Medical oncology

1 Description of the specialty and clinical needs of patients

Medical oncologists are physicians trained in the management of cancer. They are an integral part of the multidisciplinary team (MDT), providing particular expertise to patients through their knowledge of the systemic treatment of cancer with hormonal treatments, conventional chemotherapy with cytotoxic drugs and newer molecular targeted treatments. Such treatments may be delivered with curative intent for patients with early cancers or with palliative intent to alleviate symptoms and prolong life, when possible, in those with more advanced cancers. Medical oncologists are specially trained to understand the biology of cancer and the pharmacology of drugs.

They are therefore ideally trained to monitor the efficacy, side effects and safety of current and future treatments both within clinical trials and standard care. They have an important role in discontinuing less effective treatments.

Medical oncologists are tumour-site specialised, focusing on two or three specific types of cancer. The specialty has a strong academic component, with many medical oncologists having a higher degree and a high proportion having combined academic and NHS appointments. Medical oncologists increasingly require skills in management and service delivery in order to understand the complex issues involved in introducing new treatments, commissioning healthcare in relation to changing models of care and monitoring standards through peer review.

Who are the patients?

Cancer affects one in three people in the UK, and the incidence is increasing as people live longer. Advances in detection and treatment have resulted in a decrease in mortality; more people are surviving and living with cancer. This trend to improved survival will continue as scientific knowledge of cancer improves and affords still better methods of prevention, diagnosis and treatment. These improvements emphasise the need for doctors fully trained in the delivery of care to patients with cancer.

The introduction of the National Cancer Research Network (NCRN) has set standards for offering patient entry to clinical trials, and medical oncologists must be familiar not only with the drugs but the governance underpinning delivery of care within the context of clinical trials. Medical oncologists are expected to develop communication skills so they can discuss the risks and benefits of treatment to allow patients to make informed decisions about their care and so they can also break bad news. Medical oncologists need to take a holistic view of patients and liaise carefully with other members of the MDT to ensure continuity of care. The improvements in rates of survival mean that survivorship of cancer is becoming an important issue for many patients, and medical oncologists increasingly are involved in identifying, monitoring and managing the late effects of cancer and its treatment.
2 Organisation of the service and patterns of referral

A typical service

The importance of cancer was highlighted by the government’s appointment of a National Cancer Director, who, in 2000, published *The NHS Cancer Plan*, which revolutionised the structure underpinning the delivery of cancer care within the NHS.¹ This was updated in 2007 in the *Cancer reform strategy*, which sets a clear direction for cancer services for the next five years in order to achieve a cancer service in the UK among the best in the world.²

Referral of patients with suspected cancer is usually initiated in primary care by the patient’s GP. Waiting-time targets have been set to ensure that the time from referral to diagnosis to treatment is as short as possible, and further action will be taken over the next five years to reduce waiting times for all modalities of treatment. Patients are now referred to experts in the relevant tumour type, initial referral is often to a cancer surgeon or physician, and all suspected and proved cases of cancer are discussed within a MDT to ensure that a treatment plan is developed appropriate to a patient’s needs. Systemic treatment is delivered under the care of medical (and clinical) oncologists.

Local and regional services

Meetings of the MDT take place within local hospitals or cancer units for common tumour types; however, less common types of tumour are centralised within a cancer centre, so that there is a critical volume of patients and staff to allow delivery of the highest possible standard of care. No cancer unit can function in isolation, and all units are part of one of the 34 cancer networks within the UK (each network serves a population of between one million and three million). Within each network, tumour site-specific boards cover all tumour types to ensure a coordinated approach to the organisation of services and delivery of care and to ensure equity of access for patients. Over the next decade, the new National Cancer Intelligence Network will monitor these processes in relation to performance and patient experience. Within the cancer strategy, focus is increasingly on new models of care, with an emphasis on centralising wherever necessary to improve outcomes – eg for complex treatment delivery – but with the principle that care should be delivered locally, whenever that is consistent with good-quality care, in order to maximise convenience for the patient. Regarding inpatient care for cancer, significant opportunities exist to move some services from inpatient to ambulatory care, and the Cancer Services Collaborative Partnership and Cancer Action Team are developing a programme of work on inpatient management to support such local implementation and changes in models of care. In all cases, care must conform with national standards – eg the Improving Outcomes Guidance (IOG)³ – and should be integrated fully with other services within the cancer network.

