Contemporary Global Standards in Oncology Training

(J Bangladesh Coll Phys Surg 2026; 44: 75-76)
DOI: https://doi.org/10.3329/jbcps.v44i1.87212

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Over the past three decades, oncology training worldwide has undergone a fundamental structural transformation. In North America, Europe, Australia, and nearly all high- and middle-income countries, Medical Oncology and Radiation Oncology are unequivocally recognized as separate primary specialties, each with distinct entry pathways, competency frameworks, accreditation bodies, and licensure requirements.[1-3]

In the United States and Canada, Medical Oncology is pursued following completion of an Internal Medicine residency, while Radiation Oncology follows a dedicated residency pathway emphasizing radiation physics, radiobiology, advanced treatment planning, image guidance, and quality assurance. Dual certification is neither expected nor permitted for independent practice, reflecting the recognition that each discipline has evolved into a full-time, highly complex profession.[4,5]

Similarly, in the United Kingdom, the historic "Clinical Oncology" model has itself evolved. Although UK Clinical Oncologists deliver both systemic therapy and radiotherapy, they undergo a uniquely long, highly regulated training pathway, supported by extensive subspecialisation, protected academic time, and a mature health-system infrastructure. Importantly, this model is not transferable to low- and middle-income settings without equivalent safeguards, faculty depth, technological support, and regulatory oversight.[6]

Across Asia, the transition toward subspecialisation has been decisive and explicit. Countries including India, Pakistan, Thailand, Malaysia, Singapore, South Korea, and Japan maintain separate specialty degrees, independent training examinations, and distinct professional identities for Medical Oncology and Radiation Oncology. Even nations that historically followed Commonwealth training traditions have moved away from combined models, recognizing the unsustainable cognitive, technical, and ethical burden imposed by dual practice.[7-10]

Bangladesh is therefore not confronting a novel or controversial proposition. Rather, it is confronting a global consensus that oncology training must align with the realities of modern cancer care.

The Revolution in Systemic Therapy: A Paradigm Shift

The argument for subspecialisation becomes even more compelling when viewed through the lens of the ongoing revolution in systemic cancer therapy.

Over the past 15–20 years, oncology has moved well beyond traditional cytotoxic chemotherapy into an era defined by: Immune checkpoint inhibitors and cellular therapies; Biomarker-driven targeted therapies; Complex multidrug and multimodality regimens; Precision dosing and pharmacogenomics; Management of immune-related and molecularly driven toxicities and Continuous integration of rapidly evolving global clinical trial data.

Medical Oncology now requires constant engagement with molecular diagnostics, tumor genomics, translational research, and international clinical trial networks. Mastery of this field alone demands lifelong focused practice and continuous subspecialty development.[11-13]

In parallel, Radiation Oncology has undergone its own technological revolution, encompassing intensity-modulated radiotherapy (IMRT), volumetric modulated arc therapy (VMAT), stereotactic radiotherapy, adaptive planning, image-guided techniques, motion management, and increasingly sophisticated quality assurance systems that directly affect patient safety and treatment outcomes.[14-16]

To suggest that a single physician can safely, competently, and contemporaneously practice both Medical Oncology and Radiation Oncology—within the constraints of current training durations in Bangladesh—is fundamentally inconsistent with global

Received: 17 Dec., 2025 **Accepted:** 29 Dec., 2025

evidence, patient-safety principles, and professional ethics.

Ethical Implications for Patients and Practitioners

Continuation of the MD (Clinical Oncology) program under present conditions raises serious ethical concerns.

From the patient perspective, it risks exposure to suboptimal or outdated decision-making in an era where treatment selection is increasingly nuanced, biomarker-dependent, and rapidly evolving. Cancer patients have a fundamental right to care delivered by physicians whose training and daily clinical focus are fully aligned with the complexity of the therapies they prescribe or deliver.[13,17]

From the physician perspective, granting licensure for dual practice imposes an unreasonable and unrealistic burden on individuals, implicitly encouraging superficial engagement with two highly specialized disciplines. Rather than empowering clinicians, this model exposes them to professional vulnerability, medicolegal risk, and inevitable dilution of expertise.

In this context, continued credentialing for dual practice is not merely an academic oversight; it represents a systemic failure of educational governance.

Conclusion: An Urgent Call for Decisive Action

The continuation of MD (Clinical Oncology) as a single pathway authorizing dual practice in Medical Oncology and Radiation Oncology is no longer defensible in the era of precision medicine, immunotherapy, and technologically advanced radiation delivery.

This is not a matter of academic preference or institutional tradition. It is a matter of patient safety, professional integrity, and global accountability.

Maintaining a unified Clinical Oncology degree in Bangladesh risks doing injustice to cancer patients, who deserve care consistent with contemporary global standards, and injustice to trainees, who are asked to shoulder an impossible scope of responsibility under the illusion of adequacy.

In the light of overwhelming global evidence—and national precedents already established through BCPS and multiple institutions—failure to discontinue this model constitutes a serious intellectual and ethical lapse. Bangladesh Medical University, as the nation's premier academic institution, bears a particular responsibility to lead, rather than lag, during this critical transition.

The MD (Clinical Oncology) program should therefore be phased out with immediate effect, while allowing currently enrolled trainees to complete their education without disruption. No new enrolment should occur from the 2026–2027 academic year onward, with replacement by independently accredited MD programs in Medical Oncology and Radiation Oncology.

Anything less risks perpetuating a legacy model that is incompatible with contemporary cancer care and indefensible in the modern oncologic era.

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