# Examination Report

## November 2013 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 was the highest since 2010 at 58% (53% oral examination). Candidates in OST are more likely to pass than those not in training posts (67% vs. 38%). 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 95 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 second 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 (0.55). 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 or had English as their first language. Statistically significant differences in performance based upon an analysis of stated ethnicity were not present for trainees in OST or who had graduated in the UK. There was a statistically significant difference in the performance of female candidates compared to their male counterparts (pass rate of 74% for women vs. 50% for men)

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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January 2014

The oral parts of the eleventh sitting of the Part 2 FRCOphth examination were held in Newcastle from Monday 11 to Thursday 14 November 2013.

## 2. Candidates

96 candidates were eligible to sit the oral examination having successfully completed the written papers in September. 95 candidates presented themselves for the examination.

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

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

## Oral examinations (Structured Viva and OSCE)

### 3. The Structured Vivas

There were five structured vivas, which were held on Monday 11 and Tuesday 12 November in the Clinical Learning Centre, Royal Victoria Infirmary, Newcastle. 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 OCT Cystoid Macula Oedema
Tuesday AM Diabetic retinopathy management
Tuesday PM Giant Cell Arteritis

**Station 2. Patient management 1**
Monday PM Child with disc pallor
Tuesday AM Diabetic retinopathy management
Tuesday PM Paediatric esotropia

**Station 3. Patient management 2**
Monday PM Herpes simplex virus keratitis
Tuesday AM Corneal graft complications
Tuesday PM Acanthamoeba

**Station 4. Attitudes, ethics and responsibilities.**
Monday PM Steroid side effects
Tuesday AM Neonatal conjunctivitis
Tuesday PM Needlestick injury

**Station 5.**
**Audit, research and evidence based practice (5 minutes)**
Monday PM Uveitis classification
Tuesday AM Optic neuritis
Tuesday PM Diabetic Macular Oedema

**Health promotion and disease prevention (5 minutes)**
Monday PM NICE guidance for embolic events
Tuesday AM Understanding the audit loop
Tuesday PM Glaucoma assessment in community

The vivas were held in multiple rooms, which were purpose built for this type of assessment. The communication skills stations were each housed in separate rooms. There were three teams of examiners (red, blue and green teams). The examination was conducted in five rounds (two on Monday and three on Tuesday).

**3a) Results:**

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

| | |
|---|---|
| Pass mark (using borderline candidate method): | 64/120 (53%) |
| Mean score: | 78/120 (65%) |
| Median score: | 78/120 (65%) |
| Range: | 28-111 (23%-93%) |
| Reliability: (Cronbach alpha) | 0.9 |
| SEM: | 6 |
| Adjusted pass mark (+ 1 SEM) | 70/120 (58%) |
| | |
| Pass rate before adjustment (64 /120) | 81/95 (85%) |
| Pass rate after adjustment (70 /120) | 68/95 (72%) |

**Table 1 Distribution of scores**

| Score | Distribution | Total |
|---|---|---|
| 21-30 | / | 1 |
| 31-40 | // | 2 |
| 41-50 | // | 2 |
| 51-60 | ///// // | 7 |
| 61-70 | ///// ///// /////| | 15 |
| 71-80 | |//// ///// ///// ///// ///// //// | 29 |
| 81-90 | ///// ///// ///// //// | 19 |
| 91-100 | ///// ///// // | 12 |
| 101-110 | ///// / | 6 |
| 111-120 | // | 2 |
| Total | | 95 |

**Table 2 Results for each station**

| Station | | Mean score | Median score | Range |
|---|---|---|---|---|
| 1 | PI | 16.5 | 17 | 2-24 |
| 2 | PM | 15.2 | 16 | 2-24 |
| 3 | PM | 16.8 | 16 | 2-24 |
| 4 | AER | 15.8 | 17 | 5-24 |
| 5 | HPDP/EBM | 13.8 | 13 | 3-23 |

**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 |
| | 0.90 | 0.87 | 0.80 | 0.79 | 0.78 |

**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 |
| | 0.93 | 0.80 | 0.67 | 0.74 | 0.72 |

**Table 5 Correlation between viva stations**

| | | Station 2 | Station 3 | Station 4 | Station 5 |
|---|---|---|---|---|---|
| | | PM | PM | AER | HPDP/EBM |
| Station 1 | PI | 0.40 | 0.34 | 0.38 | 0.39 |
| Station 2 | PM | | 0.25 | 0.43 | 0.43 |
| Station 3 | PM | | | 0.23 | 0.25 |
| Station 4 | AER | | | | 0.53 |

**3b) Standard setting for the structured vivas**

**Table 6**

| | *1* | | *2* | | *3* | | *4* | | *5* | | *Total* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Number of borderline candidates* | *23* | *21* | *24* | *21* | *22* | *18* | *24* | *22* | *29* | *35* | |
| *Median borderline candidate mark* | *6* | *6* | *7* | *6* | *7* | *7* | *7* | *6* | *6* | *6* | *64* |

The pass mark for the structured viva was increased by 1 SEM from 64/120 (53%) to 70/120 (58%).

**4. The OSCE**

There were seven OSCE stations in all. The six clinical stations were held on Wednesday 13 and Thursday 14 November 2013 at the Royal Victoria Infirmary, Newcastle. The communication OSCE was conducted with the vivas. There were two teams of examiners (red team, blue team and green team) and five rounds (three on Wednesday and two on Thursday).