These changes can be delivered only with strong commissioning and with primary care trusts (PCTs) supported by cancer networks to ensure that the NHS delivers value for money while funding world-class cancer services. The new cancer strategy will:

- support workforce development and training
- conduct good-quality horizon scanning
- increase support for research
- continue working in partnership with stakeholders
● provide national leadership and support
● publish annual reports.

The focus is not only on delivery of care for established cancer but also on prevention of cancer, as more than half of all cancers could be prevented by lifestyle changes and, for some cancers, interventions (secondary prevention) may afford further opportunities to prevent development of the disease. Such strategies may include immunisation against cervical cancer, increased screening for breast and bowel cancer, and increased regulation of tobacco.

3 Working with patients: patient-centred care

Interaction with patients

Medical oncologists work with patients and their families to provide a holistic approach to care that recognises their right to information, autonomy, support and guidance that is sensitive to their cultural background and appropriate to their knowledge and beliefs. They work with other healthcare professionals to ensure that all patients with suspected cancer are seen by a hospital specialist within two weeks and receive their first treatment within 62 days from being referred by their GP. This will be supported by a new National Awareness and Early Diagnosis Initiative to support local interventions to increase public awareness of the symptoms and signs of early cancer.

Involving patients in decisions about their treatment

Medical oncologists are trained in high-level communication skills to enable them to provide information that is easily comprehensible for patients. They should be supported, if necessary, by appropriate interpreters and patient advocates. They should be able to describe treatment options and consequences clearly to patients, who should be invited to participate in making treatment decisions to the degree that they wish. Verbal information should be complemented with written, audio or video material. Validated internet resources such as the websites provided by Cancerbackup (www.cancerbackup.org.uk), National Cancer Research Institute (NCRI, www.ncri.org.uk) and Cancer Research UK (www.cancerresearchuk.org) should be advocated to interested patients. A three-way partnership between Cancerbackup, Cancer Research UK and Macmillan Cancer Support is developing a system to support tumour-specific information pathways to help cancer health professionals offer appropriate advice tailored to the individual needs of patients; this will be launched in 2008.

Coordinated MDTs, which bring together all relevant healthcare professionals involved in a patient’s care, ensure that the patient is at the centre of any treatment decision and improve the patient’s experience and outcome. Each patient should have a ‘key worker’ (often a clinical nurse specialist) to help them through their journey with cancer. Adherence to national guidelines – such as the IOG3 – should ensure high-quality services and eliminate the postcode lottery. In many cases, clinical trials allow patients to access drugs that are otherwise not provided through the NHS, and all patients should have access to clinical trials where appropriate. Comprehensive information about trials should be given to patients to allow them to make an informed decision about the pros and cons of entering a trial. Patient representatives in the NCRI Clinical Studies Groups ensure that patients’ voices are heard as early as possible during the planning stages of clinical trials.
Increasing importance will be paid to provision of psychological support and also to access to information regarding financial support. A National Cancer Survivorship Initiative will consider approaches to improve life for cancer survivors, as modern treatment not only improves survival from cancer but also increases the number of people living with cancer, which increasingly can be regarded as a chronic disease.

Patient support groups

Local self-help groups within hospitals and the community can improve patient education and support. Medical oncologists provide staff education within the specialist oncology team, general hospital and community services that provide much of the patient care. The Expert Patients Programme provides lay-led, group-based support for patients, empowering them to improve their quality of life despite living with a long-term condition, and ‘buddy systems’ can give patients additional lines of support and advice. A new National Awareness and Early Diagnosis Initiative will coordinate a programme of activity to increase public awareness of the signs and symptoms of early cancer to encourage people to seek help sooner.

