The Royal College of Radiologists

# FINAL EXAMINATION FOR THE FELLOWSHIP IN CLINICAL ONCOLOGY – PART B
# APRIL 2025

The Examining Board has prepared the following report on the April 2025 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.

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## EXAMINERS' REPORT

| Categories | Number of candidates | % passing |
|---|---|---|
| Overall | 64 / 113 | 56.6% |
| UK trainee | 31 / 40 | 77.5% |
| NHS Contributors | 12 / 24 | 50% |
| Global (all) | 21 / 49 | 43% |

The examination was delivered online via the MS Teams platform, with the candidates at one of our remote venues, and the UK examiners based at the RCR premises in London. During this exam 113 candidates were examined in the UK, Malta 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.

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.

From an IT perspective, there was an unexpected interruption in the internet connection from the College during the Saturday exam. This affected the majority of the rooms. The team reacted very quickly and within 20-30 minutes the exam was able to continue again. The examiners would like to apologise to any candidates that were affected by this. The College is investigating why the backup connection failed to kick in correctly.

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 some general themes 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.

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.

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 a 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.

**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. 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.

**Contouring station** – There is an instructional video available about using the pen and scrolling through image series available through the College website. Furthermore, candidates sitting the exam in this sitting were all sent a link to enable them to practice scrolling through image sets and using the pen. 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 eg establishing what is a blood vessel / node or confirming with a lung PET scan if an abnormality on the planning CT is active disease or lung atelectasis.

The contouring station in this sitting involved review of pelvic imaging. Many candidates did not seem to demonstrate the familiarity with this that one might expect given the number of disease sites that involve pelvic radiotherapy. As ever, time spent being actively involved in planning is vital in preparing for this exam.

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 e.g. “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.

Scales are also included on scans and clinical images to help candidates e.g. estimating the size or depth of lesions. Please use them when describing clinical findings or deciding on beam energies etc.

Various solutions now exist for OAR drawing in planning systems (e.g. planning staff doing it or AI generated contours) but there is an expectation that candidates can do this themselves as required (after all, it is a clinician’s job to ensure that these are correct when reviewing plans). Contouring cases may involve outlining of OARs as a result.

Breast nodal outlining was not done well during the exam. Although the Board recognise that this is not used routinely in every centre it is rapidly becoming something that is used in a proportion of breast cases and as part of clinical trials. There is an expectation that candidates are familiar with this development in such a common disease site.

In previous reports we have highlighted the importance of candidates familiarising themselves with all parts of the radiotherapy pathway. This includes plan review and cone beam image guidance. Both of these were again done poorly in this sitting.

There is a rapid adoption of pre-chemotherapy Hepatitis B screening across the UK. We are conscious that this is still not routine in every centre and it is therefore not an absolute requirement in answers at present. However, candidates would be wise to appreciate that this might evolve quite quickly over the next year or two.