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Letters

Is it Time to Have a Further Debate on Separating Radiation and Medical Oncology Specialties Rather than Continue the Clinical Oncology Model?

Madam — We read with interest the recent editorial highlighting the ongoing and future recruitment issues in clinical oncology in the UK [1]. Various contributing factors were discussed and some short- and long-term solutions presented.

Historically, this clinical oncology model combining radiation and systemic therapy skills has served the UK well, but now, as this editorial points out, both radiotherapy and systemic therapies, now also with immunotherapy, are rapidly changing, as never before. Can one keep up to date with the ever-increasing knowledge base for both?

Trainees in clinical oncology now have multiple-line chemotherapies, targeted therapies, immunotherapies as well as physics and radiobiology, but minimal essential imaging training, crucial for planning future high technology radiotherapy.

By emphasising systemic therapies, has radiation oncology been held back? A search on the ClinicalTrials.gov website for 'reirradiation' shows that there are 68 clinical trials on the website, either in progress or completed/withdrawn. Unfortunately, not a single of these purely radiotherapy-related trials is registered in the UK [2].

There is also a huge disparity and disadvantage in academic radiation oncology posts and research resource, when clinical oncology is essentially seen, not by the Royal College of Radiologists, but others, as for service only.

There is a need to re-visit the debate on separating radiation and medical oncology specialities. There will be reasoned opposition from 'traditionalists' within clinical oncology; hospital management where pleuripotential clinical oncologists are seen as very good value, and by some in private practice. Re-discussion is surely needed for the future of the profession.

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Is It Time to Rethink Non-surgical Oncology in the UK?

Madam — We agree with Drs Iqbal and Kelly [1] that a fresh appraisal of the roles of clinical and medical oncologists is required. Our current main challenge is to deliver increasingly complex, individualised treatment plans for more patients with a workforce that is shrinking in real terms [2]. This requires more collaboration with medical oncologists and other health professionals rather than more separation.

The SHAPE of Training report [3] favours more generalists and fewer specialists. With our medical oncology colleagues, we continue to argue that possession of an MRCP should not mandate taking part in acute unselected take but this argument is not won. In response to SHAPE, the General Medical Council has stipulated a curriculum rewrite for all specialties. We have been asked to identify transferable competencies common to clinical and medical oncology.

The defining skills of an oncologist – understanding each cancer in the context of an individual, assessing fitness for therapies, communicating uncertainty – are common to both specialties. The few patients and healthcare professionals who know that there are two types of oncologist struggle to understand the differences between us and the reason for this dichotomy.

The principal curative non-surgical cancer therapy is radiation, so the need for a technically skilled radiotherapy workforce is paramount. As much curative radiotherapy is now delivered as combined modality therapy and with more new agents that enhance the effect of radiotherapy on the horizon, the need for clinical oncologists to have some systemic therapy training is increasing. We do not have enough oncologists of either type to pursue a fully separate North American model.

If we focus on training and supporting the oncology workforce as a whole, fostering our common aims and skills while encouraging individual expertise, such as in technical radiotherapy, we will stand a better chance of improving outcomes for people with cancer.

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Oncology is Missing out on the FOAM Party

Madam – The Royal College of Radiologists' *Clinical oncology UK workforce census report 2017* [1] adds to the stark warnings by Tharmalingam *et al.* [2] in their editorial regarding oncology training. In the UK, the current 15% shortfall in clinical oncologists is expected to worsen to 22% by 2022 [1]. Despite the recruitment crisis, medical students are given little exposure to oncology in undergraduate curriculums. Furthermore, in early postgraduate training few doctors are exposed to the very specialised services and therapies in oncology, hampering their ability to make informed career decisions.

We applaud the creation of the national annual taster course at Mount Vernon Cancer Centre and other initiatives to demystify oncology [2]. However, while such rare programmes are limited by availability and cost, they could be complemented by online platforms that are free and scalable to all trainees considering oncology. Yet surprisingly there is a dearth of online material for trainees contemplating this career.

We can learn from the fields of emergency, intensive and anaesthetic medicine that have built a vibrant community online around the concept of FOAM (Free Open Access Meducation). This is a philosophy of 'medical education for anyone, anywhere, anytime'. Curators worldwide have formed a vibrant online community producing blogs, podcasts, tweets, videos, online journal clubs and websites, all free to use [3]. So far oncology has broadly failed to exploit the internet to cheaply and effectively engage the millennial generation of trainees who are currently deciding on their specialty training [4].

To begin responding to this need we have developed an oncology FOAM platform (www.oncopods.com) to help those considering an oncology career. It covers career advice, the basics and current 'hot topics' in oncology. We encourage others to help build an oncology FOAM community with resources of their own.

Conflict of interest

CD is a freelance managing editor for Elsevier.

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