Patients may wish to explore complementary therapy in conjunction with standard treatment. Some cancer units provide massage and other treatments, and these may also be found in support groups and in the palliative-care setting. This need has been recognised in a paper published by the Joint Collegiate Council for Oncology (JCCO).4

4 Interspecialty and interdisciplinary liaison

Multidisciplinary team working

All newly diagnosed patients are discussed in a relevant meeting of the MDT, and a recommended treatment plan is agreed in accordance with tumour-site specific guidelines and protocols. Within this context, medical oncologists work closely with surgeons, physicians, clinical oncologists, specialist nurses, primary care physicians and the palliative-care team. Medical oncologists are often the coordinators of such treatment plans and are responsible for overseeing the holistic care of the patient.

Continuing liaison between members of the MDT is necessary to refine and develop a patient’s treatment. Definitive treatment, as agreed by the MDT, begins within four weeks of referral. Whether based in an academic cancer centre or cancer unit in a district general hospital (DGH), medical oncologists will work with other specialties to create defined protocols and care pathways. In smaller units, and in liaison with haematology, medical oncologists will be responsible for the inpatient care of all patients with cancer, working closely with visiting colleagues from clinical oncology and haematologists.

Working with other specialties

Since the publication of The NHS Cancer Plan, all patients with suspected cancer referred urgently by their GP or consultant are seen by an appropriate cancer specialist within two weeks.1 The 31-day standard will cover all treatments for cancer.2 Most new referrals to medical oncology are from specialist surgeons or physicians who have made a diagnosis or who wish to
seek advice regarding the care of a patient with cancer. Direct referrals from GPs currently account for only a small proportion of the workload.

**Working with GPs and GPs with a special interest**

In the palliative-care setting, frequent communication with GPs is vital to the provision of seamless care at all stages of a patient's illness, while patients in remission require a coordinated follow-up strategy that increasingly will be based in the community rather than the hospital.

Medical oncologists are frequently the non-surgical oncology leads for the hospital trust, providing input into the management and planning of services and working closely with the trust's management and the PCT on commissioning issues. Within each trust, there will be individual leads for tumour types and for generic subjects such as chemotherapy.

**Other specialty activity beyond local services**

Most medical oncologists will be based in a cancer centre and will provide a number of direct clinical care programmed activities (PAs) in a peripheral cancer unit within their network. For some, the principal site of activity, and consequently inpatient admitting rights and responsibilities, is within the cancer unit of a DGH, and they will visit their cancer centre for a limited number of PAs relating to audit, research and continuing professional development (CPD). The activities at the secondary site may include meetings of the MDT and a range of outpatient consultation and treatment services, but they should not involve sole responsibility for inpatient care.

If the secondary site is a cancer unit, arrangements must be made for local consultant cover (eg by a haematologist or general physician), with appropriate protocols for the care of oncological emergencies.

**5 Delivering a high-quality service**

**What is a high-quality service?**

A high-quality service can be judged by the criteria of patient satisfaction, adherence to national and network guidelines, and accreditation standards and by the achievement of outcomes that are deemed to be excellent when audited and compared with national standards of cancer care and published reports.

**Maintaining and improving the standard of care**

The consultant medical oncologist can function fully only when supported by a MDT and with appropriate support from the colleagues whose roles are outlined below:

- Members of the trainee medical staff assist in patient care and outpatient clinics.
- Clinical nurse specialists (key workers) coordinate treatment, investigations and information and should be available for all patients with tumours at common sites. Their role includes counselling patients about their diagnosis and explaining treatment options and their consequences. They are the point of contact for patients and relatives to discuss
issues relating to diagnosis or treatment and for emotional support, and it is advisable that a clinical nurse specialist is on call for urgent advice, as patients can feel very isolated if they experience a problem out of hours.

