderland from 12 to 15 November 2012.

1. Candidates

Seventy-seven candidates were eligible to sit the oral examination having successfully completed the written papers in September. Seventy-six candidates presented themselves for the examination as one candidate had passed the Fellowship Assessment following the written 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, 77/95 candidates passed the written papers and were invited to attend the oral examination.
This represents a pass rate for the written papers of 81%.

Oral examinations (Structured Viva and OSCE)

2. The Structured Vivas

There were five structured vivas, which were held on Monday 12 and Tuesday 13 November in the Education Centre at Sunderland Royal Infirmary. 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 Epiretinal membrane and central serous retinopathy
Tuesday AM Sixth nerve palsy
Tuesday PM Fourth cranial nerve palsy

Station 2. Patient management 1
Monday PM Paediatric Watery Eye
Tuesday AM Watery eye in adult
Tuesday PM Retinal tear

Station 3. Patient management 2
Monday PM Dissecting carotid aneurysm
Tuesday AM Uveitis glaucoma secondary to JIA
Tuesday PM Vogt Koyanagi Harada syndrome

Station 4. Attitudes, ethics and responsibilities.
Monday PM Consent in an adult lacking capacity
Tuesday AM Gillick competence and parental responsibility
Tuesday PM Visual Impairment

Station 5.
Audit, research and evidence based practice (5 minutes)
Monday PM Diabetic Maculopathy
Tuesday AM Post-operative endophthalmitis
Tuesday PM Open Angle Glaucoma

Health promotion and disease prevention (5 minutes)
Monday PM CRVO
Tuesday AM Steroid
Tuesday PM DR Screening

The vivas were held in 7 rooms, with two viva stations per room partitioned by curtains. The communication skills stations were each housed in separate rooms. There were 2 teams of examiners (red and blue teams). The examination was conducted in 6 rounds (2 on Monday and 4 on Tuesday).

2a) Results:

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

Pass mark (using borderline candidate method):	
Mean score:	84/120 (70%)
Median score:	85.5
Range:	41 - 106
Reliability: (Cronbach alpha)	0.76
SEM:	6
Adjusted pass mark (+ 1 SEM)	70 (58%)
Pass rate before adjustment (pass mark 64/120)	71/76 (93%)
Pass rate after adjustment (pass mark 70/120)	65/76 (86%)

Table 1 Distribution of scores

Score	Distribution	Total
41-50	//	2
51-60	//	2
61-70	///// ///	8
71-80	///// ///// ///	13
81-90	///// ///// ///// ///// ///// ///// /	31
91-100	///// ///// ///	13
101-110	///// //	7
Total		76

Table 2 Results for each station

Station		Mean score	Median score	Range
1	PI	7.6	8	2 – 11.5
2	PM	9.3	9.5	3 – 12
3	PM	8.0	8	3 – 12
4	AER	8.7	9.25	2 – 12
5	HPDP/EBM	8.3	8.5	2.5 - 12

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
Both	0.51	0.82	0.87	0.92	0.67
Blue	0.62	0.72	0.88	0.88	0.69
Red	0.61	0.89	0.88	0.96	0.63

Table 5 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*
Both	0.61	0.90	0.89	0.84	0.69
Blue	0.62	0.89	0.95	0.72	0.87
Red	0.63	0.90	0.82	0.94	0.52

Table 6 Correlation between viva stations

		Station 2	*Station 3*	*Station 4*	*Station 5*
		PM	*PM*	*AER*	*HPDP/EBM*
Station 1	PI	0.32	0.17	0.13	0.21
Station 2	PM		0.14	0.34	0.08
Station 3	PM			0.20	0.16
Station 4	AER				0.24

2b) Standard setting for the structured vivas

	1		*2*		*3*		*4*		*5*		*Total*
Number of borderline candidates	*17*	*36*	*7*	*8*	*23*	*17*	*15*	*16*	*8*	*21*	
Median borderline candidate mark	*6*	*7*	*8*	*6*	*6*	*6*	*6*	*6*	*6*	*7*	*64*

The pass mark for the structured viva was increased by 1 SEM to 70/120 (58%).

3. The OSCE

There were seven OSCE stations in all. The six clinical stations were held on Wednesday 14 and Thursday 15 November 2012 at Sunderland Eye Infirmary. The communication OSCE was conducted with the vivas. There were 2 teams of examiners (red team and blue team) and 6 rounds (3 on Wednesday and 3 on Thursday).

Four of the OSCE stations lasted 15 minutes. The medicine and neurology stations ran as a double station and lasted 30 minutes. The communication OSCE lasted 10 minutes. There were two examiners at each station. In the communication OSCE, one examiner was a trained lay examiner.

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

Wednesday Morning

Station 1 - Anterior Segment

- Bilateral fixed dilated pupils with iridoschisis, previously dislocated lenses with sutured posterior chamber IOL
- R HSV corneal scar
- Sarcoid, uveitis, IIH with shunt, arthritis
- FED+cataracts, bilateral DSAEK + IOL
- Congenital cataract, glaucoma, previous trab small pupil
- lt ac iol , rt disc cupping ,rt DSEK

- Right PSCLO, Left early PSCLO, Bilateral nuclear sclerosis
- Inactive TED, Bilat Pseudophakia (yag capsulotomies) Bilat Keratoconus. Reduced elevation and mild proptosis
- Iris atrophy secondary HSV, IOL
- R - Choyce IOL and peripheral corneal oedema. L previous HSV keratitis and IOL
- Marfans. R iridodenesis, L secondary PC Artisan IOL, PI.
- L iris coloboma. R chorioretinal coloboma
- HSV keratitis. Iris atrophy, guttata +/- kps
- R endothelial keratoplasty and sutured PC IOL. L corneal oedema and Choyce AC IOL
- NF1. Early Fuchs dystrophy. R ERM. Bilat IOL
- R DSEK for PBK. Bilat IOLs
- Previous HZO, corneal thinning

Station 2 - Glaucoma and Lid

- L endstage glaucoma, vitrectomy, oil. R pseudophakic, large nasal bleb. CD0.6 sl pale
- CACG, Pseudophakia + PIs. Bilat cupping
- Trauma. Iris dialysis and angle recession. Normal IOP
- POAG. L disc changes
- Cuppping R>L. Pseudophakia
- POAG
- L VII. Aberrant regen on showing teeth
- Medial ectropions
- Ehlers - Danlos. Skin changes. LUL bleph. No angioid streaks
- LT Lower lid BCC
- RLL BCC
- POAG L>R. Cataracts. Early cupping R eye
- NTG. Cupping superiorly L > R
- L inf disc notch and arcuate field defect
- Primary open angle glaucoma 1996
- Congenital glaucoma. L calcific degeneration. R Haab striae, PI, small bleb, Los, cupping
- Xanthelasma ++. Bilat PSCLOs
- L congenital ptosis and amblyopia (4mm and poor LF)
- Lt inner canthal BCC
- L LMN VII , Acoustic neuroma. Gold weight

Station 3 - Posterior Segment

- Central Retinal Vein Occlusion, Pseudophakia
- Bests. RPE changes and subret fibrosis
- L Coats may have had laser / avastin
- Pseudophakia, Myopic degeneration, macular scar left eye
- Father with VHL. Angioma and exudate
- Son with VHL. R disc angioma and exudate
- R RD surgery. Dialysis I.T.Q. explant and laser 2005. 2011 Trauma → Superior R.D Vity/Cryo/Gas
- RP
- Congenital 'disc vasculature' / diabetic
- Inactive treated PDR. Previous vitrectomies. R AC IOL. L PCO
- Right CRVO with laser scars

