

Cancer World survey on Cancer Care during the Pandemic: problems and solutions

Who and When?

The survey was conducted between June 4 and June 12 through a mail shot to European oncology professionals who subscribe to *Cancer World* and/or have signed up to receive communications from the European School of Oncology.

What?

We asked 37 questions, grouped under 6 sections. The overall responses, with some breakdowns by discipline, workplace or country, are presented below.

- [You and your workplace – p2](#)
- [Impact on patient outcomes of disruptions to cancer care – p4](#)
- [Clinical decision making – p6](#)
- [Communication with colleagues – p11](#)
- [Communications with patients – p 13](#)
- [Protection of patients and staff – p15](#)

Respondents

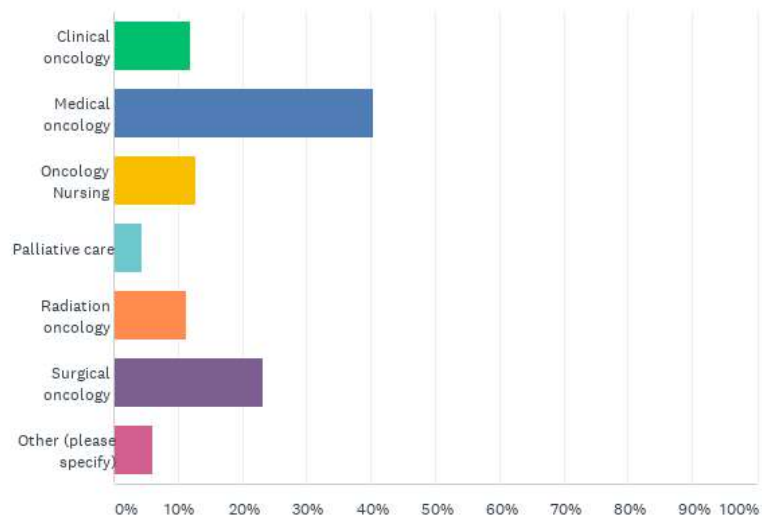
136 people filled out the full survey, from all main cancer disciplines, and specialties across 30 European countries: Albania, Austria, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czechia, Denmark, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Moldova, Monaco, Montenegro, Netherlands, North Macedonia, Norway, Portugal, Romania, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Kingdom.

We contacted selected respondents again in late August to follow up on their responses.

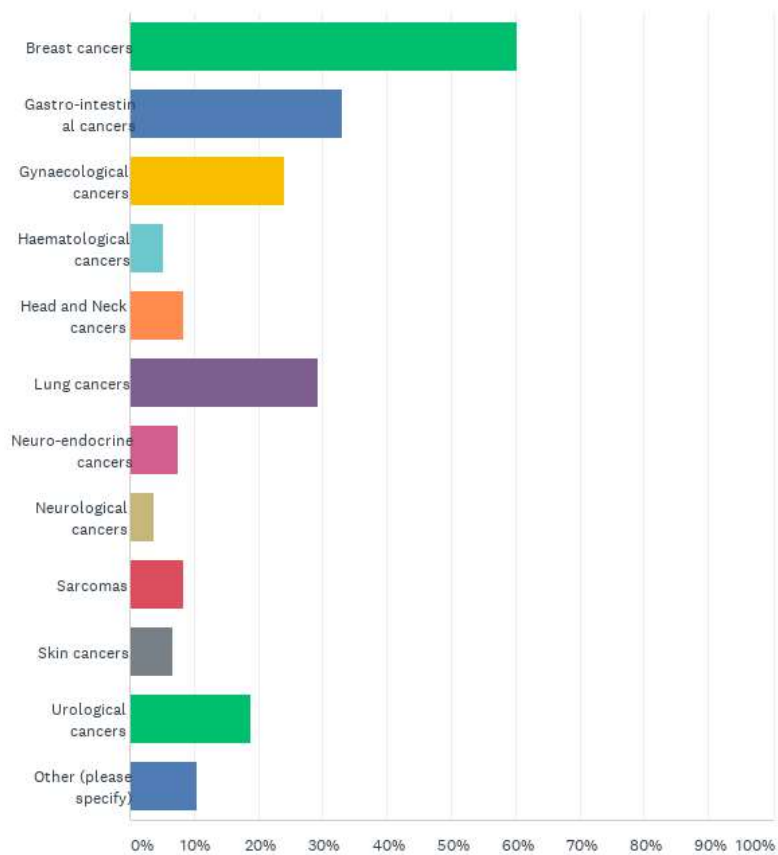
We thank all our respondents for taking the time to respond to this long survey, and for their comments which provide important insights into the impact of the COVID pandemic on the delivery of cancer care across Europe in early June 2020.