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

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

**Wednesday Morning**

**Station 1 - Anterior Segment**

- Pseudoexfoliation No Glaucoma
- Bilateral Congenital Cataract surgery, Lid Surgery, RD repair
- Vortex Keratopathy
- Post HZO
- Laser PIs
- Aniridia Glaucoma
- Post corneal laceration
- Right Pseudoexfoliation
- Cataracts
- Bilateral Fuch's
- Vortex Keratopathy Amiodarone
- Transillumination
- Right Herpes Simplex
- Keratouveitis
- Old Herpetic Uveitis Right eye
- Fuch's Right DSAEK
- HSK Post PK
- Fuchs Right DSAEk Left PKP
- Traumatic Cataract post surgery
- Iris Naevus

**Station 2 - Glaucoma and Lid**

- Previous Left Angle Closure
- Rieger Anomaly - multiple surgery
- Pigment Dispersion
- Congenital Glaucoma post surgery
- Congenital glaucoma post goniotomies and trab
- CPEO previous Ptosis surgery
- Right Congenital ptosis
- Aphakic Glaucoma
- Orbital fat atrophy secondary to bimatoprost
- Congenital Glaucoma Post Surgery
- Tilted optic Discs Glaucoma Suspect
- Bilateral Involutional Ptosis
- Ectropion
- Congenital Glaucoma post-surgery
- Aniridia Secondary Glaucoma
- DM Rubeotic Glaucoma Baerveldt tube Right
- Previous Right Angle Closure
- Thyroid Orbitopathy and Dermopathy
- Generalised Myasthenia
- Trichotillomania, recurrent corneal erosion

**Station 3 - Posterior Segment**

- Stargardt's Disease
- Right RD silicone oil (now removed) pseudophakic
- Right Choroidal Osteoma
- Left Vitelliform ? Bests
- Bilateral RD repair Pigment dispersion
- Left Asteroid Hyalosis Right Choroidal Naevus
- Left Peripapillary membrane
- Dry AMD
- Bilateral macular BRVOs CMO left ERM
- Birdshot Choroiditis
- Right Inferior Chronic RD Left Trab
- POHS
- Macular Telangiectasia type 2
- ARMD Both eyes
- Late Onset retinal Degeneration Anterior Lens Zonules
- Stargardt's
- Right Giant retinal tear post-surgery
- Post op RD residual silicon oil
- Right CRAO Rubeosis PRP
- Right ARMD
- Previous right RD Left Laser to tear
- Left Disciform, Right PED and retinoschisis
- Bilateral Paravenous Pigmentary Retinopathy

**Station 4 - Strabismus and Orbit**

- Inactive Graves
- Anophthalmic Socket
- Left 3rd with Ptosis
- Bilateral VI
- Right III
- Left Browns
- Graves Post op Orbital Decompression
- Sensory XT Chronic Uveitis
- IVth N palsy
- Duane's type 1
- Convergence Excess ET
- Ocular Albinism
- Anophthalmic post socket reconstruction
- Right Partial III
- Left IV
- Ocular Albinism

**Medicine and Neurology Station 5 and Station 6**

- Chiasmal Glioma Nasal Field loss left eye

- Bilateral Optic nerve Glioma
- Isolated Right IR Myopathy ? Graves
- Hypothyroid ? Graves
- Bronchiectasis Left Lower Lobectomy
- Marfans Aphakic Trabs Aortic Dilatation
- Right Optic Disc drusen
- Progressive Supranuclear Palsy
- Blepharospasm Reduced Corneal Sensation
- Pituitary Tumour Left optic Atrophy
- Bilateral Optic Nerve head Drusen
- Mild background diabetic retinopathy
- BRVO Diabetic Sensory neuropathy
- Bronchiectasis Pulmonary fibrosis Left superior Oblique palsy
- Left IV
- Paraganglioma Right Horners, Right 9, 10, 11, 12 Palsies
- Graves
- Congenital Rubella
- Pre CRVO Diabetic
- Marfans Dislocated Lenses
- RA Raynaud's, Peripheral corneal thinning
- Left III Brainstem AVM
- Bilateral Optic Atrophy Left Eye Blind
- Right III Bitemporal Hemianopia Cavernous sinus Meningioma
- Left Optic Atrophy Bitemporal Field Loss
- Bilateral Intermediate Uveitis Possible Sarcoidosis
- Aphakic Retinitis Pigmentosa
- Addisons disease, APS 1 Hypoparathyroidism
- T2dm with neuropathy Ankylosing spondylitis
- Type 2 DM Hypertension Post CRVO right
- Right AION Left BRVO
- Graves
- Left CRAO Recent PCI
- Bitemporal Hemianopia Meningioma
- Old BRVO DM
- Blepharospasm
- MS Bilateral INO
- Right Horners
- Left IV
- Esotropia Downbeat Nystagmus
- Left Inferotemporal BRVO
- Diabetic Retinopathy
- RA Dry Eyes

**Wednesday Afternoon**

**Station 1 - Anterior Segment**

- Bilateral Congenital Cataract surgery, Lid Surgery, RD repair
- Vortex Keratopathy

- Laser PIs
- Aniridia Glaucoma
- Traumatic cataract AC IOL
- Anterior stromal dystrophy
- Right Herpes Simplex, Keratouveitis
- Right Iris and chorioretinal coloboma
- Cataracts
- HSK Post PK
- Posterior polymorphous dystrophy
- Iris Naevus
- Rieger Anomaly

**Station 2 - Glaucoma and Lid**

- Congenital Glaucoma post surgery
- Left Normal Tension Glaucoma
- Advanced Right Glaucoma, Epiretinal membrane
- Right Congenital ptosis
- Floppy eyelids
- Dermatolipoma
- Ptosis
- Congenital Glaucoma Post-Surgery
- Cupped Disc, excess hair growth due to bimatoprost
- Post left punctoplasty and medial spindle procedure
- Left Medial Canthal BCC
- Myasthenia
- Congenital Glaucoma post-surgery
- Aniridia Secondary Glaucoma
- DM Rubeotic Glaucoma Baerveldt tube Right
- Previous Right Angle Closure
- Thyroid Orbitopathy and Dermopathy
- Generalised Myasthenia
- Trichotillomania, recurrent corneal erosion

**Station 3 - Posterior Segment**

- Left Peripapillary membrane
- Diabetic retinopathy Pigment dispersion
- Sorsby fundus Dystrophy
- Stargardt's
- Sector Retinitis pigmentosa
- Unilateral RP
- Coat's disease Left eye
- Dry ARMD Glaucoma
- Birdshot Choroiditis
- Stargardt's
- Right Giant retinal tear post-surgery
- Post op RD residual silicon oil
- Right CRAO Rubeosis PRP

- Right ARMD
- Previous right RD Left Laser to tear
- Left Disciform, Right PED and retinoschisis
- Bilateral Paravenous Pigmentary Retinopathy
- Stargardt's
- Right Giant retinal tear post surgery
- Post op RD residual silicon oil
- Right CRAO Rubeosis PRP
- Right ARMD
- Previous right RD Left Laser to tear
- Left Disciform, Right PED and retinoschisis
- Bilateral Paravenous Pigmentary Retinopathy