- R optic disc pit. Pigment at mac /previous fluid. Leye subtle parafoveal telangiectasia
- L RPE hypertrophy
- RP (excellent signs)
- Sorsbys. R IOL. L cataract. RXT.
- Prev R RD. total RD and dislocated lens. L IOL and laser
- PDR. R NVD/PRP. L mac ischaemia
- Chronic left RD with spont reattachment. Field defect
- R choroidal colobomas, AC phimosis, L AE

Station 4 - Strabismus and Orbit

- Left hyperostotic fibrous dysplasia (longstanding). Globe displaced, L optic atrophy
- Left/Alternating divergent squint
- Large decomp X. V pattern
- LSO plasy. +ve 3 step test. R head tilt
- R Duanes
- R Browns, slight AHP
- TED. Bilat proptosis. No diplopia
- L - Brown's Syndrome with Exotropia
- L congenital IV. R head tilt
- Intermittent XT
- Consec XT
- Distance esophoria. Prisms. Myopia

Medicine and Neurology Station 5 and 6

- Goitre. Intermittent diplopia ?cause
- L LMN VII , Acoustic neuroma. Previous lat tarsorraphy, mild lagophthalmos
- Disc drusen. Anisometropia / amblyopia. Referred headaches and blurred discs
- Constricted fields - Advanced retinitis pigmentosa both eyes
- Inferior field loss, Disc Drusen, RA
- Relative Afferent Pupil Defect, Divergent Squint, Field Loss,upper field loss , blind right eye
- Chronic progressive external ophthalmoplegia. R>l disc cupping, L amblyopia. Proximal myopathy, absent reflexes,pseudoathetosis
- Central Retinal Artery Occlusion
- CVA. L lower quadrantanopia
- Parkinsons - tremor, rigidity, cogwheeling. Recent exophoria surgery
- R Horners after neck surgery
- Disc drusen on USS
- Previous L CRAO. L RAPD and optic atrophy
- Left Homonymous, Upper Quadrantanopia
- CVA R homon hemianopia
- R optic atrophy and RAPD. Ataxic gait. Dandy-Walker on MRI scan
- ON glioma. Pale discs, nystagmus,L RAPD
- Left optic neuropathy (Devic's disease)
- L Holmes Adies pupil. Anisocoria, vermiform movements. Light/near dissociation
- Thyroid
- Adies pupil

Wednesday Afternoon

Station 1 - Anterior Segment

- Iris atrophy secondary HSV, IOL
- Bilateral fixed dilated pupils with iridoschisis, previously dislocated lenses with sutured posterior chamber IOL
- R HSV corneal scar
- congenital cataract , glaucoma,previous trab small pupil
- lt ac iol , rt disc cupping ,rt DSEK
- Right PSCLO, Left early PSCLO, Bilateral nuclear sclerosis
- Aniridia (inherited). Nystagmus, stem cell failure,aniridia, smallish discs
- Prev Lasik. Bilat R.D. - extensive periph holes and lattice. Cryo and encircled 360 indent
- Spont hyphaema. Iris vessels? Cause
- Inactive TED, Bilat Pseudophakia (yag capsulotomies) Bilat Keratoconus. Reduced elevation and mild proptosis
- R - Choyce IOL and peripheral corneal oedema. L previous HSV keratitis and IOL
- L iris coloboma. R chorioretinal coloboma
- HSV keratitis. Iris atrophy, guttata +/- kps
- R endothelial keratoplasty an sutured PC IOL. L corneal oedema and Choyce AC IOL
- NF1. Early Fuchs dystrophy. R ERM. Bilat IOL
- R DSEK for PBK. Bilat IOLs
- HSV keratitis
- JIA uveitis, Cataract, Ozurdex
- Recurrent HSV stromal keratitis
- Pemphigoid, Symblepharon

Station 2 - Glaucoma and Lid

- L endstage glaucoma, vitrectomy, oil. R pseudophakic, large nasal bleb. CD0.6 sl pale
- CACG, Pseudophakia + PIs. Bilat cupping
- POAG. L disc changes
- Cuppping R>L. Pseudophakia
- POAG
- L VII. Aberrant regen on showing teeth
- Medial ectropions
- Ehlers - Danlos. Skin changes. LUL bleph. No angioid streaks
- LT Lower lid BCC
- pseudophakic, small ccc,vertical cup R+L and pale,small pupil +ps LE. Superior arcuate defect and nasal step LE
- POAG L>R. Cataracts. Early cupping R eye
- L inf disc notch and arcuate field defect
- Primary open angle glaucoma 1996
- Xanthelasma ++. Bilat PSCLOs
- L congenital ptosis and amblyopia (4mm and poor LF)
- L LMN VII , Acoustic neuroma. Gold weight
- Lt inner canthal BCC
- L angle recession secondary glaucoma
- Rt lower lid entropion

Station 3 - Posterior Segment

- Congenital 'disc vasculature' / diabetic
- L Coats may have had laser / avastin
- Pseudophakia, Myopic degeneration, macular scar left eye
- Father with VHL. Angioma and exudate
- Son with VHL. R disc angioma and exudate
- R RD surgery. Dialysis I.T.Q. explant and laser 2005. 2011 Trauma → Superior R.D Vity/Cryo/Gas
- RP
- L BRVO with shunts and laser Rx. R&L Disc cupping
- Right central retinal vein/
- Occlusion
- Retinitis pigmentosa
- Right CRVO with laser scars
- R optic disc pit. Pigment at mac /previous fluid. Leye subtle parafoveal telangiectasia
- L RPE hypertrophy
- RP (excellent signs)
- Sorsbys. R IOL. L cataract. RXT.
- Inactive treated PDR. Previous vitrectomies. R AC IOL. L PCO
- Prev R RD. total RD and dislocated lens. L IOL and laser
- R choroidal colobomas, AC phimosis, L AE
- Chronic left RD with spont reattachment. Field defect
- Previous L mac off RD. Vitrectomy, cryo,oil. RE two free floating opercula and untreated flat holes
- PDR. L NVs ++, recent R vitrectomy

Station 4 - Strabismus and Orbit

- Left hyperostotic fibrous dysplasia (longstanding). Globe displaced, L optic atrophy
- Left/Alternating divergent squint
- Large decomp X. V pattern
- LSO plasy. +ve 3 step test. R head tilt
- MS. Bilat VI weakness. ET dist>nr with diplopia. Prisms in glasses
- ? Mild Parry-Romberg. RSO weakness.Face turn L, chin up AHP. Mild facial asymmetry/atrophy. Poliosis and white brow. ? Mild R proptosis
- TED and goitre
- L Browns
- L congenital IV. R head tilt
- Consec XT
- Distance esophoria. Prisms. Myopia

Medicine and Neurology Station 5 and 6

- L LMN VII , Acoustic neuroma. Previous lat tarsorraphy, mild lagophthalmos
- Constricted fields - Advanced retinitis pigmentosa both eyes
- Inferior field loss, Disc Drusen, RA
- Relative Afferent Pupil Defect, Divergent Squint, Field Loss,upper field loss , blind right eye
- Chronic progressive external ophthalmoplegia. R>l disc cupping, L amblyopia. Proximal myopathy, absent reflexes,pseudoathetosis

