

FINAL EXAMINATION FOR THE FELLOWSHIP IN CLINICAL ONCOLOGY

AUTUMN 2014

The Examining Board has prepared the following report on the Autumn 2014 sitting of the Final Examination for the Fellowship in Clinical Oncology. It is the intention of the Fellowship Examination Board that the information contained in this report should benefit candidates at future sittings of the examinations and help those who train them. This information should be made available as widely as possible.

FINAL EXAMINATION FOR THE FELLOWSHIP IN CLINICAL ONCOLOGY
EXAMINERS' REPORT – AUTUMN 2014

Part A

Of the 56 candidates who had taken the examination, 29 had been successful, giving an overall pass rate of 52%. 26 of the 41 UK candidates were successful, giving a pass rate of 63% and of the 30 UK 1st timers, 22 were successful giving a pass rate of 73%. 3 of the 15 non-UK trained candidates passed giving a pass rate of 20%

The average scores achieved overall by topic are detailed below:

Topic	Average score %
Breast	57%
Respiratory	61%
CNS	62%
Head & Neck/ENT	60%
Upper GIT	55%
Lower GIT	56%
Gynaecology	61%
Haematology	56%
Skin	55%
Urology	67%
Miscellaneous	61%

Part B

50 candidates attempted the examination and 26 were successful, giving a pass rate of 52%. 24 of the 43 UK trained candidates were successful, giving a UK pass rate of 56%. 11 of the 24 UK trained candidates making their first attempt were successful, giving a UK first time pass rate of 46%. 2 of the 7 non-UK trained candidates were successful, giving a non-UK trained pass rate of 29%. Two non UK trainees attempted for the first time both failed on this occasion.

Clinical Examination: 62% of 50 candidates passed this component of the examination.

Once again breast examination was poorly conducted by many candidates who missed very obvious masses. The increasing use of neo adjuvant chemotherapy means that these clinical skills are more important now than ever and candidates should take every opportunity to examine patients in breast clinics under supervision.

Examiners commented on candidates offering inappropriately toxic therapy for elderly patients with breast cancer. It is important that candidates take account of the age and co morbidity of the patient when presenting a management plan. Both inappropriately aggressive surgery and chemotherapy were offered when there was very little prospect of improving survival or quality of life compared to less toxic alternatives.

A number of candidates asked whether they were expected to measure lesions or seemed reluctant to do so when in the clinical station. Candidates are best advised to measure any lesion when clinically appropriate especially if it will have a bearing on treatment such as in the breast or skin stations. The examiners are likely to intervene if they feel the actual measurement is not required to help the candidate along.

There were a number of stations when a palliative radiotherapy plan was required and candidates often presented unnecessarily over complicated plans particularly for old and frail patients.

Unfortunately at this sitting nodal examination was generally poorly undertaken. Obvious nodes in patients with lymphoma were missed.

In the ENT station on this occasion there was generally good assessment of the primary lesion and lymph nodes, but evidence from other stations suggests that this is still an area that candidates need to be well versed in before attempting the examination. Candidates should take the opportunity to use review clinics to practice their examination techniques.

Candidates are reminded that this is a clinical examination and the treatments suggested must reflect the general health of the patient being discussed and not to give a textbook answer. The examination does test applied clinical wisdom as well as knowledge.

Oral Examination: 48% of 50 candidates passed this component of the examination.

This was the second sitting that the length of the entire oral had been increased from 40 minutes to 44 minutes.

In the oral examination there was still evidence of poor palliative radiotherapy technique. Attention needs to be paid to simple measures aimed at reducing toxicity, such as avoidance of exit beams through an organ at risk or simple adjustment of beam angles to reduce the volume of lung or bowel without being over complicated. Equally clinical judgement needs to be applied to a situation where an adjacent structure may or may not need to be included in the field to provide effective palliation.

Summary:

In Part B the pass rate for UK trainees attempting the examination for the first time was the equal lowest with Autumn 2012 since the exam split into Part A and Part B in Spring 2011, at 46%. This may well reflect candidates who have reasonable theoretical knowledge but are not sufficiently experienced to put that knowledge into practice in more challenging scenarios. It is noteworthy that the pass rate for UK first timers attempting Part A at this sitting was high at 73%, some of these candidates may have spent a lot of preparation time on the more theoretical aspects of clinical oncology in order to pass the Part A but still did not demonstrate sufficient clinical experience.

In order to pass candidates do need to attend MDTs regularly and make sure that their training programme has enabled them to gain broad based experience. Some candidates may not have worked on a specific tumour site since their first rotation and therefore not fully appreciated the nuances of a particular topic area. This may apply to those attempting the examination for the first time on this occasion.

It is important that candidates have acquired sufficient clinical knowledge and wisdom before they attempt the exam so that they are able to tailor their answers to the individual patient they are being asked about.

Candidates are likely to be asked about management of patients where co morbidity, age and performance status have a significant bearing on the final treatment decision. They are encouraged to discuss this with their training supervisors so that their examination preparation can be appropriately tailored.