

Principals underpinning high quality training in Clinical Oncology

Introduction

This document arose because of concerns expressed by many trainee representatives at the RCR Oncology Registrars' Forum (ORF) meeting on 9 May 2008, and has been updated in April 2016.

The main concern originally expressed was that NHS service commitments are eroding away the practical experience necessary to train to become a competent consultant in clinical oncology. Trainees often now work for more than one (and sometimes as many as seven) consultants simultaneously as a result of the (welcome) consultant expansion. Unless great care is taken to plan the trainees' timetable it is likely they will be expected to participate in the busiest and most overloaded clinical activities at the expense of one-to-one trainer-supervised sessions. At the same time specialist trainees are finding themselves spending more time on wards directly supervising, or even covering for, more junior medical staff.

As much of clinical oncology is a practical specialty and much of training is based on an apprenticeship-type model, direct supervision and coaching is particularly important as many skills cannot be acquired by reading a book. This document therefore aims to suggest the various components required in a trainee timetable to ensure a broad and thorough training experience.

Suggestions regarding specialist trainee job-plans

Below is a series of suggestions from ORF members of the desirable features of a trainees' weekly timetable. It is neither exhaustive nor prescriptive but is designed to stimulate discussion.

- Maximum of 4-5 outpatient clinics per week perhaps including 1-2 peripheral clinics. Ideally trainees should be able to see and assess new and follow-up patients during these clinics and have the opportunity to discuss the management of the patients with their supervising consultant when appropriate. The exact number of clinics would be dependent on the site which the trainee is specialising in at the time. For example, a head-and-neck attachment is unlikely to need a dedicated chemotherapy clinic whereas a breast attachment should include one. Particular attention should be paid to how new trainees are to be supervised in both seeing new patients and also participation in peripheral clinics if their consultant is away
- The opportunity to review and supervise patients during their treatment, manage side effects, etc., both in terms of chemotherapy and radiotherapy (e.g. "floor clinic").
- Two dedicated technical planning sessions per week with direct supervision by the relevant consultant. Appropriate support from radiographers and dosimetrists as necessary would also be ideal. It was

felt by the majority of ORF members that this dedicated planning time was extremely important and also that this was the time that was often sacrificed by other clinical commitments. Ensuring this time is protected wherever possible is therefore ideal.

The supervising consultant also needs to have these technical planning sessions in their job plan and also be prepared to provide tuition and constructive feedback to their trainee.

- Timetabled weekly consultant ward round for review of inpatients and teaching surrounding in patient oncology problems. Where possible, this should be a dedicated session on a weekly basis.
- Active MDT participation. A number of trainees valued being able to participate actively in multidisciplinary team meetings. In some situations it may be possible for the MDT to be run so that the oncology and surgical SpRs were 'in charge' - i.e. were expected to make the decisions first, with consultants contributing afterwards if necessary. This was felt to be very useful educationally.
- Some time during the training programme spent with diagnostic radiologists, in theatre with surgeons, working with the dosimetrists and also "on set" with radiographers would all be valued. Time spent "on set", in mould room and with dosimetrists was felt to be particularly beneficial in the early stages of training and might form part of an induction programme.
- Some time during the training programme spent with the palliative care team, gaining experience of symptom control and management of difficult pain symptoms.
- Admin, study, audit and teaching time. Beyond the "protected time" for Part I and Part II courses.

Implementation

Possible consideration to be made of a *Training Contract in Clinical Oncology* between the trainee and the training department which more explicitly outlines the expected contributions and commitments from both parties.

A suggestion that has worked well in at least one training scheme is that the allocation of trainees to each timetabled clinical session is based upon the educational experience likely to be gained during that session rather than the need for the "extra pair of hands" to provide clinical input. This required quite rigorous enforcement from the Regional Specialty Adviser and Training Programme Director but seems to have worked well in a department where there are twice as many consultants as trainees.

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