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Perspective

Practicing Oncology in the UK National Health Service Versus Kingdom of Saudi Arabia Ministry of Health Hospitals: A Personal Reflection

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Abstract

While oncology is guided by universal scientific principles, its practice is profoundly shaped by healthcare systems, training structures and professional culture. Drawing from personal experience as a senior consultant clinical oncologist in both the United Kingdom's National Health Service (NHS) and the Kingdom of Saudi Arabia's (KSA) government sector Ministry of Health (MOH), this article explores key contrasts in governance, communication, training, workload, and multidisciplinary practice. These observations illustrate that excellence in oncology depends as much on system design and culture as on medical knowledge.

Keywords: *Oncology Practice, Healthcare Systems, Multidisciplinary Care, Clinical Governance, Practicing Oncology in the UK NHS Versus Saudi Government Hospitals*

Introduction

Cancer care requires precision, coordination, and compassion. Yet how these principles are applied varies enormously between healthcare systems. Having worked as an oncologist in both the UK's NHS and Saudi Arabia's MOH hospitals, I have observed that while oncology's scientific foundation is universal, its practice is profoundly shaped by local culture, infrastructure, organizational systems and professional ethos.

This reflection compares both environments across training, governance, communication, and patient care highlighting how system design and professional culture influence the daily realities of oncology practice.

Personal Background and Perspective

My reflections are shaped by having trained entirely within the United Kingdom's structured and rigorous oncology system. I completed my general medical training over four years, obtained the Membership of the Royal College of Physicians [1], and underwent the full Clinical Oncology training pathway regulated by the Royal College of Radiologists [2]. Over many years, this training exposed me to a comprehensive range of clinical scenarios across both medical and radiation oncology and strengthened an approach grounded in evidence-based practice, research, clinical audit, multidisciplinary collaboration, and reflective learning. The sheer volume of clinical exposure within the NHS over this training programme served as a solid foundation for future senior grade practice.

I worked for a substantial period as a consultant oncologist in the NHS with a range of clinical and leadership roles. The governance structures, emphasis on evidence-based practice, research, quality improvement, audit and continuous educational and professional development integrated and culture of open, non-punitive discussion were integral parts of my daily practice and professional identity.

Relocating to Saudi Arabia to establish a new Radiotherapy centre was therefore both enriching and eye-opening. The environment is dynamic, resource-rich, and ambitious, yet many of the processes I had long relied upon coordinated communication systems, and structured chain of command processes, open and reflective practices and robust IT infrastructure were at different stages of development or not established. My UK foundation gave me a clear reference point from which to observe contrasts, appreciate local strengths, and identify opportunities for system improvement. This personal journey underpins the comparisons explored throughout this article.

Training and Professional Scope

Training pathways reflect a major structural contrast. In the UK, Clinical Oncology is a nationally recognized specialty under the Royal College of Radiologists (RCR). Entry requires completion of the MRCP (often over three or four years internal medicine training), followed by a five-year structured program culminating in the Fellowship of the Royal College of Radiologists examinations. The FRCR is split into two parts, the first usually completed in the first and second years of training and the second in the penultimate year. Training encompasses both medical and radiation oncology, allowing consultants to prescribe systemic therapies and plan or deliver radiotherapy. Typically, reaching consultant level takes at least ten years post-graduation, often longer if additional research degrees are undertaken. This extensive, integrated training equips UK oncologists with a broad, holistic perspective.

In Saudi Arabia, the Saudi Commission for Health Specialties (SCFHS) [5] recognizes either medical or radiation oncology, but not both. Medical oncology training is usually two years. Radiation oncology, a recently accredited training programme, is five years. Consultants therefore enter independent practice at a younger age but generally with less cumulative experience. The shorter, more narrowly focused training produces early autonomy but limits the breadth and integration of skills compared to the UK system.

Healthcare Systems and Workload

The NHS provides publicly funded, universal healthcare organized through regional cancer networks. Oncology services are standardized, with clear governance and pathways, ensuring timely access and coordination.

By contrast, Saudi Arabia's government hospitals have expanded rapidly over the past decade, offering high-quality care in tertiary centers, but with considerable variation in institutional maturity, coordination, and governance.

Workload in the NHS is high, with strict performance targets such as the two-week wait and 62-day treatment pathway [3]. Consultants manage large numbers of patients alongside extensive documentation, audit, research, and teaching responsibilities. Strong IT systems, integrated patient records, and centralized referral pathways support efficient decision-making despite these demands.

In Saudi Arabia, patient numbers are generally lower, but consultations often take longer. Fragmented care, weak IT infrastructure, and patients having received parts of their treatment across multiple institutions sometimes in different cities mean that consultants must often collate diagnostic information themselves before making decisions. Patients are frequently tasked with bringing imaging CDs, pathology slides, and reports from outside hospitals. This can involve significant travel, expense, and delay, and the materials are sometimes incomplete or incompatible with the receiving hospital's systems.

By contrast, in the UK, these tasks are managed centrally within the NHS. Imaging and pathology are usually transferred electronically between hospitals through established regional networks, ensuring that the clinician receives complete diagnostic information before the consultation. The difference underscores a broader distinction: in the UK, the system coordinates the patient's journey; in Saudi Arabia, the patient and family are often the coordinators.