- Dedicated oncology pharmacists prepare chemotherapy treatment in appropriate facilities, which is then administered by trained nurses. The pharmacists check all prescriptions and advise on drug interactions, protocol deviations and safety.
- Research nurses recruit and treat patients in clinical trials. They should be present in all units within the NCRN to help with assessment of patient eligibility for specific trials, to provide counselling and explanation of treatment options and trial procedures in conjunction with the written patient information sheet, to coordinate trial-related investigations and clinic visits, to assess patients in trials, and to provide assistance with the completion of case report forms according to good clinical practice (GCP).
- Data managers collect information on all patient treatment and outcomes, complete case report forms, record and report adverse events, assist in preparing data records for external monitoring, and, together with research nurses, maintain trial conduct according to the principles of GCP.
- Secretaries and clerical staff provide and file results of investigations and records of letters and meetings of the MDT.

**Service developments to deliver improved patient care**

Coordination of care for patients with cancer through regular meetings of the MDT has improved patient access to oncological care and the timeliness of delivery. Medical oncology continues to develop MDTs for all tumour sites.

Cancer medicine and systemic treatment are undergoing rapid change with the development of multiple diagnostic tools and treatment modalities. The assessment and introduction of this new technology has, for the most part, been led by medical oncology, with an emphasis on audit and research. The National Institute for Health and Clinical Excellence (NICE) issues guidance on the use of not only drugs but also new technologies.

Medical oncology promotes awareness of the principles of good cancer care throughout the extended medical community through hospital-based teaching and educational activities in primary care. It also improves patient awareness of how to access and attain good-quality care through careful dissemination of information and local self-help groups.

In addition, medical oncologists frequently take on extra leadership roles, such as clinical director, medical director, director of clinical trials units, lead clinician for cancer networks and adviser for a variety of organisations, such as the Association of Cancer Physicians (the medical oncology specialist society, [www.cancerphysicians.org.uk](http://www.cancerphysicians.org.uk)), the Royal College of Physicians (RCP), the Joint Collegiate Council for Oncology (representing medical and clinical oncology), the Department of Health (DH), cancer charities such as Cancer Research UK and ethics committees.

**Education and training**

Medical oncologists who retain clinical activities will be expected to participate in local clinical teams and duty rotas and to lead their particular field of research activity within a cancer centre and the wider cancer network. Additional academic duties may include developing and
assessing curricula, teaching undergraduates, postgraduates and allied healthcare professionals, examining and inspecting at other institutions and participating in national societies and research committees.

The training and supervision of specialty registrars (StRs) in medical oncology is becoming more detailed and time consuming. A new competency-based curriculum has been developed, in which formal assessment of competence in practical procedures and the assessment of knowledge, skills and attitudes will fall to the existing consultant body. Assessment tools are being developed, including a mini clinical examination exercise (mini-CEX), multisource feedback appraisal and directly observed procedural skills (DOPS). Many such assessments are designed to be conducted during normal outpatient clinics or ward rounds, and, as a consequence, consultants who are involved regularly in the supervision of trainees may be able to see fewer patients than previously.

Clinical governance

With its tradition of audit and research, medical oncology is strongly oriented towards maintaining clinical effectiveness through the application of staff appraisal, CPD, audit and the acceptance of responsibility for clinical governance.

Research – clinical studies and basic science:

- Medical oncology is an excellent research-based specialty. Treatment is in a constant state of evolution, depending on the results of the latest validated clinical research. As such, medical oncologists are expected to be competent and committed clinical scientists, whether they are working in academic units or cancer units.
- Clinical trials are at the core of medical oncology. Patients treated within the context of a clinical trial fare better than those not included in clinical trials. The NCRN’s target is that 10% of patients should be entered into randomised clinical trials, and this is supported, in part, by the central facility of research nurses at the level of the trust. Many oncologists conduct laboratory research during their training, which leads to the award of higher degrees. Although this is not mandatory, it would be a prerequisite for posts with a significant component of clinical pharmacology or new drug development.

