Clinical Oncology
The Royal College of Radiologists

FINAL EXAMINATION FOR THE FELLOWSHIP IN CLINICAL ONCOLOGY – PART B
AUTUMN 2019

The Examining Board has prepared the following report on the Autumn 2019 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 – AUTUMN 2019

Part B

Categories	Number of passing candidates from total number taking the examination	%
Overall	42 / 78	54%
UK	26 / 37	70%
UK 1st Timers	19 / 27	70%
Non-UK trained	16 / 41	39%
Non-UK 1st Timers	7 / 22	32%

Clinical Examination:

Total Score in clinicals (range)	Number of candidates (out of 78)
10 – 15	0
16 - 20	9
21 - 25	13
26 - 30	38
31 - 35	14
36 – 40	4

Oral Examination:

Total Score in orals (range)	Number of candidates (out of 78)
0 - 25	1
26 – 30	4
31 – 35	10
36 – 40	13
41 - 45	18
46 – 50	15
51 – 55	9
56 – 60	4
61 – 64	4

Clinical Examination:

Candidates and trainers are encouraged to familiarise themselves with the instructional videos for both examination components to gain a better understanding of the examination process and focus teaching.

Whilst the clinical video was shot in an examination room, candidates should be aware that most of the clinical encounters will take place in larger rooms with only curtains dividing one station from another – not unlike the real life situation of a hospital ward.

Candidates are reminded of the need to show respect to the patients and refrain from any rough technique that may require examiner interventions on their behalf. Examiners are aware of patient welfare during the examination and a candidate who is unnecessarily rough or firm in their examination technique will be marked down.

Whilst respecting the patient is clearly very important some candidates waste time by asking permission to examine various areas during the examination. Patients will expect to be greeted in a polite manner but thereafter as they are present for the examination and will already have seen a number of candidates, further permission need not be sought.

Whilst gloves are available it is not expected that candidates will wear gloves unless specifically directed by the examiners.

There are still examples of poor and cursory breast examination and as a result very obvious masses were either not detected or incorrectly reported. Time is wasted by examining peripheral areas away from the breast and draining lymphatics. It is very valuable to carry out a brief inspection of the patient from the end of the bed, but it is not necessary to examine the hands for example. Occasional candidates still use just one hand to examine the breast and others had awkward techniques for axillary examination. Whilst not marking on technique a poor technique is more likely to result in a poor examination.

Head torches have been purchased specifically for the FRCR candidates to use in the head and neck station. These are available at both clinical venues. We allow candidates to practice for a few minutes with one headtorch, prior to the start of every round during the senior examiner's briefing.

The head torch leaves hands free to use the tongue depressors correctly without causing the patient to gag. This is current head and neck practice and as such good practice would suggest that head torches should also be standard in the examination. Candidates can use their own or the RCR head torches but a hands free method is now the current FRCR standard. If candidates do not have the opportunity to practice with a high quality headtorch similar to those in use in the clinical examination at their centre, a cheaper running style headtorch will give candidates the chance to be familiar with the correlation between the movement of their head and the distance the light moves on the patient.

There remain instances where candidates have great difficulty visualising their radiotherapy treatment when asked to demonstrate on the actual patient. This relates to palliative treatments such as treatment of neck nodes. Other difficulties arise when treating a limb or extremity where it is necessary to position the patient in a particular way, examples being conditions such as mycosis fungoides or kaposi sarcoma.

As candidate numbers for the sittings increase, rest stations remain a part of the delivery of the clinical examinations. Candidates should be prepared for this.

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 must listen to the initial command of the examiner, the senior examiner always tells candidates to ask for the command to be repeated if they have not heard it clearly.

Immunotherapy is becoming mainstream treatment for a number of sites now and all oncologists are likely to encounter patients on immunotherapy whilst on call or covering acute oncology even if the drugs have not

found a place for all primary sites. There will be questions on this topic so candidates will need to be familiar with management of patients on immunotherapy.

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

In the clinical it is not always possible to prepare images well in advance of the examination as can be done for the orals. Candidates should have an approximate idea of surrogates for a ruler such as the width of a vertebra. Some candidates used an actual ruler to measure sizes on a scan print out that was plainly not "actual" size

In a similar vein it should be remembered that the clinical examination tests a number of aspects of clinical judgement. A fundamental principle is to be able to match or adjust treatment to suit the patient seen in the station rather than simply a textbook answer making no adjustment for actual patient just seen.

A number of candidates asked if examiners would be marking them on handwashing technique. Gel will be available outside the stations and candidates are expected to use it but examiners will not be observing this and it would benefit the candidate if the gel has evaporated by the time they enter the station.

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.

Examiners are there to guide candidates through the oral exam and so if candidates feel they are being directed or pushed they should be aware this is in their own interest to enable the candidate to score as many marks as possible.

Time can be wasted by candidates when asked for investigations giving a long list of routine blood tests, instead of stating renal function, liver function , bone profile for example it is sufficient to state biochemical profile. Other additional tests such as markers should be specifically mentioned.

General Points:

Two examiners score the candidate in all situations. New or visiting examiners, senior examiners and sometimes a third co-examiner observe the exam process but none will score the candidate. Scoring will be done by 2 examiners one of whom will lead the questioning. It may seem daunting to enter a clinical station with a number of people in the room. The advice is to focus on the examiner who introduces themselves as they will be asking all the questions as well as the patient.

Candidates should ensure that they arrive at the examination venue in good time as delays have a huge knock on effect for the running of the entire day. Whilst reasonable effort will be made to accommodate very late running candidates at another time, there is a risk that the candidate may not be able to be examined at all if the high candidate numbers in Autumn 2019 are reproduced in the future.

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.

Training programme directors should 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 Final examination.

It is 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.