- Central Retinal Artery Occlusion
- CVA. L lower quadrantanopia
- R Horners after neck surgery
- L BRAO with emboli. Nasal scotoma
- Homonymous Hemianopia
- Laurence-Moon-Biedl. RP. Pale discs / ettenuated vessels. IOLs
- R Horners and hemisensory loss. Medullary infarct
- Congenital myaesthenia. Ptosis. Reduced EOM. Small LXT
- MS. Intermediate uveitis. Previous L retinal vasculitis (old occluded vessels). Mild LOs. Uhthoffs. Gait?
- Disc drusen on USS
- Previous L CRAO. L RAPD and optic atrophy
- Left Homonymous, Upper Quadrantanopia
- CVA R homon hemianopia
- R optic atrophy and RAPD. Ataxic gait. Dandy-Walker on MRI scan
- ON glioma. Pale discs, nystagmus,L RAPD
- Left optic neuropathy (Devic's disease)
- Thyroid
- Adies pupil
- R LMN VII. Previous acoustic neuroma
- Hemianopia, Homonymous
- L Horners post CVA
- Parkinsons - tremor, gait. CACG/Bilat IOLs, L disc cupping ++
- Left hemianopia / hemiparesis. Physiological cupping

Thursday Morning

Station 1 - Anterior Segment

- Uveitis, glaucoma, trabs, Cat X
- R - Choyce IOL and peripheral corneal oedema. L previous HSV keratitis and IOL
- Blind R eye. RD due to Sticklers. White cataract and corneal tattoo (fading)
- Inactive TED, Bilat Pseudophakia (yag capsulotomies) Bilat Keratoconus. Reduced elevation and mild proptosis
- L iris coloboma. R chorioretinal coloboma
- Pemphigoid, glaucoma
- HSV keratitis. Iris atrophy, guttata +/- kps
- Bilateral fixed dilated pupils with iridoschisis, previously dislocated lenses with sutured posterior chamber IOL
- FED+cataracts, bilateral DSAEK + IOL
- R Fuchs / cataract. L DSAEK + IOL. Glaucoma
- Prev L penetrating eye injury. Corneal scar, IOL, PI
- Iris atrophy secondary HSV, IOL
- Keratoconus.Central scarring / striae RE. L INTACS
- Chronic HSV keratitis R
- NF1. Early Fuchs dystrophy. R ERM. Bilat IOL
- ARMD. Right cataract. Left pseudophakia. Left DSEK.
- Sarcoid, uveitis, IIH with shunt, arthritis
- removal of bifocal lens +insertion of monfocal lens ,yag vitreous strand
- lt ac iol , rt disc cupping ,rt DSEK
- Band keratopathy, L pseudophakia, R cataract

Station 2 - Glaucoma and Lid

- POAG
- Bilat trabs. R cupping
- POAG L>R. Cataracts. Early cupping R eye
- NTG. Cupping superiorly L > R
- L inf disc notch and arcuate field defect
- Essential Iris Atrophy RE, cupped disc
- Involutional ptosis. Chin up. On anticoagulants
- Xanthelasma ++. Bilat PSCLOs
- Floppy eyelid syndrome / sleep apnoea
- L LMN VII , Acoustic neuroma. Gold weight
- L endstage glaucoma, vitrectomy, oil. R pseudophakic, large nasal bleb. CD0.6 sl pale
- CACG, Pseudophakia + PIs. Bilat cupping
- Ex advanced POAG, Disc cupping, left trab, right brev tube
- Trauma. Iris dialysis and angle recession. Normal IOP
- POAG. L disc changes
- Cuppping R>L. Pseudophakia
- L VII. Aberrant regen on showing teeth
- Ehlers - Danlos. Skin changes. LUL bleph. No angioid streaks
- Involutional ptosis and dermatochalasis
- LT Lower lid BCC
- Right upper lid actinic keratosis

Station 3 - Posterior Segment

- Right CRVO with laser scars
- R optic disc pit. Pigment at mac /previous fluid. Leye subtle parafoveal telangiectasia
- L RPE hypertrophy
- L Coats may have had laser / avastin
- RP (excellent signs)
- Pseudophakia, Myopic degeneration, macular scar left eye
- Prev R RD. total RD and dislocated lens. L IOL and laser
- L previous UTQ U-tear lasered. R lattice and PVD. Bridging vessel across tear.
- RP ?Xlinked
- Chronic left RD with spont reattachment. Field defect
- Iris and Choroidal colobomata
- Congenital 'disc vasculature' / diabetic
- Central Retinal Vein Occlusion, Pseudophakia
- Father with VHL. Angioma and exudate
- Son with VHL. R disc angioma and exudate
- L coloboma and Los
- Possible FEVR. Old R RD. IOL, dragging, extensive lattice
- Previous L mac off RD. Vitrectomy, cryo,oil. RE two free floating opercula and untreated flat holes
- R choroidal colobomas, AC phimosis, L AE
- Choroideraemia
- PDR. R NVD/PRP. L mac ischaemia

- RP
- Bilateral advanced AMD

Station 4 - Strabismus and Orbit

- Crouzons, shallow orbits, previous globe subluxation, inf iris colobomas,prvious carniofacial surgery
- L congenital IV. R head tilt
- Consec XT
- Distance esophoria. Prisms. Myopia
- Dysthyroid Eye Disease, Vertical Squint
- Ethmoidal osteoma. Multiple excisions. L proptosis and Browns
- Consec XT
- Left/Alternating divergent squint
- TED

Medicine and Neurology Station 5 and 6

- R - secondary optic atrophy, bilaterial pterygium. R RAPD, R optic atrophy (old CRAO). L branch retinal emboli
- Sgogrens / ME. Periph vascular closure and laser. Regressed NVE
- ?Marfans / Connective tissue disorder. High myopia. Bilat iris/choroidal coloboma (atypical). Recent echo showed dilated sinus of valsalva, bicuspid aortic valve. High arched palate, retrognathia. Mild chest pain on exertion
- Thyroid
- Adies
- MS. Bilat VI weakness. ET dist>nr with diplopia. Prisms in glasses
- TED
- Excision of right parasellar/ meningioma Sept 02/
- right optic atrophy
- Left optic neuropathy (Devic's disease)
- Ank spond and left ant uveitis. Early PSCLOs
- L Horners
- L LMN VII , Acoustic neuroma. Previous lat tarsorraphy, mild lagophthalmos
- Disc drusen on USS
- Relative Afferent Pupil Defect, Divergent Squint, Field Loss,upper field loss , blind right eye
- Chronic progressive external ophthalmoplegia. R>l disc cupping, L amblyopia. Proximal myopathy, absent reflexes,pseudoathetosis
- Central Retinal Artery Occlusion
- CVA. L lower quadrantanopia
- R optic atrophy and RAPD. Ataxic gait. Dandy-Walker on MRI scan
- Thyroid
- Rheumatoid arthritis
- Adies

Thursday Afternoon

Station 1 - Anterior Segment

- Uveitis, glaucoma, trabs, Cat X
- R - Choyce IOL and peripheral corneal oedema. L previous HSV keratitis and IOL
- Blind R eye. RD due to Sticklers. White cataract and corneal tattoo (fading)

