

FINAL EXAMINATION FOR THE FELLOWSHIP IN CLINICAL ONCOLOGY

SPRING 2016

The Examining Board has prepared the following report on the Spring 2016 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 2016

Part A

Of the 70 candidates who had taken the examination, 49 had been successful, giving an overall pass rate of 70%. 29 of the 34 UK candidates were successful, giving a pass rate of 85% and of the 19 UK 1st timers, 14 were successful giving a pass rate of 74%. 20 of the 36 non-UK trained candidates passed giving a pass rate of 56% and of the 18 non-UK 1st timers, 13 were successful giving a pass rate of 72%

Part B

Of the 60 candidates who had taken the examination, 37 had been successful, giving an overall pass rate of 62%. 31 of the 43 UK candidates were successful, giving a pass rate of 72% and of the 29 UK 1st timers, 19 were successful giving a pass rate of 66%. 6 of the 17 non-UK trained candidates passed giving a passed rate of 35% and of the 7 non-UK 1st timers, 3 were successful giving a pass rate of 43%

Clinical Examination: 38 (63%) of 60 candidates passed this component of the examination.

The majority of candidates had viewed the instructional video on the clinical and oral examinations available via the college website. It is hoped that this gives an impression of the nature of the examination and trainers involved in examination preparation are encouraged to view the video. It should be noted that the clinical video was shot in the most conducive environment for filming. At the clinical venues there are commonly two or three stations in the same room - whilst the stations are separated by screens candidates should be prepared for some unavoidable background noise from adjacent stations.

In the clinical, candidates will be questioned after their examination, and must recognise that any radiotherapy planning is related directly to the patient just seen. There were a number of instances when candidates failed to relate the drawing of fields to the patient, e.g. reluctance to use bolus in a patient with obvious skin involvement.

The examiners reported that during breast examination some candidates adopted some unusual techniques requiring the patient to lean forwards and backwards more than was necessary in a manner that did not provide additional useful information. This can be tiring for the patient and is unlikely to be a technique used in clinic. Similarly a lot of time was wasted by some candidates by moving from one side of the bed to the other in order to examine the opposite breast and axilla. Candidates should take every opportunity to

examine patients in breast clinics under supervision.

In the head and neck station candidates should remember that, if asked to examine “the head and neck region” or “the face” there may be abnormalities to detect in the skin, nose, scalp, orbits or maxillary antrum as well as the oral cavity, upper oropharynx and neck. Often the instructions will be more explicit “examine the oral cavity / oropharynx” or “examine the orbit and neck” but otherwise a brief but critical consideration of all areas should be included. Out of consideration for the patients, candidates should not perform digital examination of the posterior oral cavity to attempt indirect laryngoscopy.

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: 34 (57%) of 60 candidates passed this component of the examination.

There were candidates who appeared unsure of the volumes to be treated in the head and neck cases presented. It is important to know in detail about the node groups that need to be included in the volumes, and the doses that those stations require.

There were no other specific issues raised by the examiners in the oral examination.

This element of the examination continues to be answered less well than the clinicals and may well reflect candidate inexperience in all tumour sites. Ideally candidates should have spent time covering all major tumour sites before attempting the Final Part B examination.

The training rotation should be tailored to an individual's requirements to take this into account especially in their posting ahead of an examination attempt.

Summary:

In Part A pass rates for UK candidates attempting the exam for the first time were consistent with previous years at 74%. It was particularly noteworthy that the pass rate for UK candidates taking the Part A at their second or subsequent attempt was 100% at this sitting. Pass rates amongst the non UK candidates attempting the examination for the first time were also high at 72%.

The pass rate for UK trainees attempting the Part B examination for the first time was 64%.

The pass rate for UK trained candidates attempting both Part A and Part B for the first time was 10 out of 19 (53%) 5 candidates failed Part A, a further 4 failed Part B.

The pass rate for those UK trainees attempting the Part B for a second or subsequent time was very high at 86%.

3 (43%) overseas candidates out of 7 attempting the Part B exam for the first time were successful, and both overseas candidates attempting both Part A and Part B for the first time were successful. Only 3 of 9 overseas candidates attempting Part B for a subsequent 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 examination 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.