August 2014

THE FACULTY OF CLINICAL ONCOLOGY

TO: TRAINING PROGRAMME DIRECTORS
REGIONAL POST-GRADUATE EDUCATION ADVISERS
COLLEGE TUTORS
EXAMINATION CANDIDATES

FINAL EXAMINATION FOR THE FELLOWSHIP IN CLINICAL ONCOLOGY SPRING 2014

The Examining Board has prepared the following report on the Spring 2014 sitting of the Final Examination for the Fellowship in Clinical Oncology. It is the intention of the Education 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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Warden of the Faculty of Clinical Oncology

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

Part A

Of the 52 candidates who had taken the examination, 27 had been successful, giving an overall pass rate of 52%. 17 of the 29 UK candidates were successful, giving a pass rate of 59% and of the 20 UK 1st timers, 13 were successful giving a pass rate of 65%. 10 of the 23 non-UK trained candidates passed giving a pass rate of 43%

The average scores achieved overall by topic are detailed below:

Topic	Average score %
Breast	67%
Respiratory	66%
CNS	65%
Head & Neck/ENT	57%
Upper GIT	48%
Lower GIT	61%
Gynaecology	59%
Haematology	61%
Skin	57%
Urology	70%
Miscellaneous	55%

Part B

57 candidates attempted the examination and 32 candidates were successful, giving a pass rate of 56%. 30 of the 49 UK trained candidates were successful, giving a UK pass rate of 61%. 11 of the 16 UK trained candidates making their first attempt were successful, giving a UK first time pass rate of 68.75%. 2 of the 8 non-UK trained candidates were successful, giving a non-UK trained pass rate of 25%. The single non UK trainee taking it for the first time passed, giving a pass rate of 100%.

Clinical Examination: 59.6% of 57 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.

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.

Candidates displayed varying levels of hand hygiene and it is to be noted that gloves can be requested when appropriate e g when a lesion is fungating.

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.

It was pleasing to see that at this sitting nodal examination was generally done well.

In the ENT station it is important to be able to examine the whole oral cavity using a light source and tongue depressors in many cases. Quite obvious lesions were missed because of poor techniques and this should be practiced. Ideal opportunities should be taken up during radiotherapy treatment review clinics, and to examine new cases actively, not relying on notes and scan findings when planning cases.

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: 59.6% of 57 candidates passed this component of the examination.

As a result of the analysis of candidate feedback questionnaires from the previous examinations and a detailed analysis of the viva question timings at the Autumn 2013 examination, it was decided to add an additional 30 seconds per question. The length of the entire viva has increased from 40 minutes to 44 minutes. Every effort was made to keep the content the same as previous years but to allow extra time, for those candidates requiring a little more thinking and reading time to be able to perform the best of their ability.

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.

Summary:

In Part B the results for the UK trainees attempting the examination for the first time were especially impressive suggesting that they were well prepared for the examination and had gained sufficient clinical

experience to pass.

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.

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.