- Inactive TED, Bilat Pseudophakia (yag capsulotomies) Bilat Keratoconus. Reduced elevation and mild proptosis
- L iris coloboma. R chorioretinal coloboma
- HSV keratitis. Iris atrophy, guttata +/- kps
- Bilateral fixed dilated pupils with iridoschisis, previously dislocated lenses with sutured posterior chamber IOL
- R Fuchs / cataract. L DSAEK + IOL. Glaucoma
- Recurrent HSV stromal keratitis
- Prev L penetrating eye injury. Corneal scar, IOL, PI
- Iris atrophy secondary HSV, IOL
- NF1. Early Fuchs dystrophy. R ERM. Bilat IOL
- ARMD. Right cataract. Left pseudophakia. Left DSEK.
- removal of bifocal lens +insertion of monfocal lens ,yag vitreous strand
- lt ac iol , rt disc cupping ,rt DSEK
- Corneal mac dystrophy.Bilat PK
- Prev Lasik. Bilat R.D. - extensive periph holes and lattice. Cryo and encircled 360 indent

Station 2 - Glaucoma and Lid

- POAG
- Bilat trabs. R cupping
- POAG L>R. Cataracts. Early cupping R eye
- L inf disc notch and arcuate field defect
- Behcets chronic uveitis secondary choroiditis , retinitis. Secondary glaucoma
- POAG, mild L cupping. Previous R CRAO. R RAPD
- Involutional ptosis. Chin up. On anticoagulants
- Xanthelasma ++. Bilat PSCLOs
- L LMN VII , Acoustic neuroma. Gold weight
- L endstage glaucoma, vitrectomy, oil. R pseudophakic, large nasal bleb. CD0.6 sl pale
- CACG, Pseudophakia + PIs. Bilat cupping
- Ex advanced POAG, Disc cupping, left trab, right brev tube
- POAG. L disc changes
- Cuppping R>L. Pseudophakia
- POAG. Asteroid hyalosis
- L angle recession secondary glaucoma
- L VII. Aberrant regen on showing teeth
- Ehlers - Danlos. Skin changes. LUL bleph. No angioid streaks
- Involutional ptosis and dermatochalasis
- LT Lower lid BCC
- Right upper lid actinic keratosis

Station 3 - Posterior Segment

- Right CRVO with laser scars
- R optic disc pit. Pigment at mac /previous fluid. Leye subtle parafoveal telangiectasia
- L RPE hypertrophy
- L Coats may have had laser / avastin
- RP (excellent signs)
- Pseudophakia, Myopic degeneration, macular scar left eye
- Prev R RD. total RD and dislocated lens. L IOL and laser

- L previous UTQ U-tear lasered. R lattice and PVD. Bridging vessel across tear.
- Chronic left RD with spont reattachment. Field defect
- Iris and Choroidal colobomata
- RP ?Xlinked
- Congenital 'disc vasculature' / diabetic
- Father with VHL. Angioma and exudate
- Son with VHL. R disc angioma and exudate
- L coloboma and Los
- Possible FEVR. Old R RD. IOL, dragging, extensive lattice
- R choroidal colobomas, AC phimosis, L AE
- Choroideraemia
- RP
- Bilateral advanced AMD
- L BRVO with shunts and laser Rx. R&L Disc cupping
- Nanophthalmos / IOLs. L folds and shallow choroidal detachment. R in exudative RD
- Right central retinal vein/
- Occlusion

Station 4 - Strabismus and Orbit

- Mild L proptosis.L LR myositis April 2012.Previous L ocular trauma. Apahakia. RAPD.
- L congenital IV. R head tilt
- Intermittent distance XT
- Consec XT
- Distance esophoria. Prisms. Myopia
- MS. Bilat VI weakness. ET dist>nr with diplopia. Prisms in glasses
- Ethmoidal osteoma. Multiple excisions. L proptosis and Browns
- Left/Alternating divergent squint
- IXT / Decomp X. Also voluntary nystagmus!
- L - probable congenital IV. LSO u/a, IO o/a, L/R

Medicine and Neurology Station 5 and 6

- Left optic neuropathy (Devic's disease)
- Thyroid
- Adies
- R - secondary optic atrophy, bilaterial pterygium. R RAPD, R optic atrophy (old CRAO). L branch retinal emboli
- L BRAO with emboli. Nasal scotoma
- R LMN VII. Previous acoustic neuroma
- Hemianopia, Homonymous
- Familial nystagmus and face turn
- Disc drusen, early band keratopthy
- LL quadrantanopia. CVA 13/10/12. ? May improve by exam
- L hemianopia / hemiparesis. Physiological cupping
- Thyroid
- R Horners after neck surgery
- Congenital myaesthenia. Ptosis. Reduced EOM. Small LXT
- Cerebellar dysfunction ataxia ,nystagmus
- L Horners

- L LMN VII , Acoustic neuroma. Previous lat tarsorraphy, mild lagophthalmos
- Disc drusen on USS
- Relative Afferent Pupil Defect, Divergent Squint, Field Loss,upper field loss , blind right eye
- Chronic progressive external ophthalmoplegia. R>l disc cupping, L amblyopia. Proximal myopathy, absent reflexes,pseudoathetosis
- Central Retinal Artery Occlusion
- CVA. L lower quadrantanopia
- R optic atrophy and RAPD. Ataxic gait. Dandy-Walker on MRI scan
- Thyroid
- Homonymous Hemianopia
- Bilat temporal pallor ?AD optic atrophy (old L BRVO)
- Incomplete left 3rd nerve palsy and a left inferior quadratanopia
- Laurence-Moon-Biedl. RP. Pale discs / attenuated vessels. IOLs

3a) Results

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

Maximum mark after weighting: 156
Stations 1-3: 2 criteria scored 0-3 for 3 patients by 2 examiners x 0.666 = 24
Station 4: 2 criteria scored 0-3 for 2 patients by 2 examiners = 24
Station 5: 2 criteria scored 0-3 for 4 patients by 2 examiners = 48
Station 6: 3 criteria scored 0-3 for 1 patient/actor by 2 examiners x 0.666 = 12

Pass mark (using borderline candidate method)	84/156	(54%)
Mean score:	103/156	(66%)
Median score:	103/156	(66%)
Range:	69-138	(44% - 88%)
Reliability (Cronbach alpha):	0.81	
SEM:	8	
Adjusted pass mark (+1 SEM)	96/156	(62%)

Pass rate before adjustment (pass mark 88/156)	58/76 (76%)
Pass rate after adjustment (pass mark 96/156)	49/76 (65%)

Table 8 Distribution of scores

Score	Distribution	Total
61-70	//	2
71-80	///// /	6
81-90	///// ///// //	12
91-100	///// ///// //	12
101-110	///// ///// ///// ///	18
111-120	///// ///// ////	14
121-130	///// //	7
131-140	/////	5
Total		76

Table 9 Station marks (before weighting)

Station		Maximum possible	Mean	Median	Min	Max
1	Anterior segment & cataract	36	29	31 (86%)	16	36
2	Glaucoma & lid	36	25	27 (75%)	7	36
3	Posterior segment	36	25	25 (69%)	7	36
4	Paediatric & strabismus	24	13	13 (54%)	4	24
5/6	Medicine and neurology	48	29	29 (60%)	13	45
7	Communication	18	13	13 (72%)	0	18