**Station 4 - Strabismus and Orbit**

- Graves
- Right III
- Left Browns
- Left IV post 3 surgeries
- Left Intraconal cavernous hemangioma
- Duane's type 1
- Left Brown's
- Recovering Traumatic left III
- Anophthalmic post socket reconstruction
- Right Partial III
- Left IV
- Ocular Albinism

**Medicine and Neurology Station 5 and Station 6**

- Chiasmal Glioma Nasal Field loss left eye
- Bilateral Optic nerve Glioma
- Hypothyroid ? Graves
- Bronchiectasis Left Lower Lobectomy
- Marfans Aphakic Trabs Aortic Dilatation
- Wegener's Granulomatosis, Right Vasculitic Ischaemic optic Neuropathy, Left Tonic Pupil
- Left optic neuropathy ? Cause
- Graves
- Bilateral Optic Nerve head Drusen
- BRVO Diabetic Sensory neuropathy
- Bronchiectasis Pulmonary fibrosis Left superior, Oblique palsy
- RA Dry eyes
- GCA Blind right eye
- Disc Drusen Right RAPD
- Left IV
- VI secondary to intracavernous aneurysm
- Congenital Rubella
- Pre CRVO Diabetic

- Marfans Dislocated Lenses
- Ankylosing Spondylitis/Recurrent Uveitis
- VI post stroke
- AF on warfarin, Probable Dural Fistula
- Left Optic Atrophy Bitemporal Field Loss
- Bilateral Intermediate Uveitis Possible Sarcoidosis
- Aphakic Retinitis Pigmentosa
- Addisons disease, APS 1 Hypoparathyroidism
- T2dm with neuropathy Ankylosing spondylitis
- Type 2 DM Hypertension Post CRVO right
- Left Horners
- Craniopharyngioma, Temporal field loss right inferior scotoma left
- Aortic valve replacement
- Right AION Left BRVO
- Graves
- Left CRAO Recent PCI
- Bitemporal Hemianopia Meningioma
- Old BRVO DM
- Blepharospasm
- Right Horners
- Left IV
- Esotropia Downbeat Nystagmus
- Left Inferotemporal BRVO
- Diabetic Retinopathy
- NF1 Lisch nodules left eye
- Blepharospasm

**Thursday Morning**

**Station 1 - Anterior Segment**

- Blue dot cataracts Left myopic CNV
- Bilateral Congenital Cataract surgery, Lid Surgery, RD repair
- Vortex Keratopathy
- Right Brown McLean Syndrome
- Peripheral corneal decompensation post cataract surgery
- Band Keratopathy post congenital cataract surgery ex prem
- Aniridia Glaucoma
- Cataracts
- Cataracts Right Choroidal Folds, Diabetes
- Vortex Keratopathy Amiodarone
- HSK
- Keratoconus Left Intacs
- Right Herpes Simplex, Keratouveitis
- Posterior Polymorphous
- Dystrophy
- IOLs post Yag Left IOL in sulcus Diabetic
- HSK Post PK
- Map Dot Dystrophy

- Fuchs Right DSAEK Left PKP
- Iris and Chorioretinal Coloboma, Left Pseudophakic Right cataract

**Station 2 - Glaucoma and Lid**

- Congenital glaucoma post goniotomies and trab
- Pigment Dispersion
- Right PXE
- Left medial ectropion post punctoplasty and medial spindle procedure
- Right Congenital ptosis
- Blateral Ectropion
- Left Lower Lid BCC
- Pigment Dispersion Marfan
- Previous Bilateral ACG
- Bilateral Involutional Ptosis
- Ectropion
- Multiple BCCs post Reconstruction
- BCC Right lower lid
- Pigment Dispersion
- Previous Right Angle Closure
- Anophthalmic Right Ptosis
- Invasive nasal polyposis affecting right, Orbit. Previous DCR and lateral, Tarsorrhaphy
- Left Aponeurosis Dehiscence

**Station 3 - Posterior Segment**

- Superotemporal BRVO Both eyes
- Previous Multifocal Choroiditis
- Angioid Streaks
- Left CRVO
- Right Macroaneurysm
- Bilateral BRVO
- RP
- ARMD Both eyes
- Right resolved Macroaneurysm
- RP
- Previous Bilateral CRVO
- Right Macroaneurysm
- Multiple arteriolar emboli Right eye
- Angioid Streaks
- Left NVE $2^{o}$ to DM
- Right superior hemisphere RVO
- Macular Telangiectasia
- Right CRVO

**Station 4 - Strabismus and Orbit**

- Graves
- Left Browns

- Right Exotropia
- Right Microtropia
- Bilateral pseudophake, Monocular diplopia
- Graves
- Sjogren Syndrome Right dacrocystocoele
- Ocular Albinism
- Convergence Spasm
- Left IV
- High Myope post surgery for ET
- Left Duanes Previous Right Optic Neuritis

**Medicine and Neurology Station 5 and Station 6**

- Bilateral Optic nerve Glioma
- Right AION
- Isolated Right IR Myopathy ? Graves
- Marfans Aphakic Trabs Aortic Dilatation
- GCA 2004 Graves Rx RadioIodine 2006. Ca Breast 2011
- Bilateral upper eyelid Retraction Rx Botox
- Generalised Myasthenia Gravis
- Right Optic Disc drusen
- Progressive Supranuclear Palsy
- Bilateral Optic Nerve head Drusen
- Left Cavernous Sinus Meningioma
- Scleritis Dry Eyes RA Radial Keratotomy Right Eye
- Marfans AC IOLs
- Right III Bitemporal Hemianopia Cavernous sinus Meningioma
- Disc Drusen and Nasal Field defect, MS Right optic Neuritis 2007 on Avonex
- Ankylosing Spondylitis and RA, Uveitis
- Type 2 DM Hypertension Post CRVO right
- Graves
- Optic Disc Drusen Visual Field Loss, Incidental Right Posterior Parietal Meningioma
- Marfans Dislocated Lenses
- NF1 Aplasia Sphenoid wing (repaired) Proptosis, Multiple Squint surgery Lisch Nodules
- V and VII post acoustic neuroma, Gold weight RUL
- Left Ptosis and Traumatic Mydriasis, Right Trabeculectomy ?RAPD
- Right Horners
- Right INO
- Diabetic Retinopathy, Left Iris IOFB
- Right Horners, Cerebellar Syndrome Post surgery for Cavernoma Previous RD surgery
- Pituitary Tumour Left optic Atrophy
- Right AION Left BRVO
- Right Horners Small Cell Lung Ca
- Diabetes Peripheral Neuropathy Cardiac Failure
- Old BRVO DM
- Marfans  Aphakic Left Corneal Decompensation, Previous Glaucoma surgery