Communication and Consent

Communication approaches also differ markedly. In the NHS, informed consent and shared decision-making are standard. Patients are given detailed explanations of diagnosis, prognosis, and treatment options, including risks and side effects, and discussions are thoroughly documented, often accompanied with a plentiful supply of written information.

In Saudi Arabia, cultural and religious factors shape communication. Families often act as intermediaries, and there is frequently a preference to soften or withhold distressing information. From experience, patients and relatives may find detailed discussions of risk overwhelming, and clinicians often simplify or downplay complications to preserve trust and hope. Navigating between transparency and empathy requires subtlety, patience, and cultural awareness.

Multidisciplinary Team Meetings

The structure and function of multidisciplinary teams (MDTs) further illustrate system differences. NHS England has streamlined guidance on MDT meetings [4] with the ultimate goal of ensuring that time in the meeting is spent most appropriately to deliver the right outcomes for patients. Overall, they are highly organized, efficiently coordinated by administrators, and chaired by senior clinicians. Even meetings reviewing over a hundred cases maintain focus and evidence-based decision-making. Clinicians are experienced at presenting concise, structured summaries, ensuring discussions remain patient-centered and clinically appropriate.

In Saudi Arabia, MDTs exist in major centers but are often less structured. Despite smaller caseloads, meetings may be prolonged due to limited preparation or administrative support. Discussions can be influenced by hierarchy and personality rather than purely clinical evidence. Decisions sometimes emphasize what is technically possible rather than what is appropriate for the patient's overall condition, and there is often reluctance to acknowledge uncertainty.

Morbidity, Mortality, and Learning Culture

Another key difference lies in professional reflection and learning. In the NHS, regular morbidity and mortality [6] (M&M) meetings are embedded into clinical practice, providing a structured, educational, and non-punitive forum for reviewing complications or deaths following treatment. These discussions prioritise learning, accountability, and continuous quality improvement.

In Saudi Arabia, formal M&M meetings are less frequent and often combine cases from across the entire hospital, which dilutes the specific focus needed in oncology. Physicians may also adopt a defensive posture regarding adverse outcomes, perceiving scrutiny as criticism rather than an opportunity for reflection. As a result, opportunities for shared learning and the development of robust clinical governance practices are significantly reduced

Palliative Care and Symptom Management

Palliative care is fully integrated into UK oncology. Most oncologists are skilled in managing complex symptoms and initiating end-of-life discussions, with specialized teams providing complementary support.

In Saudi Arabia, palliative care is an emerging specialty. While growing in tertiary centers, it is not yet universally embedded in routine oncology practice. Oncologists frequently defer symptom management to palliative teams, and families may resist referrals, equating them with the withdrawal of care. Integrating palliative principles into everyday oncology practice remains a developing area.

Communication Systems and Professional Etiquette

The NHS relies on secure email and internal messaging platforms for professional communication. Information is directed only to those involved in patient care, and structured channels protect confidentiality and efficiency.

In Saudi Arabia, communication is predominantly via mobile phones and WhatsApp. Consultants are often contacted directly by multiple staff across departments. While this can facilitate rapid responses, it fragments communication, increases workload, and raises confidentiality concerns. Consultants may spend significant time managing patient data on personal devices, highlighting systemic inefficiencies and effectively longer working hours.

Research, Audit, and Professional Development

Research and audit are central to NHS oncology practice. Cancer centers participate in national and international trials, contribute data, and regularly review outcomes in the context of clinical audit to drive quality improvement.

Saudi hospitals are increasingly evidence-based but rarely participate in patient recruitment for international trials. Audit and structured outcome review are not yet standard. While treatment often reflects global best practice, local generation and evaluation of evidence remain limited. Expanding research and audit infrastructure is essential to support professional growth and system improvement.

Professional Culture, Lifestyle, and Work–Life Balance

Work culture also differs. The NHS provides structure, accountability, and professional satisfaction, though workload and administrative burden are high.

Saudi Arabia offers competitive salaries, with similar working hours, but offering greater flexibility. However, hierarchical structures, inconsistent governance, and a defensive professional culture can limit open discussion and reflective practice. Adaptability, diplomacy, and cultural awareness are essential for success.

Conclusion

Practicing oncology in the NHS and Saudi Arabia's government hospitals offers two distinct but complementary perspectives.

The NHS exemplifies structured governance, comprehensive training, integrated organizational systems and targets and a culture of continuous learning. Saudi Arabia offers resources, flexibility, and ambition, yet continues to evolve toward greater transparency, multidisciplinary coordination, and academic engagement.

Experience in both systems has underscored that excellence in oncology is not solely about technology or treatment availability. It depends on how systems communicate, learn, and support both patients and clinicians. When the system coordinates care effectively, the patient journey is streamlined, clinical decisions are informed, and learning is continuous. When these structures are weaker, even fewer patients can demand disproportionate time and effort from consultants and families.

Ultimately, high-quality oncology emerges where clinical science is combined with coordinated systems, reflective culture, and compassion delivering care that is evidence-based, patient-centered, and continuously improving.

Competing Interests

The author declare no competing interests.

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