Table 10 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.
Both	0.72	0.84	0.77	0.80	0.73	0.64
Blue	0.86	0.84	0.67	0.86	0.68	0.81
Red	0.64	0.84	0.79	0.76	0.74	0.55

Table 11 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.
Both	0.76	0.077	0.64	0.79	0.69	0.67
Blue	0.88	0.69	0.58	0.90	0.72	0.84
Red	0.56	0.87	0.67	0.65	0.61	0.49

Table 12 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	0.32	0.26	0.23	0.26
Station 2	Glauc/lid		0.18	0.13	0.20	0.40
Station 3	Posterior			0.21	0.49	0.10
Station 4	Orbit/Strab				0.26	0.14
Station 5	Med/neuro					0.25

3b) Standard setting for the OSCE

Station	*1*		*2*		*3*		*4*		*5 & 6*		*7*	
No. of borderline candidates	*18*	*12*	*16*	*18*	*16*	*16*	*19*	*26*	*29*	*25*	*11*	*7*
Median borderline candidate score	*8*	*7*	*7*	*7*	*6*	*6*	*6*	*7*	*15*	*13*	*3*	*3*

The pass mark for the OSCE was increased by 1 SEM from 88/156 (56%) to 96/156 (62%)

4. The overall examination (oral and written papers)

4a) Overall results for the oral examination

Pass mark	166/276	(60%)
Mean	187/276	(68%)
Median	190/276	(69%)
Range	123-239	(45%-87%)

To pass the oral examination candidates must achieve 166/276 overall, 64/120 in the viva and 88/156 in the OSCE.

Pass rate for the oral examination	48/76	(63%)
Pass rate for the entire examination	48/95	(51%)

Table 14 Distribution of scores

Score	Distribution	Total
121-130	//	2
131-140	/////	5
141-150	/	1
151-160	/////	5
161-170	////// ////	9
171-180	///// ////	9
181-190	///// ///	8
191-200	///// ///// //	12
201-210	///// ///// /	11
211-220	///// /	6
221-230	////	4
231-240	////	4
Total		76

Table 15 Correlation between scores in each part of examination

	EMQ	*VIVA*	*OSCE*
MCQ	0.57	-0.20	-0.33
EMQ		-0.25	-0.23
VIVA			0.66

Correlation between written and oral examinations -0.32

4b) Breakdown of Oral Examination

Table 16 Breakdown of results by training

	Failed	Passed	Total
In OST	14	44	58
Not in OST	14	4	18
Total	28	48	76

These differences are statistically significant (p = 0.00)

Pass rate for the oral examination for candidates in OST	(44/58)	76%
Pass rate for the Part 2 examination for candidates in OST	(44/70)	63%

Table 17 Breakdown of results by gender

	Failed	Passed	Total
Female	6	13	19
Male	22	35	57
Total	28	48	76

These differences are not statistically significant (p = 0.58)

Table 18 Breakdown of results by deanery

	Failed	Passed	Total
East Midlands	1	0	1
East of England	0	0	0
London	3	11	14
Mersey	1	0	1
North Scotland	1	1	2
North Western	3	5	8
Northern	0	3	3
Northern Ireland	1	2	3
Oxford	0	4	4
Peninsula	1	1	2
Scotland South East	0	2	2
Scotland West	1	1	2
Severn	0	2	2
Wales	0	3	3
Wessex	0	1	1
West Midlands	0	3	3
Yorkshire	2	5	7
	14	44	58

Table 19 Breakdown of results by level of training

	Failed	Passed	Total
ST3	0	0	0
ST4	0	0	0
ST5	2	9	11
ST6	6	18	24
ST7	5	16	21
Total	13*	43*	56

* Level unknown for 2 candidates in OST

Table 20 Breakdown of results by country of qualification

	Failed	Passed	Total
UK	10	30	40
Outside UK	18	18	36
Total	28	48	76

These differences are statistically significant (p = 0.024)

Table 21 Breakdown of results by first language

	Failed	Passed	Total
English	10	25	35
Other	18	23	41
Total	28	48	76

These differences are not statistically significant (p = 0.167)

Table 22 Breakdown of results by ethnicity

	Failed	Passed	Total
White	1	22	23
Non-white	25	24	49
Total	26*	46*	72

* Ethnicity undeclared by 4 candidates

These differences are statistically significant for white/non-white (p = 0.00)

Table 23 Ethnicity of candidates in OST

Ethnicity	In OST	Not in OST	Total
White	20	3	23
Non-white	34	15	49
	54*	18	72

* Ethnicity undeclared by 4 candidates

Table 24 Breakdown for candidates in OST by ethnicity

Ethnicity	Fail	Pass	Total
White	1	19	20
Non-white	11	23	34
	12*	42*	54

* Ethnicity undeclared by 4 candidates

These differences are statistically significant for white/non-white in training (P = 0.020)

Table 25 Breakdown of results by number of previous attempts

Attempts	Failed	Passed	Total
1 (First)	10	18	28
2	9	20	29
3	6	7	13
4	2	2	4
5	1	1	2
6	0	0	0
Any resit	18	30	48

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

** 1 candidate who passed the written examination did not sit the oral examination*

Table 26 Breakdown of results by training

	Failed	Passed	Total
In OST	26*	44	70
Not in OST	21	4	25
Total	46	48	95

These differences are statistically significant (p = 0.000)

Table 27 Breakdown of results by gender

	Failed	Passed	Total
Female	11*	13	24
Male	36	35	71
Total	47	48	95

These differences are not statistically significant (p = 0.68)

Table 28 Breakdown of results by deanery

	Failed	Passed	Total
East Midlands	2	0	2
East of England	0	0	0
London	4	11	15
Mersey	3	0	3
North Western	3	5	8
Northern	1	3	4
Northern Ireland	1	2	3
Oxford	0	4	4
Peninsula	2	1	3
Scotland North	1	1	2
Scotland South East	0	2	2
Scotland West	2	1	3
Severn	0	2	2
Wales	3	3	6
Wessex	0	1	1
West Midlands	1	3	4
Yorkshire	3	5	8
TOTAL	26*	44	70

Table 29 Breakdown of results by level of training

	Failed	Passed	Total
ST3	0	0	0
ST4	0	0	0
ST5	5	9 (64%)	14
ST6	12	18 (60%)	30
ST7	7	16 (70%)	23
Total	24	43 (64%)	67

Table 30 Breakdown of results by country of qualification

	Failed	Passed	Total
UK	21	30	53
Outside UK (Inc Republic of Ireland)	25	18	41
Total	46	48	94

These differences are not statistically significant (p = 0.10)

Table 31 Breakdown of results by first language

	Failed	Passed	Total
English	20	25	46
Other	20	23	43
Total	40	48	89

These differences are not statistically significant (p = 0.85)

Table 32 Breakdown of results by ethnicity

	Failed	Passed	Total
White	4	22	27
Non-white	38	24	62
Total	42	46	89

These differences are statistically significant for white/non-white (p = 0.00)

Table 33 Breakdown for candidates in OST by ethnicity for the examination overall (written and oral parts)

Ethnicity	Fail	Pass	Total
White	2	19	21
Non-white	19	23	42
	21	42	63

These differences are statistically significant for white/non-white candidates in ophthalmic specialist training (p = 0.005)

