FINAL EXAMINATION FOR THE FELLOWSHIP IN CLINICAL ONCOLOGY

SPRING 2019

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

FINAL EXAMINATION FOR THE FELLOWSHIP IN CLINICAL ONCOLOGY
EXAMINERS' REPORT – SPRING 2019

Part A

Categories	Number of passing candidates from total number taking the examination	%
Overall	52/83	63%
UK	21/34	62%
UK 1st Timers	16/24	67%
Non-UK trained	31/49	63%
Non-UK 1st Timers	11/21	52%

Part B

Categories	Number of passing candidates from total number taking the examination	%
Overall	34/63	54%
UK	20/32	62.5%
UK 1st Timers	14/22	64%
Non-UK trained	14/31	45%
Non-UK 1st Timers	6/18	33%

Clinical Examination:

Total Score in clinicals (range)	Number of candidates (out of 63)
10 – 15	1
16 - 20	5
21 - 25	13
26 - 30	28
31 - 35	13
36 – 40	3

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.

Oral Examination:

Total Score in orals (range)	Number of candidates (out of 63)
0 - 25	1
26 – 30	6
31 – 35	6
36 – 40	7
41 - 45	12
46 – 50	12
51 – 55	12
56 – 60	5
61 – 64	2

It should be remembered that there is no passing score for the oral examination. Candidates are required to pass 5 or more oral questions.

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.

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 no 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 as they are present for the examination and will already have seen a number of candidates, further permission need not be sought.

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.

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 practise for a few minutes with one headtorch, 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 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 practise 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.

A number of candidates seem to have great difficulty visualising their radiotherapy treatment when asked to demonstrate on the actual patient. This relates primarily to palliative treatments especially those where it is necessary to position the patient in a particular way, for example treating the lower limbs in conditions such as mycosis fungoides or kaposi sarcoma.

We will continue to employ one or two 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 must listen to the initial command of the examiner, there were a number of instances when the examiner told candidates not to touch an area as it was tender, only for the candidate to go ahead and do just that. The senior examiner always tells candidates to ask for the command to be requested if they have not heard it clearly.

Cranial nerve examination was done poorly by many candidates. There is a failure to enquire correctly about diplopia when testing eye movements and subjective differences in perception of sensation from one side of the body to another when testing the trigeminal nerve.

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 is the 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.

On this occasion candidates seemed more knowledgeable about on-treatment imaging and the use of Image Guided Radiotherapy. These points suggest that candidates are now taking the opportunities to observe therapy in progress on the radiotherapy treatment floor. Candidates do need to have a management plan for skin care and care of the eye during radiotherapy.

Summary:

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 FRCR Part 2.

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.