FINAL EXAMINATION FOR THE FELLOWSHIP IN CLINICAL ONCOLOGY

AUTUMN 2018

The Examining Board has prepared the following report on the Autumn 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 – AUTUMN 2018

Part A

Categories	Number of passing candidates from total number taking the examination	%
Overall	38 / 72	53%
UK	27 / 38	71%
UK 1st Timers	21 / 28	75%
Non-UK trained	12 / 34	35%
Non-UK 1st Timers	7 / 19	37%

Part B

Categories	Number of passing candidates from total number taking the examination	%
Overall	36/61	59%
UK	29/42	69%
UK 1st Timers	20/28	71%
Non-UK trained	7/19	37%
Non-UK 1st Timers	2/8	25%

Clinical Examination:

Total Score in clinicals (range)	Number of candidates (out of 61)
10 – 15	2
16 - 20	3
21 - 25	12
26 - 30	21
31 - 35	18
36 – 40	5

The overall passing score for the FRCR Part B is 71, provided 3 or more clinical and 5 or more oral stations have been passed. It should be remembered that there is no passing score for the clinicals but in order to score 71 a rough guide would suggest a numerical score of 27 in the clinical and 44 in the oral is desirable,

but not essential.

A total of 11 candidates scored 26 or less in the clinical and passed 3 or more stations, 5 of these 11 candidates passed overall. The lowest score in the clinicals that still led to an overall pass was 22.

Oral Examination:

Total Score in orals (range)	Number of candidates (out of 61)
0 - 25	2
26 – 30	-
31 – 35	3
36 – 40	13
41 - 45	15
46 – 50	11
51 – 55	12
56 – 60	4
61 – 64	1

A total of 13 candidates scored 43 or less in the oral and passed 5 or more questions, 6 of these 13 candidates passed overall. The lowest score in the orals that still led to an overall pass was 39.

Clinical Examination:

This was the seventh sitting since the release of the instructional video and all candidates indicated that they had viewed it and feedback indicates that it is useful. It is also hoped that trainers will also view the video to understand better the exam process and focus their teaching.

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 were pleased to report that again there were very few instances where a lack of respect was shown to the patient.

One or two candidates had a rough technique but not so poor that examiners felt the need to intervene on behalf of the patient.

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 are present for the exam and will already have seen a number of candidates so further permission need not be sought.

Breast technique is improving but there are still examples of poor and cursory examination and as a result signs were not detected or correctly reported. There is time wasted by examining areas away from the breast and draining lymphatics before examining these areas. It is very valuable to carry out a brief inspection of the patient but it is not necessary to examine the hands for example.

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 enable candidates to practise for a few minutes with one head torch, prior to the start of the 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 exam. Candidates can use their own or those provided but a hands free method is preferred.

We will continue to employ 1 or 2 rest stations in the clinicals. 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 the clinical it is not always possible to prepare images well in advance of the exam as is the case in the orals. Candidates should have an approximate idea of surrogates for a ruler such as the width of a vertebra. Some candidates used the 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 actual patient so care must be taken to describe treatments suitable for the patient just seen rather than a textbook answer based on the stage of the disease.

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 common error in both the clinical and the oral was incorrect use of bolus. Candidates seemed very unsure of the shape of bolus required for a fungating lesion on the skin. In addition there may still be benefit to applying surface bolus when treating a fungating lesion with high energy electrons. A greater error was failure to appreciate the importance of bolus around the edges of such a lesion to ensure sufficient dose is applied to these areas.

Once again as in Spring 2018, 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.

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 programmes 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 Part B.

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 there is no single, clearly best management approach 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, but 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 53%, pass rates for UK candidates attempting the exam for the first time were still high at 75%. The pass rate for UK candidates overall was 71% in the Part A. Pass rates amongst the non UK candidates was 35% and for those overseas candidates attempting the Part A exam for the first time pass rates were down at 37%, representing a significant rise for the overseas candidates.

The pass rate for Part B overall was 59%, 71% of UK trainees attempting the Part B examination for the first time passed. The pass rate for those candidates from the UK attempting both Part A and Part B for the first time at this sitting was 15 out of an initial total of 28 attempting part A for the first time (54%), the fact that over half the candidates attempting Part A and Part B for the first time and all at the same sitting passed is very encouraging.

The pass rate for overseas candidates including NHS contributors was 7 out of 18 (37%) Two (25%) overseas candidates out of 8 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.