The Royal College of Radiologists

FINAL EXAMINATION FOR THE FELLOWSHIP IN CLINICAL ONCOLOGY – PART B
NOVEMBER 2025

The Examining Board has prepared the following report on the November 2025 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.

EXAMINERS' REPORT

Categories	Number of candidates	% passing
Overall	69 / 116	59%
UK trainee	37 / 44	84%
NHS Contributors	6 / 15	40%
Hong Kong	6 / 7	86%
Global (including HK)	26 / 57	46%

General

The examination was delivered online via the MS Teams platform, with all the candidates at one of our remote venues, and the UK examiners based at the RCR premises in London. During this exam 116 candidates were examined in the UK, Hong Kong and India.

We would like to thank the local examiners in India and Hong Kong for their help in examining and marking the candidates. It was a great pleasure to work with them again.

During the exam the members of the Board were grateful for all the administrative and IT support provided by the College staff. We would also want to thank the invigilators in the various regional facilities who made it possible and the very professional role-players who spent a long day examining all the candidates in the communications station.

IT

As mentioned in previous reports, the examiners are fully aware that the “pen” can produce an occasional “jump” in a smoothly drawn line when candidates use it to draw on slides. This has been investigated by the RCR IT team and seems to be related to an issue between Powerpoint and Teams which is therefore outside our control at present. Candidates can be reassured that the examiners understand the issue and take it into account when watching a contour being drawn.

Feedback

As a Board we are keen to provide feedback that will prove helpful to future candidates and their trainers. The following are issues that were noted by members of the Board:

A recurring theme in previous reports has been the Board stressing the importance of candidates needing to focus their answers on the specific questions being asked on the slides. A lot of thought goes into the wording of these and it is important to read these carefully before responding. Candidates who do this are more likely to score well and will avoid putting themselves under unnecessary time pressure. Even using just 5-10 seconds per slide to say unrelated things soon adds up to a wasted minute across a question and

that is a significant proportion of the 5.5 minutes available. For instance, if the instruction is to draw your CTV on a slide then that is what will be marked. Similarly, if you are asked to say “what treatment do you recommend” it can be assumed that you have been given the necessary information to make that decision and there will be no marks for further investigations. An answer along the lines of “I would recommend palliative radiotherapy to the left chest wall” or “ I would offer palliative chemotherapy using…..” is likely to be what the examiner is expecting. There remains a significant group of candidates that disadvantage themselves by failing to do this. As mentioned before, please practice under time pressure and really try to slim down what you say to the key information required to answer the specific question being asked.

Candidates are reminded that the clinical information presented about patients in questions is very carefully chosen / considered. It is usually there because it has some bearing on the case. Comorbidities, occupations, regular medications and the circumstances of the patient are worth considering in this light. For instance, in this exam, a patient was described as being abroad with a swollen left leg and potentially about to embark on a long car journey. It was expected that candidates would advise the patient to seek medical advice locally to rule out a DVT before their journey.

In the new format of the exam, domains such as “communications” and “patient centred care” are tested throughout the exam. When this is the case, questions are phrased accordingly (eg “How would you discuss this with the patient?” or “How would you explain this to the patient?”) and we are asking candidates to summarise the approach they would take to explaining the issues / treatment / situation to the patient described. Please bear this in mind when answering these questions. We are looking to assess the language and medical accuracy of what you would say to the specific patient (rather than a medical colleague). This may well require some empathy as to what the patient may be concerned about or be struggling to understand at that time. If it is made clear that the patient has specific views or issues related to their care, then it is reasonable to expect an answer that takes this into account.

There is a rapid adoption of pre-chemotherapy Hepatitis B screening across the UK. We are conscious that this is still not routine in every centre and it is therefore not an absolute requirement in answers at present. However, candidates would be wise to appreciate that this might evolve quite quickly over the next year or two.

In at least 2 parts of the recent exam candidates were required to adapt a standard chemotherapy treatment protocol to accommodate specific issues that affected the patient. In one case, it was a strong desire from the patient to avoid hair loss if possible and there were also co-morbidities such as cardiac issues and peripheral neuropathy that made some options inappropriate. The examiners were surprised how difficult some candidates found this, suggesting an inadequate knowledge of the side effects with commonly used chemotherapy agents. Making these decisions is a common part of oncology practice and learning from trainers how to adapt standard protocols in such circumstances is important.

Some candidates fall back on saying that they would discuss a patient “at the MDT”. In itself, this will score nothing without making clear the reason for doing it. For instance, “I would refer the patient to the Brain MDT to discuss debulking surgery, or a biopsy, to get a tissue diagnosis” is a much more useful thing to say. Try and get into the habit of making very clear what your question is for any MDT. This is good practice in everyday clinical work as well.

