Clinical Oncology
The Royal College of Radiologists

FINAL EXAMINATION FOR THE FELLOWSHIP IN CLINICAL ONCOLOGY

AUTUMN 2017

The Examining Board has prepared the following report on the Autumn 2017 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 and those from all previous sittings should benefit candidates at future examination attempts 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 2017

Part A

Categories	Number of passing candidates from total number taking the examination	%
Overall	53/79	67%
UK	43/52	83%
UK 1st Timers	36/42	86%
Non-UK trained	10/27	37%
Non-UK 1st Timers	3/10	30%

Part B

Categories	Number of passing candidates from total number taking the examination	%
Overall	41 / 69	59%
UK	34 /46	74%
UK 1st Timers	30 / 41	73%
Non-UK trained	7 / 23	30%
Non-UK 1st Timers	2 / 7	29%

Clinical Examination:

Total Score in clinicals (range)	Number of candidates (out of 69)
16 - 20	6
21 - 25	10
26 - 30	23
31 - 35	23
36 – 40	7

It should be remembered that there is no passing score for the clinicals but in order to pass the examination overall, candidates are required to pass 3 or more clinical stations. A total of eight candidates scored 26 or less and passed 3 or more stations. The lowest score in the clinicals that still led to an overall pass was 26.

Oral Examination:

Total Score in orals (range)	Number of candidates (out of 69)
21 - 25	1
26 – 30	4
31 – 35	6
36 – 40	7
41 - 45	18
46 – 50	9
51 – 55	11
56 – 60	13

It should be remembered that there is no passing score for the oral examination. Candidates are required to pass 5 or more oral questions. A total of 14 candidates scored 43 or less and passed 5 or more questions. The lowest score in the orals that still led to an overall pass was 41.

Clinical Examination:

The instructional video continues to be a useful training tool for candidates and trainers alike providing better understating of the examination process and focus to training.

It should be noted that the clinical video was shot in an examination room whereas most of the clinical encounters will take place in larger rooms with only curtains dividing one station from another. This is not unlike the real life situation of a hospital ward.

Examiners reported that there were very few instances where a lack of respect was shown to the patient. In particular, the breast station where some unacceptable clinical examinations were observed in Spring 2017, has shown a noticeable improvement.

It seems that candidates are heeding the comments from previous reports and this is a gratifying outcome which we will expect to be continued in subsequent sittings.

On this occasion nervous system examination, specifically the assessment of sensory loss was poor. Candidates should remember to ask the patient if they are aware of differences in sensation in a way that is likely to elicit the correct response.

For the first time this sitting 2 head torches, purchased specifically for the FRCR candidates to use in the head and neck station, if they wish, were provided by RCR. These will be available at both clinical venues. The senior examiners and head and neck examiners have used the equipment, it is easy to use. Candidates were given the opportunity to practice with the headtorch in the pre-examination waiting room during the senior examiner's briefing and this will continue at future examination sittings.

Candidates are still entirely at liberty to bring their own equipment if they wish, and pen torches will be available. Most cases will require a candidate to make an inspection of the mouth and upper oropharynx, a head torch with tongue depressors is employed in most ENT clinics. Should candidates wish to use a pen torch they are free to do so, but should be careful not to get so close to the patient that the torch enters the patient's mouth. Patients can be asked to remove dentures if this would improve the examination of the oral cavity.

As a result of the high numbers of candidates in this examination, we employed 2 rest stations on all but one of the clinical rounds. This worked well from the patient's perspective meaning that fewer rounds were required. The examination ran better to time and this will be used again in future examinations as it will also reduce the number of patients required for the examination. Following feedback received in the candidate questionnaires, the rest stations will be separated and there will be no more than 2 rest stations on any

clinical round. There is a strong sense amongst examiners that this has advantages over a standard 5 candidate round.

Examiners have stated that candidates should NOT give a running commentary during their examination since their findings may be incorrect and thus confusing or worse, distressing for the patient if overhearing. Examination should be conducted silently as would be the case in the clinic.

Candidates measure lesions but some then report an approximate size, it would be preferred that candidates report the exact size they have measured.

Oral Examination:

Since all the information required to answer the question in the orals is on the slide, examiners do now prefer candidates to read the text out loud. This allows the examiner to be sure that the candidate understands the case and if there has been a reading error it can be corrected before the candidate suggests incorrect management.

Palliative radiotherapy was generally done reasonably well but the principles set out in the Spring 2017 report still apply.

A number of examiners reported that whilst candidates suggested IMRT as a preferred delivery method, when questioned about exactly how this would be delivered, knowledge of where the beams would be directed in an IMRT plan showed up some major deficiencies in understanding. There was also poor understanding of on-treatment imaging and the use of Image Guided Radiotherapy. These points suggest that candidates are not taking the opportunities to observe therapy in progress on the radiotherapy treatment floor.

In the oral examination, and where possible in the clinical, when asked to draw on a scan there will always be a measuring scale on the image. Candidates have been seen to draw unrealistically small volumes yet stating that the expansion is much greater, for example there were some very small CTVs drawn around a brain tumour whilst the candidate stated that the margin at the correct but greater distance. The effect of this is to avoid dealing with the CTV encroaching into areas that the candidate may wish to avoid if the correct margin had been drawn. Examiners are likely to question candidates on these aspects in future examinations. A planning examination is still being worked upon and it is expected that these issues will be addressed more realistically in this environment in the future. There was evidence of poor understanding of the differences between isodose curves generated by IMRT compared to a conformal plan in some instances.

Chemotherapy was offered to patients without sufficient regard for their age and comorbidity in a number of cases. It is very important to appreciate the advisability of toxic yet potentially curable therapies for patients with co-morbidity.

Trainers and trainees need to be aware that the Part B is an exam that requires understanding, clinical judgement and day to day skills in the practical aspects of radiotherapy and systemic therapy. The best place to learn and experience this is in the working environment rather than in private study.

It is also important that training schemes ensure that trainees have had the opportunity to rotate through all the tumour sites or at least to have been given the chance to “plug any gaps” by the time they attempt the examination.

There appears to be a perception that if a candidate scores more than 2 1s they are at risk of a fail. The published Final Examination for the Fellowship in Clinical Oncology (Part B) Scoring System on the website indicates that the candidate’s scores will be reviewed at the final exam board for a decision. The purpose of this is as a final check that the candidate has not made a major error that would seriously compromise patient outcome and that this is not repeated in other parts of the examination. The board will assess performance in other parts of the examination. At the time of writing, no candidate has ever failed the

examination as a result of just scoring 2 or more 1s, but examiners still find this a useful final check for such a candidate who has otherwise passed by the criteria of scoring 71 or more and passing 3 or more of 5 clinical stations and 5 or more of 8 oral questions.

It is also important for candidates and trainers to appreciate that the FRCR examiners do try as much as possible to reflect the typical range of problems encountered in regular oncology practice. We accept that oncology is a subject with areas of certainty and uncertainty. There are questions where candidates will not have the absolute right answer because there is no right answer and marks will be gained in this circumstance by a sensible weighing up of options for the patient. Clearly within a summative examination efforts will be made to ask questions where there are at least clear ‘wrong’ answers as well as many where there is a clear correct answer. However candidates need to be aware that we are not always expecting a single correct answer, occasionally a discussion of options. Answers stating “I would take this to the MDT” will not be sufficient, candidates will need to have an idea of why they are doing so and the type of treatment options open as well as a view on what might be the preferred outcome.

Summary:

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.

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.