Local management duties

Examples for medical oncologists may include:
- leadership of tumour group at trust or network level
- leadership and involvement in drug and therapeutic committees
- leadership in guideline development
- clinical service lead or medical director
- regional specialty advisor
- education programme leadership
- regional and national work.
Specialty and national guidelines

The development of comprehensive guidelines for the management of different cancers is incomplete. NICE has taken on this role in some areas, but for many types of cancer there is a lack of national treatment guidelines. As discussed in previous sections, the delivery of cancer care may be in cancer units, but these function in the context of a wider network within cancer networks at a local level and across the country.

Standards are set nationally through the IOG on delivery of care.3 NICE also provides guidance on new technologies. The default position for all new drugs to treat cancer and for significant new licence indications will be that they are referred to NICE – as long as NICE agrees there is a sufficient patient population and evidence base on which to carry out an appraisal. The guidance issued by NICE is subject to audit by the National Cancer Director to ensure that patients have access to drugs positively appraised by NICE.

Tumour-specific national information pathways will be launched in 2008; these will make nationally agreed information sets available to healthcare professionals in the frontline of cancer care so that they can offer support to patients at key points during their journey through cancer. This will be done through a three-way partnership between Cancerbackup (www.cancerbackup.org.uk), Cancer Research UK (www.cancerresearch.org) and Macmillan Cancer Support (www.macmillan.org.uk) to ensure that all patients receive high-quality information tailored to their individual needs. National cancer quality initiatives bring together key stakeholders from the profession’s voluntary sectors, academia and equality groups to develop research proposals to minimise cancer inequalities. This initiative will also focus on data collection and audit.

The publication of original research and meta-analyses in oncological journals provides outcome measures against which treatment of specific patient groups can be compared.

Medical oncology has developed specialty-specific standards of good medical practice that can be used for auditing medical oncologists. The Joint Collegiate Council for Oncology also provides standards of care against which the quality of a chemotherapy service can be assessed.5 Standards for training accreditation are produced by the College, the Joint Royal Colleges of Physicians Training Board (JRCPTB) and the postgraduate medical and dental education deans. Standards for research governance derive from the Medical Research Council (MRC)’s guidance on GCP and the European Union’s (EU) directive on clinical trials.6,7

Quality tools and frameworks:

- The DH’s NHS cancer plan (recently updated as the Cancer reform strategy) sets down a framework of standards relating to the diagnosis and treatment of cancer.1,2
- National standards of cancer care based on The NHS cancer plan and the IOG published by NICE provide an extensive framework for measuring the quality of care.3 Adherence to these standards is monitored by a peer-review accreditation system coordinated by the Commission for Healthcare Audit and Inspection (CHAI).
- National audits of NICE-approved anticancer drugs will ensure equity of access for patients. Definition of datasets for chemotherapy will allow an understanding of variations in treatment.
- Local and network audit is an integral part of service delivery.
Clinical work of consultants

How a consultant works in this specialty

The medical oncologist is the leader and coordinator of an extended team of healthcare professionals who aim to provide optimum cancer care for the patient. The increasing range and complexity of cancer treatment has led to tumour-site specialisation, with a consultant having the expertise to treat no more than three sites – the number depending on the volume of work and complexity of treatment. Coordination of care for patients with cancer through regular meetings of the MDT has become a keystone of practice, with the consultant medical oncologist attending one or more such meetings per week depending on tumour-site specialisation.

Few consultant medical oncologists are accredited in acute general medicine; however, they all manage patients with multiple co-morbidities and treat critically ill patients with oncological emergencies such as neutropenic sepsis. They must therefore maintain a general level of competence in internal medicine in order to effectively coordinate the provision of treatment for cancer. Most patients with cancer receive their care in the outpatient setting of clinics and day-care wards, supported by sufficient inpatient facilities for intensive diagnosis, treatment and management of complications, with the latter area being a key role of the medical oncologist.

