Chapter 2
ANOTHER VIEWPOINT OF PREPARATION FOR THE PART II EXAMINATION IN RADIATION ONCOLOGY

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[I agree with David and Geoff about examination preparation. I shall detail my personal approach to highlight some additional factors that you should consider.]

I started my run to the Part II on the day that I received notice of passing the Part I. Certainly, a good number of registrars seemed to "take a year off". I resisted this urge and made sure that I completed the Statistics Assignment and one article in the first 12 months. I also joined with a study group of senior registrars.

The issue of experience at different hospitals is one that you should consider at the end of this year - consider training program, pass rates, registrar:consultant ratio and presence of examiners on staff (I personally consider the latter two almost vital). I moved to a new hospital at the end of the first year.

In my second year post-Part I, I made the wise choice to use public transport. I fully utilised the daily 140 minutes of travel. Far from being a chore, I found it difficult to gather enough reading material to occupy this time fully! I read anything and everything oncological. I believe that this concentrated period of wide reading formed the solid platform for passing. In this year I aimed to publish one paper. At the end of this year I moved to a department with an examiner and 1:1 registrar:consultant

In the year before the Part II, I spent the first 6-7 months working on disease treatment summaries for each disease stage, (eg., in situ/early operable/locally advanced/metastatic breast cancer), radiotherapy techniques (dogleg, mantle, nasopharynx are three characteristic fields that you MUST be able to plan in your sleep - no hesitation). I then spent 3-4 months on past papers using my resident examiner to perfect the approach (see below). In the 2 months before the exam I "wore in" my exam clothes.

To summarise my preparation, I started very early and kept up a steady moderate effort and aimed to become a competent well-read oncologist. I attended all training registrar activities available. My one regret is that I did not take holidays 6 months before the examinations as I became quite jaded in the last 6 weeks (felt like treading water). My ideal plan would be :

Year 1	months 1-6 months 7-12	Statistics Assignment read, read, read, ...
Year 2	months 1-12	read, file, read, file, read, file, read, ...
Year 3	months 1-6 month 7 month 8-12	prepare summaries take annual holidays summaries, mock examinations, "consultoid"

The crux of the examination is that you are NOT being examined to see whether you are a good senior registrar, but you ARE being examined to see whether you are a good junior consultant. To this end, you should consider the standard and type of dress of a consultant (ie., "what will I look like when I am a consultant?", when you answer this, go out and buy the clothes at least 6 months before the exam) and the language of the consultant (in this matter, I suggest that you hear how your bosses talk and I think you will find that the personal [I, My] far outweighs the impersonal [You]). I made sure that in the last 6 months, all of my discussions and opinions about management started with the word "I ...." and that I dressed as I expected to as a consultant.

There are three results from this examination - 1. "*you have demonstrated what you will do, and because it is correct, you may be a consultant*", 2. "*you have demonstrated what you will do, and because it is incorrect, you may not be a consultant*", 3. "*you have not demonstrated what you will do, and until you do, I cannot make a judgement about how you will act, you may not be a consultant.*" On entering the examination room, your demeanour, dress and speech must scream "I am a consultant" before you open your mouth (David & Geoff point out the same thing)

In the written questions, I developed a similar style. My captive examiner definitely preferred this style and pushed me to develop it. My style was personal and direct - I started all my essays this way (that is, with "I"!!). I found that the terms "discuss" etc. really require little discussion of differing viewpoints but rather a description of my approach to a problem and how relevant factors impinge on my approach. Introductions are nice but should be relevant and short - if they are not, ditch them! Everything you write must 'score'. In the writtens you have only 30 minutes per question. Questions about the relative roles of surgery, radiotherapy and chemotherapy will only permit 10 MINUTES on each modality so you have to be personal and succinct. As David & Geoff say, don't forget recurrence and palliation - also consider brachytherapy and local modalities (eg., laser). Most questions had 2-4 asked-for or natural subdivisions so lengthy discourses were never pertinent. I can't actually recall quoting more than a single study in the whole process. I learnt in one mock examination that 'article ping-pong' always ended with me losing - someone always knows more!

In the viva examinations, I discovered that the examiners don't get you by having you examine the difficult, or rare case. They get you by placing you under such time pressure that you can only 'knee jerk' a response - they test your instinctive responses. As a result you should practice mock examinations in the same way - 6 minutes per short case (2-3 minutes to examine, 3-4 minutes to answer 3-5 prepared specific questions) and 30 minutes per long case with a 20-minute viva. You should insist on keeping to the exam format (marathon runners don't train by doing sprints) and as you near the date be able to sustain 3-4 short cases in succession.

My short cases were a good illustration. I diagnosed the 'spleen' while still in the corridor! A helper exited the room and I could see the spleen from 4 metres (well, it was on the left, moved with respiration and had a notch medially - what else could it be?)! I was asked to examine the abdomen. I went for the spleen first. When I had finished my examination of the spleen, I was asked to step back and then asked questions - what did you find? (enlarged spleen) how do you know that it's a spleen? (respiratory movement, left sided, dull percussion, non-ballotable, medial notch, can't get above), what are the causes of splenomegaly? (benign, malignant, etc.), what are your indications for treating a spleen with radiation? (MY INDICATIONS are pancytopaenia unresponsive to other medical treatment), how do you treat a spleen? (I TREAT WITH clinically determined anterior/posterior fields, 0.25Gy 3 times a week to the midpoint, FBC before each treatment (cease if WCC<3, Plat<100), assess spleen each week to see if field can be reduced). And that was it - 6 minutes.

There is absolutely no excuse for dipping out on the planning examination. The techniques are not difficult and only need be practised. The biggest and most consistent failure that I have seen is the failure to understand that while drawing the isodose curves constitutes only 1/7th of the marks it takes 6/7ths of the time. The other 6/7ths of the marks are gained by writing and labelling in the remaining 1/7th. When I understood this, I placed as much of the writing in the **first** 1/7th of the time as possible. Planning became very easy after that. To successfully negotiate this hurdle, you require organisation born of repetition.