

FINAL EXAMINATION FOR THE FELLOWSHIP IN CLINICAL ONCOLOGY – PART B
APRIL 2026

The Examining Board has prepared the following report on the April 2026 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

Categories	Number of candidates	% passing
Overall	77 / 111	69%
UK Resident	47 / 53	89%
NHS Contributors	10 / 13	77%
Global (all)	20 / 45	44%

The examination was delivered online via the MS Teams platform, with the candidates at our remote venues, and the UK examiners based at the RCR premises in London. During this exam 111 candidates were examined in the UK, and India.

We would like to thank the local examiners in India for their help in examining and marking the candidates. It was a great pleasure to work with them again.

It was also a pleasure to welcome our 3 examiner colleagues from Hong Kong who attended the exam in London and participated in examining the candidates.

During the exam the members of the Board were grateful for all the administrative and IT support provided by the College staff.

We would also want to thank the invigilators in the various regional facilities who made it possible and the very professional role-players who spent a long day examining all the candidates in the communications station.

IT

As mentioned in previous reports, the examiners are fully aware that the “pen” can produce an occasional “jump” in a smoothly drawn line when candidates use it to draw on slides. This has been investigated by the RCR IT team and seems to be related to an issue between Powerpoint and Teams which is therefore outside our control at present. Candidates can be reassured that the examiners understand the issue and take it into account when watching a contour being drawn.

Feedback

As a Board we are keen to provide feedback that will prove helpful to future candidates and their trainers.

The following are issues that were noted by members of the Board:

A recurring theme in previous reports has been the Board stressing the importance of candidates needing to focus their answers on the specific questions being asked on the slides. A lot of thought goes into the wording of these and it is important to read these carefully before responding. Candidates who do this are more likely to score well

and will avoid putting themselves under unnecessary time pressure. Even using just 5-10 seconds per slide to say unrelated things soon adds up to a wasted minute across a question and that is a significant proportion of the 5.5 minutes available.

For instance, if the instruction is to draw your CTV on a slide then that is what will be marked. Similarly, if you are asked to say “what treatment do you recommend” it can be assumed that you have been given the necessary information to make that decision and there will be no marks for further investigations. An answer along the lines of “I would recommend palliative radiotherapy to the left chest wall” or “I would offer palliative chemotherapy using.....” is likely to be what the examiner is expecting.

There remains a significant group of candidates that disadvantage themselves by failing to do this. As mentioned before, please practice under time pressure and really try to slim down what you say to the key information required to answer the specific question being asked.

Candidates are reminded that the clinical information presented about patients in questions is very carefully chosen / considered. It is usually there because it has some bearing on the case. Co-morbidities, occupations and regular medications are worth considering in this light. For instance, in this exam, a 75-year-old patient was described with lymphoma in the mediastinum and L SCF. He had a history of smoking, type 2 diabetes and hypertension. When considering his treatment, the cardiac risk factors were important when comparing the cumulative anthracycline exposure between different options.

In the new format of the exam, domains such as “communications” and “patient centred care” are tested throughout the exam. When this is the case, questions are phrased accordingly (e.g How would you discuss this with the patient?” or “How would you explain this to the patient?”) and we are asking candidates to summarise the approach they would take to explaining the issues / treatment / situation to the patient described. Please bear this in mind when answering these questions. We are looking to assess the language and medical accuracy of what you would say to the specific patient (rather than a medical colleague). This may well require some empathy as to what the patient may be concerned about or be struggling to understand at that time. If it is made clear that the patient has specific views or issues related to their care it is reasonable to expect an answer that takes this into account.

Communications station

Often the most effective communications occur when candidates very carefully watch and listen to the role player during the encounter. The role players are experienced actors and their body language, tone of voice and what they say are calibrated to the situation. Reacting to what they say, allowing them time to speak and checking they understand what you are saying are important. Try and use vocabulary that is clear and understandable to the individual you are speaking to. Try to avoid jargon or euphemisms that can simply be confusing. If the role-player clearly has an issue on their mind it is important to acknowledge and address this appropriately. In the latest exam the role player was very irritated and frustrated at the start and this quickly became apparent to candidates. Failing to respond to this or failing to listen to what they were irritated by would not be appreciated in real life and it was therefore marked accordingly.

Remember you are being scored on how well you identify and address the role player’s concerns. This is best achieved by picking up on both verbal and non-verbal cues from the actor. This is why listening and observing carefully are important. We are also scoring candidates on the accuracy and clarity of the medical information being provided. Try and imagine the scenario is as real as possible and try to adopt an appropriate demeanour / manner that befits the topic being discussed and the emotions being demonstrated.

Contouring station

This is a 16 minute stand-alone station. Candidates interact directly with their examiner who navigates them through various tasks such as reviewing 3D image sets and contouring on representative slides. In practice, discussion occurs as candidates progress through the case rather than at the end.

There is an instruction video available about using the pen and scrolling through image series available through the College website. We are hoping to ensure that candidates sitting the exam will also be sent a link to enable them to practice scrolling through image sets and using the pen themselves. If trying to replicate the exam conditions over Teams it works best to use the Teams app rather than the browser version.

We really want to allow candidates to become as familiar as possible with moving through image sets and activating / deactivating the pen for contouring before the exam. Examiners realise this is a little fiddly (and the time available for the station reflects this) but candidates would be wise to practice this in advance to minimise wasted time during the exam. There remains a feeling that some candidates were unfamiliar with what to expect on the day.