## 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) | 86/156 | (55%) |
| Mean score: | 101 | (65%) |
| Median score: | 102 | (65%) |
| Range: | 36-143 | (23%-92%) |
| Reliability (Cronbach alpha): | 0.8 | |
| SEM: | 9 | |
| **Adjusted pass mark (+1 SEM)** | **95/156** | **(61%)** |
| | | |
| Pass rate before adjustment (pass mark 86/156) | 71/95 | (75%) |
| **Pass rate after adjustment (pass mark 95/156)** | **60/95** | **(63%)** |

**Table 7 Distribution of scores**

| Score | Distribution | Total |
|---|---|---|
| 31-40 | / | 1 |
| 41-50 | / | 1 |
| 51-60 | | 0 |
| 61-70 | ///// | 5 |
| 71-80 | ///// | 5 |
| 81-90 | ///// ///// ///// / | 16 |
| 91-100 | ///// //// ///// //// | 19 |
| 101-110 | ///// ///// /// | 13 |
| 111-120 | ///// ///// ///// ///// | 20 |
| 121-130 | ///// // | 7 |
| 131-140 | ///// // | 7 |
| 141-150 | / | 1 |
| Total | | 95 |

**Table 8 Station marks (before weighting)**

| Station | | Maximum possible | Mean | Median | Min | Max |
|---|---|---|---|---|---|---|
| 1 | Anterior segment & cataract | 36 | 24 | 24 | 3 | 36 |
| 2 | Glaucoma & lid | 36 | 23.8 | 24 | 3 | 36 |
| 3 | Posterior segment | 36 | 24.6 | 25 | 1 | 36 |
| 4 | Paediatric & strabismus | 24 | 14.4 | 14 | 6 | 24 |
| 5/6 | Medicine and neurology | 48 | 29.9 | 30 | 8 | 47 |
| 7 | Communication | 18 | 12.6 | 14 | 1 | 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. |
| | 0.86 | 0.86 | 0.92 | 0.87 | 0.91 | 0.84 |

**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. |
| | 0.83 | 0.82 | 0.89 | 0.90 | 0.89 | 0.80 |

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

| | | Station 2 | Station 3 | Station 4 | Station 5/6 | Station 7 |
|---|---|---|---|---|---|---|
| | | Glauc/lid | Posterior | Orbit/Strab | Med/neuro | Comm. |
| Station 1 | Cat/AS | 0.24 | 0.46 | 0.22 | 0.16 | 0.20 |
| Station 2 | Glauc/lid | | 0.29 | 0.14 | 0.22 | 0.23 |
| Station 3 | Posterior | | | 0.32 | 0.34 | 0.25 |
| Station 4 | Orbit/Strab | | | | 0.38 | 0.10 |
| Station 5 | Med/neuro | | | | | 0.34 |

**4b) Standard setting for the OSCE**

**Table 12**

| *Station* | *1* | | *2* | | *3* | | *4* | | *5 & 6* | | *7* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *No. of borderline candidates* | 30 | 28 | 29 | 34 | 15 | 23 | 32 | 32 | 27 | 25 | 19 | 25 |
| *Median borderline candidate weighted score* | 6.7 | 6.7 | 6.7 | 6.7 | 7.3 | 6.7 | 7 | 6 | 14 | 13 | 2.7 | 2.7 |
| | 10 | 10 | 10 | 10 | 11 | 10 | 7 | 6 | 15 | 15 | 5 | 4 |

The pass mark for the OSCE was increased by 1 SEM from 86/156 (55%) to 95/156 (61%)

## 5. Overall results for the oral examination

### 5a. Results

| | | |
|---|---|---|
| Pass mark | 165/276 | (60%) |
| Mean | 179/276 | (65%) |
| Median | 176/276 | (64%) |

To pass the oral examination candidates must achieve 165/276 overall, 64/120 in the viva and 86/156 in the OSCE.

| | |
|---|---|
| Pass rate for the oral examination | 55/95 (58%) |
| Pass rate for the entire examination | 55/103 (53%) |

**Table 13 Distribution of scores**

| Score | Distribution | Total |
|---|---|---|
| 61-70 | / | 1 |
| 71-80 | / | 1 |
| 81-90 | | 0 |
| 91-100 | | 0 |
| 101-110 | | 0 |
| 111-120 | / | 1 |
| 121-130 | /// | 3 |
| 131-140 | //// | 4 |
| 141-150 | ///// / | 6 |
| 151-160 | ///// /// | 8 |
| **161-170** | ///// //// // | 12 |
| 171-180 | ///// ///// //// | 14 |
| 181-190 | ///// ///// / | 11 |
| 191-200 | ///// //// | 9 |
| 201-210 | ///// /// | 8 |
| 211-220 | ///// //// | 9 |
| 221-230 | //// | 4 |
| 231-240 | / | 1 |
| 241-250 | // | 2 |
| 251-260 | / | 1 |
| Total | | 95 |

**Table 14 Correlation between scores in each part of examination**

| | *VIVA* | *OSCE* | Oral examination |
|---|---|---|---|
| *MCQ* | 0.54 | 0.47 | 0.55 |
| *VIVA* | | 0.61 | |

## 5b) Breakdown of Oral Examination

### Table 15 Breakdown of results by training

| | Failed | Passed (%) | Total |
|---|---|---|---|
| In OST | 22 | 44 (67) | 66 |
| Not in OST | 18 | 11 (38) | 29 |
| Total | 40 | 55 | 95 |

These differences are statistically significant (p = 0.01)

Pass rate for the oral examination for candidates in OST 44/66 (67%)
Pass rate for the Part 2 examination for candidates in OST 44/69 (64%)

