**FINAL EXAMINATION FOR THE FELLOWSHIP IN CLINICAL ONCOLOGY**

**AUTUMN 2015**

The Examining Board has prepared the following report on the Autumn 2015 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.

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# EXAMINERS' REPORT – AUTUMN 2015

## Part A

Of the 50 candidates (UK and Joint HK) who had taken the examination, 24 had been successful, giving an overall pass rate of 48%. 19 of the 32 UK candidates were successful, giving a pass rate of 59% and of the 25 UK 1st timers, 15 were successful giving a pass rate of 60%. 5 of the 18 non-UK trained candidates passed giving a pass rate of 28% and of the 5 non-UK 1st timers, 2 were successful giving a pass rate of 40%

## Part B

24 of the 48 candidates who attempted this sitting were successful, giving an overall pass rate of 50%. 22 of the 36 UK candidates were successful giving a pass rate of 61%. 15 of the 20 UK candidates attempting the examination for the first time were successful giving a pass rate of 75%. 2 of the 12 overseas trained candidates were successful giving a pass rate of 16.6%. None of the 2 overseas trained candidates attempting the examination for the first time were successful.

### Clinical Examination:

32 of 48 (66.7%) candidates passed this component of the examination. Seven of the candidates who passed the clinical failed the examination overall because their performance in the oral component was too far below the standard required to pass.

This was the first clinical examination since the instructional video was available to candidates which all candidates had seen.

A short introduction was displayed at each of the clinical stations thereby making the station more akin to everyday practice and helping focus the candidates mind ahead of the case.

There was a strong impression that there had been an improvement in breast examination overall although there were still examples of poor technique and a failure to pick up the physical signs needed to stage the patient such as axillary nodes and accurate T stage of the primary. 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.

As a general rule candidates should not hesitate to ask for gloves if they are examining a patient with a fungating tumour at any site.

Some candidates were wasted time by examining a patient from both sides of the bed. They started on the patient's right and then moved to the patient's left to examine their left breast and axilla before returning to the right side. In daily practice it should only be necessary to inspect and examine a patient from one side and from the end of the bed unless there are unusual findings that need further exploration.

Candidates should practice their examination technique so that it becomes slick and accurate.eg it should only be necessary to lean a patient forward to examine from the back once

Candidates are measuring lesions when required more readily, careful attention to accurate size measurement will gain more marks. The examiners are likely to intervene if they feel the exact measurement is not required to help the candidate along.

On this occasion there were some very poor examples of neurological examination. Such cases can present with a number of signs that can be difficult to piece together but it is an important skill that candidates should perform competently. In a complex neurological case it is very likely that a candidate who detects most of the physical signs and can give an indication of the location of the lesion will already be close to passing that station.

In the ENT station as in many others the key to passing the station well is to pick up the physical signs such as the extent of any abnormalities, whether or not there is extension into adjacent structures such as skin and muscle and then to apply that information to the drawing of volumes. At times candidates will describe a lesion correctly indicating its extent but then will not cover that area when drawing the GTV onto paper.

Time spent actually examining patients in treatment review clinics would improve many candidates abilities in this area

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:**

26 of 48 (54%) candidates passed this component of the examination. Four of the candidates who passed the oral failed the examination overall because their performance in the clinical component was too far below the standard required to pass.

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.

As treatment improves, patients will be living longer and will present with disease close to previously irradiated areas. Candidates need to be able to weigh up the need to either overlap partially with previous radiotherapy fields if required or to modify treatment to avoid damage. As ever this decision needs to be taken in the light of the patient's condition. There are times when a patient needs a simple plan to avoid delay and a longer treatment time and others when it will be necessary to produce a more complex answer.

**Summary:**

In Part B the pass rate for UK trainees attempting the examination for the first time was the highest at 75% since the exam split into Part A and Part B in Spring 2011. This represents a steady rise from Autumn 2014 when the pass rate for UK first timers was 46%.

The pass rate for UK candidates attempting the Part A examination for the first time was 60% which is slightly lower than the average of 69% over the last 9 exams since the split in Spring 2011.However in Part B the pass rate for UK trainees attempting the examination for the first time was the highest at 75% in that time period.

The pass rates for candidates from abroad fluctuates widely reflecting candidate numbers and their training. However, overseas candidates are reminded that the examination is based on UK practice and treatment guidelines in order to improve their chances of success.

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.

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. This also applies when weighing up decisions about further treatment in patients who have had prior radiotherapy

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.