

**Sir,
Comments on 'Confidence of ophthalmology trainees in the management of posterior capsule rupture and vitreous loss'**

We would like to thank Turnball and Lash for their study on 'Confidence of ophthalmology trainees in the management of posterior capsule rupture and vitreous loss'¹ and for drawing attention to the importance of training in the management of complications in cataract surgery.

Their study illustrates that confidence in dealing with the complications of cataract surgery cannot be acquired by simply performing 350 cataract procedures and they express a view that 'a competency based assessment framework of assessment in cataract surgery, instead of the current numerical goal of 350 is required.'

The Royal College of Ophthalmologists Curriculum for Ophthalmic Surgical Training (<http://curriculum.rcophth.ac.uk>) in the UK is competency based.

The 350 cases required during training in the UK are not a goal, but a minimum number felt necessary to acquire surgical skills; and the minimum number required to have a meaningful continuous audit of complications.

Developing competence is assessed annually using a specific Objective Assessment of Surgical and Technical Skills (OSATS) assessment and feedback tool (<http://curriculum.rcophth.ac.uk/assessments/osats>). It is mandated that this tool be used on at least 2 occasions per year with a senior trainer, although more frequently is recommended. The tool includes the recording of the difficulty of the case and it is expected that increasingly complex cases will be undertaken as training progresses; these assessments are reviewed at the Annual Review of Competence Progression (ARCP); satisfactory progress is essential for the trainee to continue to the next year of training.

The Learning Outcome (SS4; http://curriculum.rcophth.ac.uk/learning-outcomes/surgical_skills/ss4), this tool assesses, includes the requirement to 'be able to manage intra-operative and post-operative complications'.

We agree with the authors that given the low rates of surgical complication,² this competence may not be developed in the in vivo situation and the curriculum is explicit in the use of simulation to teach and assess such skills.

In short, all trainees should have satisfied this learning outcome and be able to deal with complications before a Certificate of Completion of Training is recommended by their ARCP panel.

Outcomes of cataract surgery are also assessed by separate audit.

Conflict of interest

The authors declare no conflict of interest.

References

- 1 Turnball A, Lash SC. Confidence of ophthalmology specialist trainees in the management of posterior capsule rupture and vitreous loss. *Eye* 2016; 30(7): 943–948.

- 2 Johnston RL, Taylor H, Smith R, Sparrow JM. The Cataract National Dataset electronic multi-centre audit of 55,657 operations: variation in posterior capsule rupture rates between surgeons. *Eye (Lond)* 2010; 24(5): 888–893.

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We are grateful to Bishop and Spencer,¹ of the Royal College of Ophthalmologists' Training Committee and Curriculum Sub-Committee, for their thoughtful comments regarding our study.² We acknowledge that OSATS represent a form of competency-based assessment, but there is still scope for these tools to become a 'tick-box' exercise.

In our experience, trainees are often assessed on uncomplicated cases, partly due to low complication rates but also because of a fear of receiving poor evaluation if, for example, posterior capsule rupture has occurred—even if the subsequent management of this is deemed satisfactory. This is an unfortunate consequence of the quite generic current format of assessments, with cataract surgery being assessed as a whole, rather than in more discrete components. It may be preferable to introduce more specific assessments for distinct aspects of cataract surgery, for example, 'managing posterior capsule rupture' or 'managing zonular dialysis'. This more targeted form of assessment would avoid trainees selectively seeking assessment on uncomplicated cases that have gone well. Trainees would likely need to seek assessment in simulated scenarios, assuming that the rate of such complications is too low to guarantee adequate exposure during the course of training. This would avoid the situation of trainees completing their training with admirably low complication rates, but with proportionally low experience of managing complex scenarios, which they will be required to handle independently as Consultants.

We are pleased to note that as of 12 September 2016 (5 months after our study was published online) there has been official notification from the RCOphth that the UK ophthalmic specialist training curriculum has been modified to tackle some of these issues.³ There is now an 'Entrustable Professional Activity (EPA1)' assessment, whereby senior trainees must demonstrate that they can manage an entire operating list of cataracts. This is in addition to the standard OSATS, rather than a replacement. We welcome this development, which is certainly an improvement upon the previous system of assessing single cases, and will hopefully increase the