### Table 16 Breakdown of results by gender

| | Failed | Passed (%) | Total |
|---|---|---|---|
| Female | 8 | 23 (74) | 31 |
| Male | 32 | 32 (50) | 64 |
| Total | 40 | 55 | 95 |

These differences are statistically significant (p = 0.0.3)

### Table 17 Breakdown of results by deanery

| | Failed | Passed | Total |
|---|---|---|---|
| East Midlands | 1 | 4 | 5 |
| East of England | 1 | 1 | 2 |
| East Scotland | 0 | 0 | 0 |
| London & KSS | 4 | 11 | 15 |
| Mersey | 2 | 4 | 6 |
| North Scotland | 0 | 0 | 0 |
| North Western | 1 | 2 | 3 |
| Northern | 0 | 3 | 3 |
| Northern Ireland | 1 | 2 | 3 |
| Oxford | 0 | 3 | 3 |
| Peninsula | 0 | 5 | 5 |
| South East Scotland | 0 | 1 | 1 |
| Scotland West | 3 | 2 | 5 |
| Severn | 0 | 0 | 0 |
| Wales | 2 | 1 | 3 |
| Wessex | 0 | 0 | 0 |
| West Midlands | 3 | 4 | 7 |
| Yorkshire | 4 | 1 | 5 |
| | 22 | 44 | 66 |

**Table 18 Breakdown of results by level of training**

| | Failed | Passed | Total |
|---|---|---|---|
| ST3 | 0 | 0 | 0 |
| ST4 | 2 | 7 | 9 |
| ST5 | 5 | 12 | 17 |
| ST6 | 8 | 12 | 20 |
| ST7 | 5 | 10 | 15 |
| Total | 20 | 41 | 61 |

* Level unknown for 5 candidates in OST

**Table 19 Breakdown of results by country of qualification**

| | Failed | Passed | Total |
|---|---|---|---|
| UK | 17 | 32 | 49 |
| Outside UK | 23 | 23 | 46 |
| Total | 40 | 55 | 95 |

These differences are not statistically significant (p = 0.15)

**Table 20 Breakdown of results by first language**

| | Failed | Passed (%) | Total |
|---|---|---|---|
| English | 18 | 44 (71) | 62 |
| Other | 13 | 11 (46) | 24 |
| Total | 31 | 55 | 86 |

*First language unknown for 9 candidates

These differences are statistically significant (p = 0.044)

**Table 21 Breakdown of results by ethnicity**

| | Failed | Passed | Total |
|---|---|---|---|
| White | 6 | 19 | 25 |
| Non-white | 30 | 36 | 66 |
| Total | 36 | 55 | 91 |

* Ethnicity undeclared by 4 candidates

These differences are not statistically significant for white/non-white (p = 0.09)

**Table 22 Ethnicity of candidates in OST**

| Ethnicity | In OST | Not in OST | Total |
|---|---|---|---|
| White | 23 | 2 | 25 |
| Non-white | 42 | 24 | 66 |
| | 65 | 26 | 91 |

* Ethnicity undeclared by 4 candidates

**Table 23 Breakdown for candidates in OST by ethnicity**

| Ethnicity | Fail | Pass | Total |
|---|---|---|---|
| White | 4 | 19 | 23 |
| Non-white | 17 | 25 | 42 |
| | 21 | 44 | 65 |

* Ethnicity undeclared by 1 candidate

These differences are not statistically significant for white/non-white in training (P = 0.10)

**Table 24 Breakdown of results by number of previous attempts**

| Attempts | Failed | Passed (%) | Total |
|---|---|---|---|
| 1 (First) | 19 | 28 (60) | 47 |
| 2 | 12 | 16 (57) | 28 |
| 3 | 1 | 8 (89) | 9 |
| 4 | 3 | 2 (40) | 5 |
| 5 | 4 | 1 (20) | 5 |
| 6 | 0 | 0 | 0 |
| 7 | 1 | 0 | 1 |
| Any resit | 21 | 27 | 48 |

**5d) Table 25 Comparison to previous examinations**

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

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

| Deanery | Number of passes | Number of candidates | Pass rate % |
|---|---|---|---|
| East Scotland | 2 | 2 | 100 |
| Oxford | 14 | 18 | 78 |
| Severn | 12 | 16 | 75 |
| Northern Ireland | 7 | 10 | 70 |
| North Scotland | 4 | 6 | 67 |
| Scotland South East | 6 | 9 | 67 |
| London KSS | 64 | 101 | 63 |
| Northern | 10 | 16 | 63 |
| Mersey | 13 | 22 | 59 |
| East Midlands | 9 | 16 | 56 |
| Peninsula | 10 | 18 | 56 |
| Wales | 12 | 25 | 48 |
| Scotland West | 5 | 11 | 45 |
| West Midlands | 16 | 37 | 43 |
| Yorkshire | 16 | 39 | 41 |
| North Western | 12 | 31 | 39 |
| East of England | 3 | 9 | 33 |
| Wessex | 2 | 8 | 25 |
| TOTAL | 217 | 394 | 55 |

**Appendix 1: Candidate evaluation**

**Structured Viva**

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

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

Comments

- (Station about visual field defect). Second examiner appeared to be distracted during the station. The other seemed to be annoyed when I did not understand the question asked. Station felt uncomfortable, especially compared to others

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

Comments

- OCT style printout quite different to those I'm used to
- Questions were not restricted to the investigation, but on the other hand dealt with management and into prescribed guidelines for management
- Some questions were not clearly explained by examiner

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

Comments

- Some cryptic style questions relating to studies looking at systemic DM treatments- I hope that they were not after DCCT or UKPDS because that was not what they asked.

**Viva station 2 Patient Management 1**

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

Comments

- One examiner clearly displayed his marking sheet on the table in front of me during his questioning. As I answered questions he wrote down comments and marks immediately. As these were low marks and negative comments it heavily affected my performance on subsequent questions and was very distracting. The examiners also ran out of time on this station. I suggest that examiners try to conceal the mark sheets as best as possible.

