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Letters

Turning Crisis into Opportunity: A Local Approach Beyond Tasters and Coasters

Madam — We agree that a national taster course is useful. We would like to share our local recruitment strategy, which we developed following 2016 recruitment failure. It encompasses: (i) targeting students and junior trainees, (ii) raising the profile of oncology in the North East and (iii) raising the profile of the North East training scheme nationally.

We have designed two taster weeks: the first for people who are already interested in either clinical or medical oncology; the second is a joint 'malignant disease allied specialties' week, incorporating clinical and medical oncology, haematology and palliative medicine, to raise the profile of oncology for potential recruits.

For our oncology foundation year 1 and 2 and core medical trainees we improved our rotation, increased exposure to radiotherapy and outpatients. We introduced teaching fellowship posts to improve our junior staffing. These attract doctors who want time before embarking on specialty training, or to confirm choice of specialty. The fellowship post is a positive response to the 'coaster' trend.

For medical students we present at career events and encourage them to take foundation taster weeks. Newcastle Medical School has a 6-week student selected component (SSC) attachment. Oncology SSCs are popular, so we have increased consultant supervisors, accommodating more students. We encouraged the establishment of an undergraduate oncology society.

We tested our strategy in 2017, achieving 100% recruitment, and took feedback. The most common reasons for choosing our training scheme were: (i) the specialty training scheme, departments and teams and (ii) the region/people/lifestyle. Reasons quoted for choosing clinical oncology as a specialty were: (i) a previous rotation in oncology, (ii) a taster week in oncology and (iii) the year 4 undergraduate SSC. In 2018, we continued with 100% recruitment.

The Royal College of Radiologists and Postgraduate Medical Education and Training Board have agreed a 10% increase in oncology national training numbers [1,2]. We must be creative to recruit trainees or we will face a workforce crisis.

X.Y. Jiang, F.E. McDonald
Northern Centre for Cancer Care (NCCC), Freeman Hospital, Newcastle Hospitals NHS Foundation Trust, Newcastle upon Tyne, UK

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[2] *Clinical Oncology workforce: the case for expansion*. Faculty of Clinical Oncology, The Royal College of Radiologists; 2014. Available at: https://www.rcr.ac.uk/system/files/publication/field_publication_files/bfco145_co_workforce.pdf. [Accessed 27 September 2018].

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Outcomes for Primary Palliative Radiotherapy for Head and Neck Squamous Cell Carcinomas

Madam — Local control in head and neck cancer is a key outcome for treatment. For patients who are unsuitable for radical dose treatment, is palliative radiotherapy worth it?.

We audited the outcomes for all patients with a head and neck squamous cell carcinoma treated with primary palliative radiotherapy during the 6-year period from 2011 to 2016. The local standard regimen is 27 Gy in six fractions over 3 weeks, which has a biologically equivalent dose of 32.6 Gy in 2 Gy fractionation, assuming an α/β ratio of 10 Gy.

In total, 33 eligible patients were identified. Sixty-one per cent had an oral cavity or oropharyngeal primary; 76% had T4 disease at presentation and 58% were node positive.