4d) Table 34 Comparison to previous examinations

Date	April 09	Sept 09	April 10	Oct 10	April 11	Nov 11	April 12	Nov 12
Candidates	15	16	21	26	46	77	104	95
MCQ pass mark	64%	64%	66%	65%	65%	58%	58%	92%
Reliability	0.81	0.77	0.83	0.77	0.70	0.70	0.70	0.70
EMQ pass mark	64%	66%	65%	64%	65%	59%	58%	59%
Reliability	0.90	0.83	0.86	0.81	0.7	0.7	0.72	0.75
Viva pass mark	59%	64%	57%	56%	63%	60%	62%	58%
Reliability	0.80	0.84	0.90	0.79	0.79	0.81	0.84	0.76
OSCE pass mark	60%	63%	61%	62%	63%	65%	62%	62%
Reliability	0.82	0.94	0.80	0.87	0.85	0.83	0.80	0.81
Written pass rate	53%	38%	48%	58%	46%	68%	65%	81%
Oral pass rate	50%	33%	50%	73%	71%	54%	57%	63%
Overall pass rate	27%	13%	24%	58%	33%	35%	37%	51%

Table 35 Cumulative results by deanery (September 2010 to date)

Deanery	Number of passes	Candidates	Pass rate %
Oxford	11	15	73
Northern Ireland	5	7	71
Severn	10	14	71
Scotland South East	4	6	67
London	40	63	63
Northern	6	10	60
East of England	2	4	50
Mersey	5	10	50
Scotland North	2	4	50
East Midlands	4	9	44
Peninsula	3	8	38
Wales	6	16	38
West Midlands	8	21	38
Yorkshire	10	27	37
North Western	8	24	33
Wessex	2	7	29
TOTAL	127	251	51

5. Summary

The Part 2 FRCOphth examination has developed into a credible assessment of the knowledge and skills of candidates who are developing their competence in ophthalmology. The pass rate for the oral examination was 63% and 51% overall. The pass rate for both the written paper was the highest to date (81%), which meant that a very large number of candidates were invited to the oral examination.

There are statistically significant differences between some groups of candidates. Candidates in OST are more successful than those who are not in training, which is to be expected if the examination is appropriately blueprinted on the curriculum. There was a difference in the performance of candidates based upon their ethnicity. This difference is still present in OST and is not explained by first language or country of qualification and should be monitored.

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6. Appendix 1: Candidate evaluation

Structured viva

Viva Station 1 Patient Investigations & Data Interpretation

Were you treated in a courteous manner by the examiners?
Yes 88%
No 12%

- The examiners were very relaxed and made me relaxed too.
- I am not sure why, but I felt the least comfortable in this station. Examiners appeared more “stand-offish” than in the other stations. Might just be their style.
- One of the examiners was very rigid in his manner of questioning. The questions were not rephrased to enable the answer to be sought.

Were the questions appropriate for the station?
Yes 94%
No 6%

- Questions were very open ended; it was difficult to know what the examiners wanted. In the pictures of OCT should include other image sections too. It can be difficult to look at just one image of an OCT and make a diagnosis which is real life we always scroll through all the OCT images.
- Felt initial clinical scenario of picture of head tilt not in keeping with theme of station.
- Relevant questions, answered comfortably. 2 OCTs, 2 FFAs - CSR & ERM. Sections of OCT could be larger for better visual impression (in exam it’s always stressful & bigger cuts are always helpful).

Were the questions of an appropriate standard for an exit examination?
Yes 94%
No 6%

- Overall less time was given to explain FFA findings. More emphasis was on getting the questions answered.

Viva station 2 Patient Management 1

Were you treated in a courteous manner by the examiners?
Yes 94%
No 6%

- Very friendly, felt at ease,

Were the questions appropriate for the station?
Yes 94%
No 6%

- Congenital dacryocystitis / NLDO; (Congenital Dacryocystocoele). Good discussion. Differentials, asked briefly about Ophth.neonatorum Mx. Acute dacryocystitis, complications (fistula formation).

Were the questions of an appropriate standard for an exit examination?
Yes 94%
No 6%

Viva station 3 Patient Management 2

Were you treated in a courteous manner by the examiners?
Yes 94%
No 6%

- Reaction seemed indifferent, as if always expected something else?

Were the questions appropriate for the station?
Yes 94%
No 6%

- Acute headache (neck pain) – history given asked differentials. Given remaining history of RTA – got acute Horner's then straightaway. Carotid dissect, asked about 'what other clinical examination' (mentioned hypochromia, anhidrosis, ptosis, Cr Nvs, couldn't think of anything else). Mx – MRA, BP refer to Neuro, asked how managed by neuro, mentioned antiplatelets (aspirin).

Were the questions of an appropriate standard for an exit examination?
Yes 94%
No 6%

Viva station 4 Attitude, Ethics and Responsibilities

Were you treated in a courteous manner by the examiners?
Yes 94%
No 6%

- Excellent examiners who really put me at ease and as a results got the answers

Were the questions appropriate for the station?
Yes 94%
No 6%

- Mental capacity assessment, consenting. Was told about 'best interest' principle in consenting but had already mentioned it before during discussing! Neglect – just enough time to define, asked about named officer in Trust, mentioned 'Child protection officer' for Child Abuse, pressed for 'adult' – said will check with Cons for care of elderly.

Were the questions of an appropriate standard for an exit examination?
Yes 94%
No 6%

- One question centered on a piece of legislation that the two examiners admitted they had never heard of before the morning of the exam!
- Interesting choice of final question about the date that fathers name was placed on the birth certificate of a child. I wonder if anybody got the answer to this question. Which led me to thinking – If this is an international exam, is it fair that foreign trainees get asked questions on Gillick competence?

Viva station 5 Audit, research and evidence based medicine

Were you treated in a courteous manner by the examiners?
Yes 94%
No 6%

- Very relaxing environment

Were the questions appropriate for the station?
Yes 88%
No 12%

- CRVO – lots of ques on investigations, not much enquiry about guidelines, happy when just mentioned - RCOphth 2010 guidelines. Detailed discussion of ALL Diabetic retinopathy guidelines including DRCR.net (asked about all 3 arms).

Were the questions of an appropriate standard for an exit examination?
Yes 94%
No 6%

Overall Feedback on the Structured Vivas

Was the structured viva well organised?
Yes 94%
No 6%

- Good venue and well organised
- Well organised; staff supportive and calm!
- Well organised Viva.

Were you given clear instructions about the structured viva examination?
Yes 94%
No 6%

- Only one station (Pt Mx 2) bit vague in accepting answers

Did you feel that the structured viva examination was a fair assessment of your knowledge?
Yes 94%
No 6%

- The strict nature of the exam, not allowing the examiners to fully probe issues, limits the discussion significantly and does not allow the candidate to fully express the breadth of their knowledge around a subject. Personally, I was so worried about what answers were on the sheet, to properly discuss any issues.
- I think it was a fair, albeit selective, assessment of my general ophthalmic knowledge. As always, I felt that huge tracts of my knowledge were not showcased.