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

Comments

- Open question about optic atrophy but not sure what they want as I listed all DD but they were trying to create a scenario, which felt, bit poor. May better approached with direct questions as time limited to summarised Neuro-ophthalmology in 10 min

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

No comments

**Viva station 3 Patient Management 2**

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

Comments

- There was a third person in the station presumably a monitor for the examination, however he was not introduced to me. One examiner in this station was very expressionless and used closed questions with no prompting to help guide the station which was in contrast to all the other stations, this may have been their style but I felt that it may have been due to the presence of the third person. Either way it made it very difficult to answer the questions.
- A little aggressive in questioning
- Felt very comfortable with the examiners while answering the questions

Were the questions appropriate for the station?
Yes 100%  No 0%

No comments

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

No comments

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

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

Comments

- One of the examiners was very unprofessional

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

Comments

- The neonatal conjunctivitis scenario felt a bit short. There wasn't much more to discuss than antibiotics, paeds referral and gum referral. I left station quite early and was concerned there wasn't much opportunity to stretch my knowledge.
- Some questions were not appropriate
- Maybe specific questions about symptoms of Chlamydia in women should be excluded from this station as this is an ethics and not a clinical station
- Questions should be more specific. It was difficult at times to determine the question the examiners wanted

- Too much emphasis on non-ophthalmic advice, which in real life would be dealt with by the GP, paediatricians and the genito-urinary medicine clinic. Not much emphasis on the actual ocular management. In reality we would manage the ocular problem and we would make the referral to the relevant teams but not do much beyond that.

Were the questions of an appropriate standard for an exit examination?
Yes 85% No 15%

No comments

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

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

Comments
- One examiner was only just "yes"
- Very nice and encouraging examiners

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

Comments
- The question on endarterectomy studies- yes know they exist but the details are for vascular surgeons
- Station was focused on the difference between 2 classification system for Uveitis which is largely irrelevant in practice as they contribute very little to patient management and as a consequence the academic difference is likely not well known by general consultants in my humble opinion.
- Shared care is not common practice in many institutions and was not an appropriate topic in my opinion

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

Comments
- Audit question was not that testing
- Whilst ideally all Consultants should be familiar with most ophthalmic papers, it is unlikely that every single paper will be read by them all. Questions based on a specific paper should not be the only questions asked and perhaps "back up" or "fall back" questions should be prepared in a similar or alternative topic. In essence, candidates who are unfamiliar with a specific paper will not get full marks at that station, but perhaps give them to the chance to earn some marks at station.

**The Structured Viva – Overall Feedback**

Was the structured viva examination well organised?
Yes 100% No 0%

Comments

- However there were timing issues, irrespective of the late start for valid reasons, each group were further delayed due to inefficiencies
- Running late but well organised
- Nicely timed, well looked after with water and explanation, etc

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

No comments

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

Yes 80% No 20%

Comments

- I believe that stations 4 and 5 were inappropriately structured
- Except for EMB station, uveitis classification was rather artificial
- Too limited in scope and focused on a few areas only
- The questions were heavily based on the college guidelines, which though important, do not necessarily test knowledge. This is because overseas candidates are at a disadvantage. Questions based on “how should this condition be managed?” rather than “ what do the guidelines say about this?” may better test core knowledge

In your opinion should the structured viva examination be included in the exit examination?
Yes 90% No 10%

Comments

- Stations 1, 2, 3 and communication skills were proper assessment of skills and knowledge. The same does not apply to stations 4 and 5
- Yes but the format should be changed to allow greater scope and focus on management and generation of differential diagnoses.
- May be should be included in part 1 and concentrate more on OSCE
- I feel that it would be more appropriate to assess MCQs, Vivas and OSCEs as separate exams

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

- Comfortable atmosphere and appropriate exam
- Overall a fair exam and at an appropriate level
- Overall it was a good exam. It was well organised and the stations were generally fair.
- The structured viva is fair with realistic scenarios and enough time given to answer them
- There is need to decouple the written, viva and OSCE into various modules since it is logistically very difficult (arranging work leave, exhausting travel, accommodation, etc) unfair and expensive to re-write the whole FRCOphth part 2 as is on different occasions/dates (especially for overseas candidates) despite having passed portions of it. A reasonable time limit for sitting/ re-sitting a modular viva and OSCE may be in order.

## 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

- Although when I asked a patient a question about what medication she was on the examiner said 'Hang on I ask the questions here' which I thought was a bit unfair as the condition was related to a drug the patient was taking.
- Professional and encouraging approach with good attitude towards candidate
- They seemed to be in a great hurry to get done with the exam

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

No comments

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

Comments

- Not much of variety in anterior segment cases. Also I referenced a paper from JCRS August issue to answer one of the questions and the examiners were not aware of it.
- Intricacies of how to manage cataract surgery in a patient with aniridia should not be pass/fail criteria as very few ophthalmologists would have to do this in real life

### OSCE station 2 Glaucoma and eyelid

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

Comments

- "This is the glaucoma and lid station, would you please examine this patient's anterior segment" I mention the lids- "I said anterior segment, lids are not part of the anterior segment!" not clear instructions and not helpful statement, put me off rest of station.
- Examiners should mention at start of the station that you are expected to comment while you are examining the patient rather than describe findings after completing examination

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

Comments

- Impressive cases provided with great signs e.g. Haab striae congenital glaucoma. Slightly odd questioning of what is most common cause of ptosis (involutional) when my case had pupil asymmetry (Horner's)

- One of the patient had some skin condition on the cheek as part of the eyelid case (the eyelid had no lesion visible) and when I was unable to make a spot diagnosis on inspection, the examiners did not ask me any other viva question about that case
- Patient used for eyelid was poor

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

Comments
- I was asked to examine ptosis in a patient with dermatochalasis, I was asked for a special examination. I said I would do the normal examination for ptosis. MRD, Lid crease, Levator function and PA. The consultant wasn't happy with that. He then demonstrated the test he wanted me to do but did not explain. I am not sure what he did? inactivated Levator. I have it up since I have come back and can't find any particular examination that is different for patients with dermatochalasis. I was also asked to grade snap back and I said a 3. Same examiner as above didn't seem to like that answer. I then started to doubt myself and stumble. Examiner then said that it was a grade 3 so I'm not sure why he didn't like my first answer.

**OSCE station 3  Posterior Segment**

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

No comments

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

Comments
- Pupil not dilated for an indirect ophthalmoscopy examination. Direct ophthalmoscopy – dilated fundus examination is not appropriate as it is hardly used in clinical examination routinely
- Very rare set of cases
- The quality of the slit lamp optics for this station were very poor, did not find quality of image to be clear which took longer to examine patient. It was disappointing since there were slit lamps of higher quality in other rooms in which they were not being used such as in the neuro/medicine station.