Bear in mind that if scrollable image sets are provided, then using them for the requested task will usually help to do this more accurately. For instance, in the most recent exam, candidates were asked to outline various structures / volumes in a head and neck case. Using the scrollable image sets would have stopped some candidates making errors.

As much as possible please take care with what is drawn. The examiners will mark according to what is actually drawn (although allowance can sometimes be made depending on what is being said eg "I'm sorry but I meant to trim off the bone there"). Where scales are provided they are there for a reason. As much as possible, try and ensure that what you draw is realistic based on this information.

It was noted that some candidates moved the mouse wheel during the exam and this could cause the slides to move forwards or backwards suddenly. Ideally, we will try and ensure that mice without wheels are provided. However, if this is not possible, please avoid touching the mouse wheel during the exam.

Other issues

Scales are also included on scans and clinical images to help candidates eg for estimating the size or depth of lesions. Please use them when describing clinical findings or deciding on beam energies etc. It can be useful when presenting findings on photographs or scans to include the size, location and appearance of an abnormality. General findings on a photograph (eg poor dentition, a coated tongue or a dressing) are also useful to describe. If appropriate (and particularly if asked specifically) an attempt to interpret or give a differential diagnosis may also be sensible.

Some candidates fall back on saying that they would discuss a patient "at the MDT". In itself, this will score nothing without making clear the reason for doing it. For instance, "I would refer the patient to the Brain MDT to discuss debulking surgery, or a biopsy, to get a tissue diagnosis" is a much more useful thing to say. Try and get into the habit of making very clear what your question is for any MDT. This is good practice in everyday clinical work as well.

The FRCR 2B exam is clearly an oral exam. It is time pressured. Candidates are required to process significant amounts of written information in a short time and then communicate their answers to the examiners orally. Having sufficient English language skills to be able to do this is essential to be successful. The examiners were concerned that a small number of candidates in the recent sitting had such poor oral English skills that, despite their very best efforts, none of the examiners who examined them found it easy to understand or hear everything that was said. Inevitably this is going to make it very hard to pass such an exam even if the candidate has the necessary oncology knowledge. Please bear this in mind when deciding whether to attempt the exam.

In the latest exam, it was clear that many candidates continue to struggle with image interpretation. The nature of modern radiotherapy is that we all need to be competent with the standard radiology sequences and anatomy in the regions we plan treatment to. Many candidates struggled with head and neck MRI images, despite their importance in contouring such cases. Surprisingly, others seemed very unsure where the posterior fossa was in the brain when asked to draw fields for partial brain radiotherapy (metastases confined to the cerebellum) despite the cerebellum and tentorium being clearly visible on the sagittal CT images provided.

Delivering simple palliative radiotherapy remains a core skill for clinical oncologists but was often done poorly in this exam. The Board is conscious that this is increasingly performed by radiographers or consultants rather than trainees. With many trainees working less than full time and having other days of absence related to on-call work, training days or acute oncology commitments it can be hard to gain the necessary experience. We would encourage all trainees and trainers to consider this carefully to ensure that they are adequately trained in this core skill. We understand that technology is evolving and VMAT techniques are increasingly standard to achieve better dose distributions but core principles such as deciding what volume needs treating and the adequate margins to field edge remain important. Candidates also need to develop confidence in when fields can overlap with prior palliative treatments since these are the sorts of situations they will be asked about as they progress in their careers.

In the current exam there seemed to be a lack of knowledge about when to use important motion management techniques such as deep inspiratory breath hold (DIBH) to reduce heart / lung doses or 4D planning scans. These have become widespread and standard techniques and candidates should be familiar with the situations where they are recommended.

In a couple of cases in the recent exam candidates were shown imaging before and after prior surgery or chemotherapy treatment and asked to draw their CTV for subsequent radiotherapy. Clearly, in this situation, it is important to cover sites that contained disease prior to treatment, and where residual tumour cells are likely to be found, but being conscious of the new anatomy and the movement of natural barriers to spread is key to creating a sensible CTV. Many candidates seemed to be unfamiliar with this sort of planning.

Examiners were pleased to see candidates perform much better with cone beam image interpretation in the recent exam. This has been a recurring theme in previous reports and suggests candidates are increasingly familiar and confident with this.

Very sadly, 4 candidates failed to complete the exam on this occasion due to arriving late at their venues for different sessions. The exam is performed across many venues in the UK and overseas. Once the morning quarantine period finishes and candidates are released it is vital for exam security that all afternoon candidates have arrived and entered their own quarantine. Anyone arriving late will not be allowed to proceed with the exam. This is made clear in the documentation provided by the RCR to all candidates and it is up to the candidates themselves to read this carefully, and plan accordingly, to ensure they arrive in good time for all their sessions.

Summary

The April 2026 sitting of the FRCR 2B exam was delivered successfully.

The examiners really hope that candidates and trainers read the advice contained in this document and reflect carefully on it when preparing for the exam.

We would remind all candidates that questions in the exam try to reflect day-to-day clinical situations that trainees will be presented with during their work on the wards, in clinic and in the radiotherapy department. Whilst book work remains very important when preparing for the exam it is also vital to be as involved as possible with clinical work to gain the necessary experience. It is often clear when examining which candidates have been exposed to a lot of real world situations that they can draw on when responding.

The members of the Board would also like to offer their thanks to everyone involved in making it happen and congratulate those candidates who have successfully passed.