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

Yes 94%
No 6%

- Definitely keep the viva, it was stressful preparing for it, but standardised and a good way of assessing candidates. However please think about possibly moving the medicine station in the OSCE to the viva, and keep the neuro-ophthalmic station on its own in the OSCE.
- It should be broader and cover a wider range of topics.
- Of course
- Some latitude must be allowed for the discussion to run and fully explore a subject. Not only will this allow a candidate to fully discuss a subject but may alleviate some boredom for the examiners
- It's very important to assess our ability to think under pressure and to test our knowledge of important eye diseases not appropriate for the OSCE so the viva is a necessary component.

General comments on structured vivas

- I think asking questions about specific pathways for things such as managing elder abuse, are inappropriate. I think candidates ought to be aware of the seriousness of situations like elder abuse and should know what to do when it is encountered in practice. However candidates should not lose marks because they can't name a particular document or list the specific titles of officers to contact in such situations.
- Over all the event was well organized and well conducted, most of the examiners were very nice and supportive except few, they need to keep in mind that it's a very stressful situation for all candidates and may be a little bit of encouragement and support boost up the moral of candidates. As this is an exit exam, candidate should feel like if they are normally working in clinics and shouldn't be that stressful. The exam result should not only be based on exam's day performance, they should also consider candidates performance over 7 years of training through ARCP outcome.
- As feedback regarding the FRCOphth Part 2 in general isn't requested elsewhere, I would like to ask if the College could/would consider decoupling the written aspect of the exam from the practical aspects (clinical viva and OSCE) please. The knowledge required for the written was felt to be significantly in-depth, yet rare/obscure conditions/knowledge seemed to be required on a regular basis (it still felt very much like a Part 1 exam). On the other hand, while the practical exams are difficult and set at a high standard, the knowledge expected (bar the occasional question) seemed to match better with what I would have thought would be expected of a new consultant. To have to go back and go over such obscure/detailed knowledge in order to repeat the written for a re-sit (even if passed before) is hard to understand.

OSCE

OSCE station 1 Cataract and Anterior Segment

Were you treated in a courteous manner by the examiners in this station?
Yes 94%
No 6%

- Very nice examiners
- One examiner left the room for what seemed like a few minutes during one of the cases

Were the patients you were asked to examine appropriate for the station?
Yes 94%
No 6%

- 1 - Iridodonesis, pseudophacodonesis LE, asked to look for iridodonesis in other eye, was subtle, pupil small, so couldn't comment on phacodonesis. DD: Trauma, Marfan's, glasses myopic, bifocal in operated eye, discussion ok. 2 - AC IOL (plate haptics) – didn't know specific model, said Binkhorst, asked complications, alternative IOLs (iris supported, sulcus), corneal decomp-EK. 3 - Unilat Gr uveitis – herpetic, discussion ok.

Were the questions of an appropriate standard for an exit examination?
Yes 94%
No 6%

OSCE station 2 Glaucoma and eyelid

Were you treated in a courteous manner by the examiners in this station?
Yes 94%
No 6%

- The examiner was very friendly and relaxed, allowing me to relax and to get out better answers.
- Very nice examiners

Were the patients you were asked to examine appropriate for the station?
Yes 94%
No 6%

- 1 - MC BCC – fixed, asked about inv – CT for lymph nodes, chest-abdo, then mentioned CT orbits, surgical options: glabellar flap, laissez faire, asked how to preserve lac canaliculi (perhaps wanted Mohs). 2 - Asymmetric cupped discs, comment on NRR regularity, colour; draw early NFL defects on paper, early field loss – mentioned enlarged b.spot, paracentral, nasal wedge/step of Ronnie (wanted something more as early defect). 3 - Cong ptosis in elderly – demonstrations ok, LPS moderately weak, got lid lag on re-exam, surgical options
- The glaucoma patients were perhaps a little simple

Were the questions of an appropriate standard for an exit examination?
Yes 94%
No 6%

- One examiner did not hear what I had said in my examination of the patient and the subsequent questions suggested that I had not picked up the clinical sign, when I had: he just hadn't heard. To say that you had mentioned the sign at the beginning appears rude, so you are in a Catch 22 situation.
- I had two misgivings at this station: My first was that I was asked something like, "which of the global indices is the best measure of the general deficit of the visual field on a Humphrey Visual Field" and I said, "Pattern Standard Deviation." The examiner said, "No, I'm thinking about a number, not the graphical display." I was a little shaken and finally said, "Mean Deviation" which he was happy with. In retrospect I think he may have misheard me, perhaps thinking I had said, "Pattern Deviation." I would be very disappointed to fail this station as a result of this. The other problem was that I ran out of time before I could measure the levator function of a patient with involutional ptosis.

OSCE station 3 Posterior Segment

Were you treated in a courteous manner by the examiners in this station?
Yes 94%
No 6%

- Fairly relaxing

Were the patients you were asked to examine appropriate for the station?
Yes 94%
No 6%

- 1 - CRVO (not hgics but possibly ischaemic) – Gave diffl: CRVO, OIS, DR - Disc collaterals, also some vessels looked like NVD! Asked difference, But could they co-exist? Asked management of CRVO, new guidelines, Ozurdex, follow-up of Isch CRVO. 2 - IO- Pupil came down! Asked to examine with 28D, could be helpful, thank god, got the Disc coloboma – good discussion, asked to examine other eye – was prosthetic. 3 - RP (AD) – asked genetics, management, CMO (Diamox could be tried), LVA, CVI, driving
- One patient was rather poorly dilated and had a rather innocuous sign.
- The patient for indirect ophthalmoscopy had small pupils (it was the end of the day, and the drops had worn off) – the examiners agreed.

Were the questions of an appropriate standard for an exit examination?
Yes 94%
No 6%

- I was expecting more fiendish cases

OSCE station 4 Strabismus and Orbit

Were you treated in a courteous manner by the examiners in this station?
Yes 94%
No 6%

- Observed from a distance, hope got to see my technique!
- In the orbit case there were too many finding in one patient. I was finding it difficult where the examiners wanted to lead me.

Were the patients you were asked to examine appropriate for the station?
Yes 94%
No 6%

- 1 - Left HT (4^{th} NP): demonstrated Parks 3 step satisfactorily, asked diff Cong/Acq. Had neck pain, said could be from spasmodic torticollis, Mx – prisms, IO Rc/Mc. 2 - Decom XT – CT good, discussion good, prisms, botox trial, FDT, Sx.
- The final diagnosis was not uncommon but few have unusual presentation and therefore it took some time to come to diagnosis and then less time left for viva. Perhaps best to have common clinical presentation, rather than case reports presentations.

Were the questions of an appropriate standard for an exit examination?
Yes 94%
No 6%

OSCE station 5 Medicine and Neurology

Were you treated in a courteous manner by the examiners in this station?
Yes 88%
No 12%

- One examiner was quite abrupt and obviously fed up at the end of the day. He did not have the patience to rephrase his questions when they were obviously not understood and instead repeated the question in an agitated manner.