Division of clinical workload

A typical job plan for a whole-time equivalent (WTE) consultant in medical oncology would comprise 7.5 programmed activities (PAs) of direct clinical care, with each four-hour outpatient clinic likely to require one to two hours subsequent administration for the organisation and prescription of patient treatment (to a maximum of four outpatient clinics and two administration PAs per week).

In addition, at least one meeting of the MDT (0.5 PA), one inpatient ward round per week and clinical management responsibilities of the lead clinician, clinical director, training director or rotation organiser would be included in the job plan. The number of ward rounds will vary according to the frequency of acute illness in the patients and the composition of the clinical team. On-call commitments will vary with the organisational structure of the unit and the intensity of care required by the patient load, with crossover with clinical oncology and haematology being common.

The remaining 2.5 PAs comprise the supporting professional activities of teaching and training, audit and clinical governance, CPD, research participation in trials organised by the NCRN and translational research in academic centres. Clinical research is a key component in every job plan to ensure that patients have access to the best care and to new agents within clinical trials, with government guidelines proposing that 10% of all patients should be treated within the trial setting. Medical oncologists with a significant role in the supervision of trainees require dedicated time (one PA) to allow delivery of complex training needs. Consultant medical oncologists who are regularly involved in the supervision of trainees will see fewer patients in a fixed four-hour period in the clinic or the wards.

In addition, medical oncologists frequently take on extra leadership roles: as clinical director, medical director, director of clinical trials units, lead clinician for cancer networks and adviser for a variety of organisations such as the Association of Cancer Physicians (the medical oncology specialist society), the RCP, the Joint Collegiate Council for Oncology, the DH, cancer charities and ethics committees.
Academic medicine

Academic medical oncologists should expect a reduced clinical commitment of five or six PAs per week for direct clinical care and, consequently, four or five more PAs for teaching and research. A sample job plan that reflects this reduced clinical commitment for an academic medical oncologist with a significant laboratory interest is appended in Table 2.

Table 1 Sample job plan for consultant medical oncologist

<table>
<thead>
<tr>
<th>Activity</th>
<th>Workload</th>
<th>Programmed activities (PAs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct clinical care</td>
<td>Clinical research is an integral part of all clinical PAs for a medical oncologist</td>
<td></td>
</tr>
<tr>
<td>Outpatient clinic</td>
<td>3–4 new patient consultations per week: about 1 hour each</td>
<td>3–4</td>
</tr>
<tr>
<td></td>
<td>Routine follow up of well patients: 10–15 minutes per consultation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Management of patients with relapsed or metastatic disease: about 30 minutes</td>
<td></td>
</tr>
<tr>
<td>Day-care ward work</td>
<td>May form part of a mixed outpatient clinic. Patient assessment and chemotherapy prescribing: about 30 minutes</td>
<td>1–2</td>
</tr>
<tr>
<td>Clinical administration</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Inpatient ward rounds</td>
<td>Number of patients will vary depending on nature of practice: 5–20 would be typical</td>
<td>1–2</td>
</tr>
<tr>
<td>MDT meetings</td>
<td>Frequency and duration will vary according to size of MDT sessions: up to four hours is not uncommon</td>
<td>1–2</td>
</tr>
<tr>
<td>Total number of direct clinical care PAs</td>
<td></td>
<td>7.5 on average</td>
</tr>
<tr>
<td>Supporting professional activities (SPAs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work to maintain and improve the quality of healthcare</td>
<td>Education and training, clinical trials and research, appraisal, departmental management and service development, audit and clinical governance, CPD and revalidation</td>
<td>2.5 on average</td>
</tr>
<tr>
<td>Other NHS responsibilities</td>
<td>eg medical director, clinical director, lead consultant in specialty, clinical tutor</td>
<td>Local agreement with trust</td>
</tr>
<tr>
<td>External duties</td>
<td>eg work for deaneries, royal colleges, specialist societies, DH or other government bodies</td>
<td>Local agreement with trust</td>
</tr>
</tbody>
</table>

Consultant physicians working with patients
Service provision in cancer centres and cancer units

Most medical oncologists will be based in a cancer centre and will provide a number of direct clinical care PAs in a peripheral cancer unit within their network. For some, the principal site of activity and, as a consequence, inpatient admitting rights and responsibilities is within the cancer unit of a DGH, and they will visit their cancer centre for a limited number of PAs relating to audit, research and CPD. If the secondary site is a cancer unit, arrangements must be made for local consultant cover (eg by a haematologist or a general physician), with appropriate protocols for the care of oncological emergencies and the attending medical oncologist acting in an advisory role.