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

No comments

**OSCE station 4  Strabismus and Orbit**

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

Comments

- Sometimes examiners weren't clear in their questioning and rather than re-phrasing or trying to make you understand what they were trying to say tended to give up rather than encourage an answer or different way of thinking
- I felt that the examiners in this station were not specific enough. I specifically asked the examiner if they wanted me to focus on ocular motility and strabismus or the orbit exam, however was told just to "examine the patient", even though both examination techniques can last for a longer time in real world clinical setting. In addition the examiner said "In 3 ½ minutes you need to tell me your findings and answer my questions". This is not helpful and perhaps a suggestion on what to focus on would be more useful.

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

Comments

- The signs were not easy to elicit, even the examiner had to do a brief exam in order to double check
- Two motility cases and no orbit case
- Very subtle findings. Not classical cases
- Second patient recently had surgery to extra ocular muscles and was therefore in pain. Had difficulty following target during EOM assessment. She complained of pain on eye movements and could not keep eyes open for examination. Examiner agreed that she was not a good patient for this assessment

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

No comments

**OSCE station 5 Medicine and Neurology**

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

Comments

- The Neurology consultant was very kind and put me at ease.
- Felt been pushed just to answer and make diagnosis quickly in two cases without enough time to examine the patients
- Phrasing of questions could be improved if the candidate is not grasping the concept. Got the feeling that they were keen to move on at times rather than trying to encourage the answers
- Very pleasant examiners

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

Comments

- One patient had multiple signs INO/supranuclear gaze palsy/RAPD/XT although the signs were spotted I was not asked about the diagnosis or given more time for

discussion before the next patient was brought in even though this was the first patient and I left the station early after the fourth so there would have been ample time, not sure if this resulted in a poor mark as not got feedback yet.
- Yes – although I was fairly confident there were no cells to be seen in my case of AS-related iritis
- Not all the patients were appropriate for an ophthalmology exam
- Extremely rare cases
- Was thrown off by 1 examiner when examining pupils. Patient had anisocoria with told me that there was a RAPD and discussion begun on RAPD. But later, on confirming with the 2nd examiner, he said that there was indeed no RAPD but anisocoria was present. Despite confusion & time waste/ crunch, discussion proceeded on anisocoria. Difficult recovery from this break in concentration and confidence.
- Cases are very much medical/neuro and in real practice we would not be making management decisions on such cases

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

Comments

- Although cases were easy, the way I was being examined was misleading and confusing so that I personally could not identify what was going on in many of the cases. Characteristically, as soon as I finished the station, I could tell what all the patients had, something that did not happen during the station. Additionally, no communication was allowed between me and the patient, which does not apply to reality.
- Again asked to examine hands for scleroderma? Leukonychia totalis? Which I have never seen in my practise for the last 9 years....got the abnormal finding including white nails and bruises and swollen joint but Examiner was not happy at all... Other candidates in the same group had been asked easier questions on TED, Rheumatoid Hands, optic atrophy and been assessed on that. I totally agree that as a doctor and ophthalmologist we need to have a wide general knowledge of systemic disease, specially related to Eyes but such cases need to be verified clearly and listed in the exams curriculum. May be it would better if the same questions and same patients ask for all candidates in the same group to be fair to all and assess their level and competencies equally.
- Again the questions asked are related to the medical management side of things, which in real practice as ophthalmologists we would refer on and only manage the ocular side of things. There is no point knowing the systemic medications since we would not prescribe these in clinical practice without consulting our medical or neurology colleagues.

**OSCE station Communication Skills**

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

Comments

- Apart from brief introduction, no interaction with examiners. Felt some guidance

needed especially when candidates may get confused and/or stray from desired answer in the limited time. In reality there would be more time to explore various patient concerns.

Was the clinical scenario explained clearly?
Yes 80%  No 20%

Comments

- In paper it was clearly explained but the 'patient' had concerns that had to be discussed thoroughly, not giving you enough time for going through the actual consent which was the main request of the station
- There was additional information on the preparation sheet, which was found to be erroneous during the consultation. Not a big issue but it was unnecessary.
- The question asked the candidates to give prognosis to a highly specialised and sensitive issue (retinoblastoma). It was not specific whether one should give e.g. the percentage of siblings being affected etc and whilst I knew this information, it is probably best given by specialists in the field. However, I did not know whether one would have marks deducted if this was not mentioned in the exam

Was the clinical scenario appropriate for an exit examination?

Yes 95%  No 5%

Comments

- Quick technical scenario and a little pushed for time – was aware that needed to show communication skills, consent skills and knowledge of refraction!
- The scenario was poorly written and explained as I have been told that I am the consultant in charge and my registrar examined a child with white pupil who has been referred by his GP as congenital cataract. The registrar diagnosed Retinoblastoma clinically and I have been ask to tell the mum about the diagnosis and prognosis and treatment option then refer her to the specialist centre, at the end of the typed scenario an added <u>hand written</u> note saying that you were on holiday, haven't seen the Mum or child before and talk to mum. I found the scenario is far away from our reality practice as I am relying on my registrar finding to tell Mum, in the nicest and less traumatic way, that your baby has a Cancer!!!!!! And I haven't even examined your child myself!!! It took me few minutes trying to get my head around it as this is absolutely contrary to a good practice and I felt I am bit confused as I didn't understand the question so after few minutes from starting the station I apologised and asked the examiner to verified that it has been defiantly diagnosed with RB and they said yes you have a competent Reg and you trust his finding and asked continue but time then was running. After I left the station the scenario was changed advising that you examined the child and diagnosed was Retinoblastoma. I wish they revised the scenario before I entered the room that would save me time and stress on this station thinking that there were tricking me.