Scales are usually included on scans and clinical images to help candidates eg for estimating the size or depth of lesions. Please use them when describing clinical findings or deciding on beam energies etc. It can be useful when presenting findings on photographs or scans to include the size, location and appearance of an abnormality (eg “there is a 5x4cm spiculate mass in the left lower lobe”). General findings on a photograph (eg poor dentition, a coated tongue or a dressing) are also useful to describe. Important negatives may also be important (eg “I can’t see any involved lymph nodes on this slice”). If appropriate (and particularly if asked specifically) an attempt to interpret or give a differential diagnosis may also be sensible.

The FRCR 2B exam is clearly an oral exam. It is time pressured. Candidates are required to process significant amounts of written information in a short time and then communicate their answers to the examiners orally. Having sufficient English language skills to be able to do this is essential to be successful.

The examiners were concerned that a small number of candidates in the recent sitting had such poor oral English skills that, despite their very best efforts, none of the examiners who examined them found it easy to understand or hear everything that was said. Inevitably, this is going to make it very hard to pass such an exam, even if the candidate has the necessary oncology knowledge. Please bear this in mind when deciding whether to attempt the exam.

(Please note: If candidates have other types of language issue, such as a speech impediment, that they believe might have an impact on their performance, then please consult the RCR adjustment policy in relation to qualifying for extra time.)

Communications station

Often the most effective communications occur when candidates very carefully watch and listen to the role player during the encounter. The role players are experienced actors and their body language, tone of voice and what they say are calibrated to the situation. Reacting to what they say, allowing them time to speak and checking they understand what you are saying are important. Try and use vocabulary that is clear and understandable to the individual you are speaking to. Try to avoid jargon or euphemisms that can simply be confusing.

Remember you are being scored on how well you identify and address the role player's concerns. This is best achieved by picking up on both verbal and non-verbal cues from the actor. This is why listening and observing carefully are important. We are also scoring candidates on the accuracy and clarity of the medical information being provided. Try and imagine the scenario is as real as possible, and try to adopt an appropriate demeanour / manner that befits the topic being discussed.

In the most recent exam the candidates were warned in their briefing document that: "…..The colorectal nurse specialist has since spoken to the patient by phone and warns you that they have a lot of concerns about the consequences of the treatment plan." It was surprising how many candidates then completely ignored the many repeated attempts by the role players to bring up the issues that were on their mind. Candidates also showed a tendency to avoid discussing issues that made them uncomfortable – instead they were suggesting other professionals like nurse specialists would deal with the issues the patient had raised. It is fair to assume, in a communications station, that we are testing the candidate's ability to have these discussions themselves.

Contouring station

There is an instruction video available about using the pen and scrolling through image series available through the College website. Furthermore, candidates sitting the exam are all sent a link to enable them to practice scrolling through image sets and using the pen. We really want to allow candidates to become as familiar as possible with moving through image sets and activating / deactivating the pen for contouring before the exam. Examiners realise this is a little fiddly (and the time available for the station reflects this) but candidates would be wise to practice this in advance to minimise wasted time during the exam. There remains a feeling that some candidates were unfamiliar with what to expect on the day. Bear in mind that if scrollable image sets are provided, then using them for the requested task will usually help to do this more accurately. For instance, in the most recent exam, candidates were asked to outline pectoralis minor in a breast case. If they had scrolled through the image set, and then come back to the relevant slice, they should have realised that what many people drew round actually included an adjacent large blood vessel.

The contouring station in this sitting required familiarity with normal thoracic anatomy. Many candidates did seem to struggle with this. As ever, time spent being actively involved in planning is vital in preparing for this exam. In an era of "AI contouring software" it remains an important role of clinicians to review such contours and confirm their accuracy. An ability of clinicians to identify and contour important structures will therefore remain important going forwards.

As much as possible please take care with what is drawn. The examiners will mark according to what is actually drawn (although allowance can sometimes be made depending on what is being said eg "I'm sorry

but I meant to trim off the bone there”). Where scales are provided they are there for a reason. As much as possible, try and ensure that what you draw is realistic based on this information.

It was noted that some candidates moved the mouse wheel during the exam and this could cause the slides to move forwards or backwards suddenly. Ideally, we will try and ensure that mice without wheels are provided. However, if this is not possible, please avoid touching the mouse wheel during the exam.

Breast nodal outlining was tested in this exam. It was pointed out in the last examiners’ report that candidates should be familiar with this development in such a common disease site. Happily, many candidates did do this well.

Summary

The November 2025 sitting of the FRCR 2B exam was delivered successfully. The examiners really hope that candidates read the advice contained in this document and reflect carefully on it when preparing for their exam. The members of the Board would also like to offer their thanks to everyone involved in making it happen and congratulate those candidates who have successfully passed.