Clinical Oncology
The Royal College of Radiologists

WHY I CHOSE A CAREER IN CLINICAL ONCOLOGY

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Why did you want to become a clinical oncologist?

I first became interested through a 3rd year medical school project during which I followed a newly diagnosed cancer patient through his oncological treatment. I particularly liked that the consultant was able to form a strong doctor-patient relationship through regular patient contact, worked closely with lots of other specialties and was able to prescribe a variety of treatments. I clearly remember how quickly the consultant was able to put the patient at ease and by establishing a good rapport, was able to give hope and reassurance at a time when the patient thought his world had ended. I knew then that this career would be challenging but extremely rewarding and set about getting more experience through oncology and palliative care posts as a junior doctor.

What was the transition like from medical SHO to clinical oncology registrar?

It was a daunting but exciting prospect! On one hand I felt ready to take on the added responsibility that comes with a more senior role but on the other I felt like a medical student again. There was a wealth of new clinical terminology, treatments and computer software to learn about as well as finding my feet in a new team. However I was made to feel at ease and supported to make important clinical decisions at an early stage. My first year included rotations with the Urology, Respiratory and Breast teams and both my educational and clinical supervisors regularly reviewed my progress in line with the curriculum to check I was on the right track.

What are the positive aspects of a career in clinical oncology?

Since starting as a registrar five years ago, every day has been different. No two cancer patients present in quite the same way, evidence-based guidelines for a given malignancy won't 'fit all' and each patient has their own wishes and expectations of what treatment will achieve. With a (hopefully!) long career in the NHS ahead, this diversity will help to keep me motivated and enthusiastic to give the best care to patients.

It's an exciting time to work in cancer care because of the major advances in treatments which are working their way into everyday medical practice. Research and clinical trials are developing state-of-the art drugs which may allow a more tailor-made treatment for the individual patient's tumour. Technological advances in the planning and delivery of radiotherapy mean that we can isolate tumours for irradiation with increasing accuracy and spare damage to normal tissues. This has obvious benefits for patients but also for the

doctors that treat them; it means such a career will be intellectually stimulating and rewarding.

I now work on a less-than-full-time (LTFT) basis as I have had children during my training. Whilst at times it can be a struggle to all get out of the house on time in the morning, I do not feel that my training has suffered and both the college and training programmes are supportive of LTFT trainees.

What are the challenges?

Despite that 50% of people will be diagnosed with cancer in a lifetime, the 'C-word' is still a taboo for some and instils real fear in patients and their families. It is a common misconception that oncologists can't cure cancer; treatments are becoming more successful and survival rates increasing but there will always be unfortunate cases where despite best efforts, patients no longer respond. Discussions regarding disease progression and withdrawal of treatment can be emotional for patients and their relatives as they come to terms with the diagnosis. However it is also demanding for the medical team and I'm constantly trying to improve my skills in breaking bad news. It's important to remain empathetic but I try to leave work at work, keep up hobbies and socialise with friends and family to try and prevent burn-out.

Most specialties have postgraduate exams and clinical oncology is no different with the first part of the FRCR examination assessing knowledge of the scientific principles of cancer care. I was particularly worried the Radiation Physics module as I hadn't done A-level physics. However it was achievable and I passed part 1 in my second year as a registrar having attended a weekly revision course in London – lunching in South Kensington each Friday did help to soften the blow of more exams! I'm now preparing for part 2, a more clinical set of examinations - again I have been able to attend a weekly regional revision course for four months in preparation for this.

Describe a typical 'Day in the Life' of a clinical oncology trainee

8.00am Arrive at a district general hospital for the Urology MDT. Discuss cases with the surgeons, nurse specialists, radiologist, histopathologist and palliative care, deciding upon the appropriate treatment to be offered to each patient. Make a note of the new patients we'll see later today in the clinic so I know what to discuss.

9.00am Telephone the on-call oncology registrar for the day back at the cancer centre to hand over the admissions from overnight (a breast cancer patient with possible neutropenic sepsis after chemotherapy and a suspected prostate cancer patient with spinal cord compression) as I was on-call from home (rota is 1:8). The resident SHO had assessed the patients during the night and as both were stable; I didn't have to go in but gave management advice over the phone.

Join the rest of the team in the canteen for a quick bacon buttie before the clinic starts!

9.30am Clinic in main outpatient department at the DGH starts. I see three gentlemen on long-term hormone therapy for prostate cancer with stable PSA results, a new patient with prostate cancer who wishes to discuss radical radiotherapy versus surgery, and consent another man for palliative radiotherapy to treat his symptomatic haematuria from a bladder cancer. I'm running to time until I see the next patient – a newly diagnosed metastatic prostate cancer patient who we're starting on hormone therapy. However during the consultation he reports a 2 day history of leg weakness and back pain. I arrange for his admission to the oncology centre for an emergency whole spine MRI to rule out cord compression.

1.15pm Clinic finishes a bit late and I accompany the consultant to the ward to review one of our patients who was admitted two days ago with fever post-chemotherapy. She doesn't have neutropenia but is being treated by the medical team for a chest infection. I make a note of her details to document this event in the computerised oncology notes as we may need to review the dose of chemotherapy for the next cycle of treatment.

Time for a quick sandwich before driving back to the cancer centre.

2.15pm Check in with the secretary to sign off some letters. Answer emails and return a call to a GP who has a query about a patient currently receiving radiotherapy.

3.00pm Attend the registrars' teaching – this week's topic is the management of uterine cancer. We review the current guidelines, discuss how we'd manage some example cases, assess the 'mock' radiotherapy plans and have a catch-up afterwards.

4.30pm Chase up the result of the spinal MRI from this morning's case. It didn't show cord compression but there are some metastases that would account for the patient's pain. I liaise with the on-call registrar to book the patient into the radiotherapy clinic tomorrow to arrange some palliative treatment to help with his pain.

Review the patient list for tomorrow's clinic and sign off some results.

5.15pm Home time!