**<u>The OSCE overall</u>**

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

Comments

- Excellently organised and well time kept overall
- We were really rushed to the stations without much of explaining
- Ran late
- Overall the exam was very well organided. I must complain however about the group of candidates who had an extra half hour rest station during the OSCE. We were told that since we were "lucky enough" to have our exams on two consecutive days, that we had to put up with a rest station in order to fit an odd number of candidates. Although I completely understand that this needed to be done to accommodate the number of candidates, it was not done to the right group of candidates, and not done in the right way. In my opinion our group was disadvantaged in several ways. 1) I do not feel that we were lucky to have the exam on two consecutive days – I would have welcomed a rest day in between. This should not have been used as a reason for why our group was chosen to have a rest station. 2) If one group of candidates did need to have an extra half hour added to their OSCE this should have been one of the groups of candidates having the exam first thing in the morning. We finished later than we expected to, but more importantly were very tired by the time it was our turn for the OSCE after a long day of waiting. I understand that one group will have to have their OSCE in the afternoon, but there should be no further undue delays to this particular group of candidates. 3) It was not fair to surprise us with the fact that we would be having an extra half hour in our OSCE. We should have been given due notice of this fact (surely this must have been known well in advance). It is extremely tiring and stressful waiting until 3pm for such an important and demanding exam. Particularly for those candidates who were starting with their rest station, to be surprised by the fact that they need to wait for another 30 minutes while all the other candidates have started their exam is very dispiriting. Furthermore, sitting amongst the patients being taken in and out of the exam is really not appropriate. Candidates must be warned in advance if their planned start time is going to be half an hour later than expected and they should be kept in a protected environment until it is their time to begin. After a whole day of building up the adrenaline for the exam, it was very unfair to spring this upon us, and make us watch while everyone else started their exam. Both energy and morale were running low by the time it was our turn to begin.
- It is an impressive achievement to recruit that many patients with such a wealth of signs
- Overall well-organised but a delayed start and prolonged rest (40 mins – not half an hour) meant it was a very long and draining examination with a finish closer to 6 o'clock than 5 o'clock, which must have been draining for the examiners as well as the candidates
- It was very well organised
- Mostly. For some stations the examination rooms were open (only 3 walls) and other candidates' and examiners' chatter could be heard - a bit disturbing. So too was the shuffling of patients around in an apparently rushed manner by examiners. Need for staff dedicated for moving patients in and out of rooms/ examination chair, and candidates can be informed of this so that they and examiners won't be distracted by this too much and can focus on the exam questioning and answering.

Were you given clear instructions about the OSCE?
Yes 90% No 10%

Comments

- We were told the examiners were NOT going to shake hands with us but a number of them did. Some stations did not have any alcohol wipe available for use. These are small points only though.
- Very well organised with clear instructions
- Candidates should be advised to describe findings during the examination at the start

Did you feel that the OSCE was a fair assessment of your knowledge?
Yes 75%  No 25%

Comments
- Not medicine and neurology station
- All the cases seemed fair and what I stumbled on was my own nerves rather than the difficulty of the cases
- Certainly not all stations, I felt I knew more than I could get across
- Too limited in scope and the ant and post segment cases were too easy whereas the neurology and strabismus stations were comparatively much more difficult.
- Yes to certain extent but not in medicine or Neuro stations
- The types of patients and questions asked are fair overall but the time pressure of the situation and the nature of the structured set questions means that some candidates may find it difficult to demonstrate their knowledge and competence in a false setting
- I had two cases of motility in the same station and my performance was not good. One case of motility and another orbital case would have been better. Other stations were fair
- Rare cases but questions were relevant
- Somewhat. Felt rushed through the stations which are not very representative of actual patient interactions where there would be more information from history taken from the patient.
- Some questions were very specific to the UK e.g. Driving standards and do not apply to candidates working in the Republic of Ireland
- Given the time constraints, it is difficult to examine patients who do not have obvious signs. Therefore, examiners should provide more specific instructions to assist the candidates. In reality, some patient will require more than 5 minutes to examine, and this should be factored in

In your opinion should the OSCE be included in the exit examination?
Yes 85%  No 15%

Comments
- At this level, we should be moving away from the limited scope of an OSCE and it is a poor reflection of patient assessment in a real setting. Greater emphasis should be placed on the ability to diagnose, generate appropriate differentials and form management plans, which more closely mimic the role of a consultant.
- This is a very important part of fellowship
- The OSCE has value but if competencies are being met then the exam does not necessarily need to test basic clinical skills such as using a slit lamp. An Exit examination should gauge a candidate's readiness to become a consultant and this is not necessarily tested in a 15 minute station, which can assess a candidate's ability to perform under exam conditions but not necessarily their capabilities as a consultant.
- But it's a matter of luck what cases you get and how the candidate perform on that

day. There should be a way of assessing overall performance of candidate during the training period like ARCP and that should have some reflection in exit exam results
- 90 minutes of OSCE examination is not an ideal way of judging a candidate's clinical knowledge
- We are constantly being assessed in our clinical practice and together with work based assessments and clinical supervision, over a 7 year period; I feel that OSCEs are not a useful exercise in assessing clinical skills as it is in an artificial environment. MCQs and Vivas can test clinical knowledge and should remain as a useful assessment tool.

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

- Good variety of patients, cooperative patients. Fair exams and appropriate for exit level examinations. Good equipment available.
- Lack of consistency in the instructions. In the strabismus OSCE, I was told to examine extraocular eye movements but was criticised for not asking enough questions during the examination and for not including a cover test. In another station, I was also asked to examine extraocular eye movements but when I proceeded to do so, I was told "do not take a history" when I was asking whether there was 1 or 2 images and was asked why was I including a cover test when it was not asked for. Confusing! In the strabismus OSCE, the Indian gentleman examiner insisted that I use the mirror and Snellen chart as a distance target, which completely masked the signs. When the signs could not be elicited, he had to do a quick examination himself and had to resort to using a different fixation target. This was inappropriate and wasted time. He was also poor at leading the OSCE and I was quite confused by his line of questioning and even though I knew the diagnosis, I was not able to demonstrate my knowledge. However he was polite throughout the station.
- Well conducted with a good selection of cases but not enough time for discussion.
- This was very well organised with an excellent range of cases. The examiners were very good and were fair.
- "Rest" periods longer than 15 minutes are not conducive to good performance
- The examiners and patients put me at ease during the OSCE and it was organised and conducted very well
- If a candidate fails either viva or OSCE, should be allowed to retake only the failed component rather than the whole exam
- The medicine and neurology station bears too much weight in this exam which is supposed to assess our ability to become future ophthalmologists. I understand this part of the exam will be changed in the future.