FINAL EXAMINATION FOR THE FELLOWSHIP IN CLINICAL ONCOLOGY

SPRING 2018

The Examining Board has prepared the following report on the Spring 2018 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.

FINAL EXAMINATION FOR THE FELLOWSHIP IN CLINICAL ONCOLOGY
EXAMINERS' REPORT – SPRING 2018

Part A

Categories	Number of passing candidates from total number taking the examination	%
Overall	32/68	47%
UK	23/33	70%
UK 1st Timers	20/25	80%
Non-UK trained	9/35	26%
Non-UK 1st Timers	7/21	33%

Part B

Categories	Number of passing candidates from total number taking the examination	%
Overall	29/55	53%
UK	23/37	62%
UK 1st Timers	14/25	56%
Non-UK trained	6/18	33%
Non-UK 1st Timers	1/5	20%

Clinical Examination:

Total Score in clinicals (range)	Number of candidates (out of 55)
10 – 15	1
16 - 20	8
21 - 25	11
26 - 30	24
31 - 35	9
36 – 40	2

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 10 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 24.

Oral Examination:

Total Score in orals (range)	Number of candidates (out of 55)
26 – 30	2
31 – 35	3
36 – 40	7
41 - 45	11
46 – 50	12
51 – 55	3
56 – 60	6
61 – 64	1

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 7 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 38.

Clinical Examination:

The instructional video continues to be a useful tool for candidates and trainers alike providing a better understanding of the exam process and a focus for teaching. It should be noted that the 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 were pleased to report that again 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 made in the Spring 2017 Examiners' report and this is a gratifying outcome which we will expect to be continued in subsequent sittings.

Despite the welcome improvement in breast technique the actual examination was poor and cursory at times and as a result signs were not detected or correctly reported.

Head torches have been purchased specifically for candidates to use in the head and neck station, if they wish. They will be available at both clinical venues and candidates are able to practice for a few minutes with one headtorch, prior to the start of the round during the senior examiner's briefing.

Although we do not wish to mandate the use of head torches they are in standard use in ENT clinics which trainees should be attending. 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 their use should also be standard in the exam.

We continued to employ 2 rest stations on all but one of the clinical rounds. The candidate numbers did not mandate this but instead it has been brought in on the basis that it seems to work well from the perspective of all those involved.

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.

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 actual patient so care must be taken to describe treatments suitable for the patient just seen rather than a textbook answer based on stage and not the actual patient just seen.

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.

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. Another aspect of this is the loss of a working knowledge of care for the patient during radiotherapy, whilst usually the preserve of allied health professionals it is reasonable to expect candidates have a management plan for skin care and care of the eye during radiotherapy.

Chemotherapy was still 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 be given the chance to “plug the gaps” by the time they attempt the Final Exam.

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:

The Part A overall pass rate was 47%, pass rates for UK candidates attempting the exam for the first time were still high years at 80%. The pass rate for UK candidates overall was 70% in the Part A. Pass rates amongst the non UK candidates was 26% and for those overseas candidates attempting the Part A exam for the first time pass rates were down at 20%.

The pass rate for UK trainees attempting the Part B examination for the first time was 56%. The pass rate for those candidates from the UK attempting both Part A and Part B for the first time was 11 out of 24 (46%), all figures are down on the previous exam's results.

The pass rate for overseas candidates including NHS contributors was 6 out of 18 (33%) One (20%) overseas candidate out of 5 attempting the Part B exam for the first time were successful.

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.