### Table 2 Sample job plan for academic medical oncologist with a major laboratory interest

<table>
<thead>
<tr>
<th>Activity</th>
<th>Workload</th>
<th>Programmed activities (PAs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct clinical care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient care (ward rounds and ward consultations)</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>MDT and related meetings</td>
<td>0.75</td>
<td></td>
</tr>
<tr>
<td>Outpatient clinics</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>Patient administration and clinical follow up (letters referrals, telephone calls)</td>
<td>1.75</td>
<td></td>
</tr>
<tr>
<td>On call (supporting junior doctor on-call arrangements)</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Total number of direct clinical care PAs</td>
<td>5.5</td>
<td></td>
</tr>
<tr>
<td>Supporting professional activities (SPAs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical education</td>
<td>0.25</td>
<td></td>
</tr>
<tr>
<td>CPD</td>
<td>0.25</td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>eg clinical trials, translational research in drug development, supervision of MD and PhD students</td>
<td>3.25</td>
<td></td>
</tr>
<tr>
<td>Other NHS responsibilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>local trust committees, eg research and development, clinical governance and audit</td>
<td>0.25</td>
<td></td>
</tr>
<tr>
<td>External duties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>eg international boards, lectures on behalf of employing institution</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Total number of SPAs</td>
<td>4.5</td>
<td></td>
</tr>
<tr>
<td>Total PAs</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

Note: Medical oncologists, particularly in academic centres, may work with other consultant medical oncologists as part of a team that shares the outpatient and inpatient care of a group of patients. In this case, responsibilities may vary weekly or monthly, for which an annualised job plan is required.
7 Workforce requirements for the specialty

In 2000, the College recommended a figure of 1.25 WTE medical oncologists per 200,000–250,000 population. This requires about 250 WTE, which equates to a total of about 300 medical oncologists in the UK. In November 2000, there were 138 medical oncologists in the UK; this figure increased to 229 in September 2006. There is, therefore, still a substantial shortfall against the figure of 300 medical oncologists recommended in 2000. Treatment options for patients with common cancers have increased substantially in the past three years, which has led to a significantly greater workload for medical oncologists. It is likely, therefore, that the predicted workforce requirement for medical oncology in the UK is actually a minimum of 400 posts.

Consultant work programme/specimen job plan

The workload of a medical oncologist measured by the number of new patient referrals seen per year should be about 200. This takes into consideration the continuing care required by most patients over repeated episodes of treatment and the intensive monitoring required for chemotherapy. This figure will depend on the sub-specialty interest and casemix of the consultant’s practice.

Academic medical oncologists with a decreased commitment to direct clinical care and a correspondingly greater requirement for teaching and research should see about 100–150 new patients per year. Due to the lack of specialist oncologists in much of the UK, however, the current workload of most medical oncologists will exceed these figures.

An on-call rota of oncology specialists should provide 24-hour emergency cover, if necessary in conjunction with colleagues from haematology or clinical oncology to ensure sufficient numbers for a rota, which should not exceed one in five.

The volume of on-call work will depend on the patient practice of the oncologist, the intensity of treatment and the cover provided by trainee staff. It varies from telephone advice with the occasional requirement for attendance (category B) to frequently required urgent attendance on, for example, transplant units or units in which only limited general medical senior house officer cover is available (category A). Further alterations in rotas may be required as a result of the introduction of the European Working Time Directive (EWTD).

References