Were the patients you were asked to examine appropriate for the station?
Yes 88%
No 12%

- 1 - Rheumatoid hands (subtle apart from 1st MCP deformity, no nodules, elbow varus deformity) examined individual IP jts, wrists, looked for nodules absent, and asked which is thenar/hypothenar eminence picked up wasting. Ocular compl: scleritis, asked commonest – sec dry eyes. Detailed discussion on systemic Treatment luckily knew about Immunosuppressives (since quite hot in my unit). 2 - L RAPD – DO – optic atrophy – AION (NA/GCA) – discussion ok. 3 - L Horners – exam was going good until Horner's started dilating a bit in dark, anisocoria hence subtle, looked for ptosis – again not enough, examiner smiled & mentioned had 'ptosis surgery', discussion very well, all about levels, pharmacology. 4 - R homo hemianopia – stroke PCA, asked about types – hgic, thrombotic, asked what would you do on Fri eveniong – said would do BP, BM, pulse (asked to check & comment), referral to 'Stroke team' – happy.
- Two of the patients were completely inappropriate for an ophthalmology exam. One patient had Parkinson's disease without a gaze palsy, indeed with no ophthalmological signs. A second patient had a 7th and 8th nerve palsy, presenting with deafness. In 10 years including 1 year of neuro-ophthalmology clinics, I have never had a patient present to me primarily with loss of hearing. Additionally I was not given a clear question on what examination was expected of me to perform.
- Case selection was not fair, as this station was conduction in two different rooms some candidates have case which we commonly see in our ophthalmology clinics (Ankylosing spondlylitis, traumatic optic atrophy) while others have Parkinson sect.
- Whilst 3 of the patients appeared suitable in this station, the 4th patient had minimal signs of Parkinsonism. While this gave an opportunity to assess upper limb peripheral nervous system examination, I was taken aback at the in-depth questioning of Parkinson's disease and associated conditions, which did not seem appropriate for an ophthalmic examination.

Were the questions of an appropriate standard for an exit examination?
Yes 76%
No 24%

- The patients had neurological signs although I question the need to be able to answer questions on the management of acoustic neuromas and Parkinson's disease.
- This station was appropriate only for a neurology exam! I was asked to discuss the treatment of Parkinson's disease. I have discussed these questions with an academic neurology consultant, and he felt it would be entirely wrong for an ophthalmologist to be treating a

patient with Parkinson's disease, both in terms of safety and in terms of masking potential Parkinson's Plus disease. I do not know why I was quizzed on non-ophthalmological conditions in the ophthalmology exit exam.
- I think the examination of a patient's hands/arms with rheumatoid arthritis is a reasonable task for the OSCE. However, I was expected to identify that the patient had symmetrical muscle wasting in his forearms which is perhaps too subtle a sign for an ophthalmologist to pick up in a thin elderly man.
- I was asked to examine a patient with headache and hearing loss. When I asked what specific aspect of neurology exam you what me to do, I was told to do whatever examination I like to do. I started with cranial nerve exam and it turned out to the case of acoustic neuroma. I think due to limited time clear instruction should be given. In second case clinical scenario given was not very clear and it a while to come to diagnosis.
- This was the toughest station with regards to questions. I am not sure whether it's because we do not regularly deal with the management of medical scenarios in clinic, or whether I was not as well prepared as I was for the other stations. However on balance the questions were tough for an ophthalmic exam and I have done some medicine!

OSCE station Communication Skills

Were you treated in a courteous manner by the examiners?
Yes 94%
No 6%

- I found the actor to be very difficult to communicate, was not satisfied with any answers had a very unwelcoming body language.

Was the clinical scenario explained clearly?
Yes 88%
No 12%

- Although the scenario did not make it clear if we were to assume a full medical history had already been taken, or if we were to repeat this.
- In the explanation it felt that the patient's relative was not willing to accept that the patient had a psychiatric illness. It looked as if he was looking for particular buzzwords only. Was not helpful at all in leading the discussion.
- I realised that there were several ways of tackling the same issue (With respect to ophthalmic management). Would it be better to give a scenario where there was only one management option, to reduce the variability in management strategies by candidates? Then you would truly be testing communication skills and not therapeutic strategies or choices.
- Functional visual loss, started well. Actor accepted plan, wanted his wife (patient) to be reassured. Summarised & agreed on final plan.

Was the clinical scenario appropriate for an exit examination?
Yes 76%
No 24%

- A "breaking bad news" type scenario is unfair to be assessed upon, as reality would be very different. For example, I would always establish some rapport with a patient, and arrange an appointment where they can bring a friend or family member, before breaking bad news.
- Complex
- The scenario was a very emotionally charged and uncommon one. In clinical

practice one would certainly deal with this very differently, depending on the layout of the clinic, the presence of absence of nursing staff, cups of tea etc. Additionally such an emotionally charged scenario does tend to shake one up, to then go and have to calmly sit a viva afterwards it rather unsettling. In practice, I would take out 5 minutes before seeing the next patient after that consultation.
- I think it was a reasonable scenario for an exit exam but it was quite obtuse, and I think the marking scheme ought to be equally obtuse (i.e. it was difficult to work out which keywords the examiners were looking for).

The OSCE overall

Was the OSCE well organised?
Yes 88%
No 12%

- Well-organised OSCE, good variety of patients across the stations.
- Staff quite courteous & helpful
- The 30 minutes rest station was very stressful especially after the most difficult station.
- Very friendly and helpful college staff. The nurses in Sunderland were super!

Were you given clear instructions about the OSCE?
Yes 88%
No 12%

- Not in all stations

Did you feel that the OSCE was a fair assessment of your knowledge?
Yes 82%
No 18%

- Apart from the medicine station where the knowledge asked for is not relevant to our day-to-day practice as an ophthalmologist.
- Some of the cases you don't come across commonly in ophthalmology clinics like diabetic foot, cardiovascular examination.
- I think the OSCE at present is a test of the speed at which candidates can recognise signs, and their ability to read the examiners' minds. No context is given for any case, which does not reflect real life. It would be far better to shift emphasis from rapid sign recognition, to management discussion… by providing a patient history, allowing the candidate to examine the patient, and then have a longer discussion on management options and treatment.
- Did not always get to show all my knowledge given the time limitation and the "prescribed" nature of the questions, which I suspect was in order to standardize the exam.

In your opinion should the OSCE be included in the exit examination?
Yes 94%
No 6%

- Cannot think of any alternatives!
- Even though it is difficult to organise, the OSCE is essential to check if candidates can actually use the equipment to see subtle pathology and know what to do about it.

- But with more emphasis on management skills, than examination skills.

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

- I feel that the wait of over 3 weeks for the results is rather excessive. Is it necessary to use the whole time for statistical analysis, or can the process be expedited? It is bad enough having such a drawn out exam process without extending the stress and anxiety even further. From the date of the first exam in September, to the results in December, I will have worried for three whole months, and that excludes the time spent revising before the exams start. Please can the College exhibit a little kindness to their trainees?
- The medicine and neurology station is completely overweighed. If neurology and medicine are so important, then we will need placements not just in neuro-ophthalmology (as 2/3 of the patients I saw would not present even to a neuro-ophthalmologist) but also in neurology and neurosurgery clinics. This begs the question, - Where does the remit of this station end? Are we supposed to have postgraduate knowledge in all of the medical subspecialties? What about other associated specialties, should I be able to have detailed knowledge of ENT, Maxillofacial surgery? Is there not enough of ophthalmology to get one's head around that we have to examine in other specialties too?
- Nerves play a big part in this exam. Is this taken into account when grading the first station that candidates are examined in?
- I feel that the VIVA and OSCE should be a separate entity, these are fairer tests for someone exiting and I feel candidates shouldn't have to repeat the written exam if they slip up in the practical side after having passed the written