SECTION 1: YOU AND YOUR WORKPLACE

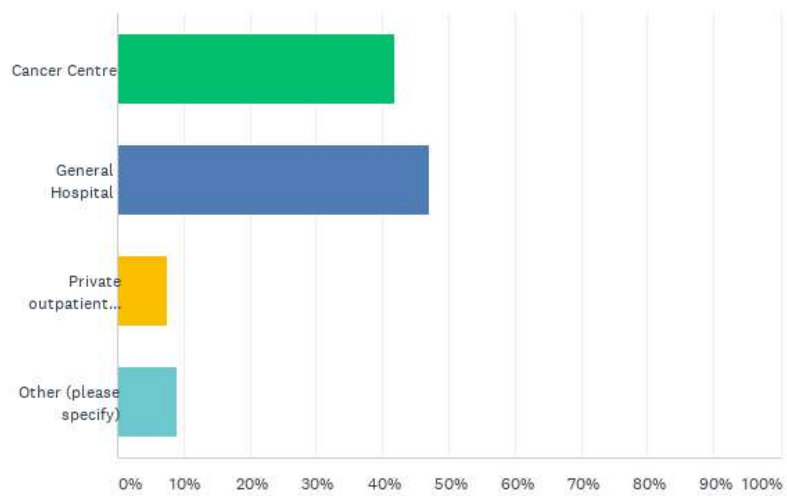
Q1 What best describes your profession/specialty?



Q2 What best describes your specialist area?



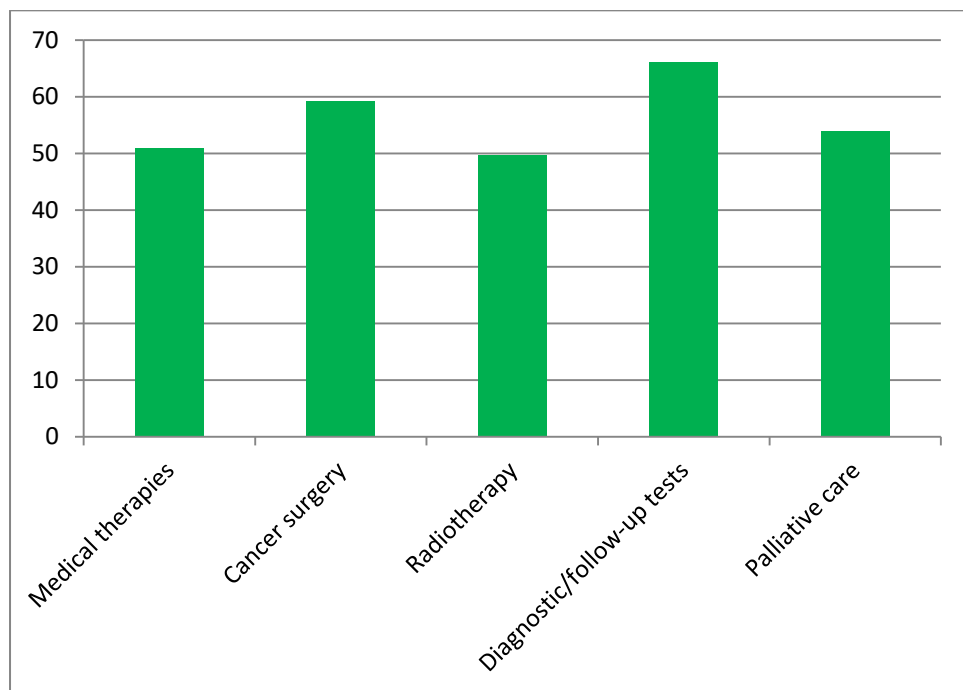
Q4 Is your workplace a



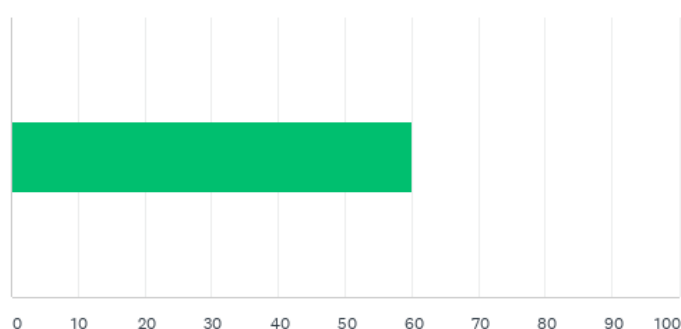
SECTION 2: IMPACT ON PATIENT OUTCOMES OF DISRUPTIONS TO CANCER CARE

Q5–Q9: How worried are you about the impact on outcomes of current delays to delivering: medical therapies (Q5), cancer surgery (Q6), radiotherapy (Q7), diagnostic/follow-up tests (Q8), palliative care (Q9) (0= not worried, 100= extremely worried)

Concerns about delays (Q5–Q9)



Q11 How worried are you about backlogs (how quickly delayed test and treatments will be rescheduled)?



Q10 Please give details about any particular concerns you have regarding the impact of delays and cancellations

- 1 My biggest concerns are about delayed diagnostics like gastroscopy, colonoskopies etc.
- 2 Most delays and cancellations were in follow-up and diagnostic (including screening) exams which will most certainly lead to late diagnosis of both initial cancer and recurrence
- 3 we are working full capacity and there are no delays or cancellations for medical or paliative care on cancer patients
- 4 . N/A
- 5 In Germany this Covid crisis has had no impact on any medical, surgeon or radiology therapy for cancer due to excellent Organisation!
- 6 Delaying the sheedule cancer treatments and investigations are catastrophic for cancer pacients.

SECTION 2: IMPACT ON PATIENT OUTCOMES cont/

7 no concerns

8 There is not clear evidence that delays may protect patients from covid but it is likely that they may affect the outcome

9 I'm afraid the worse delays are seen in the surgical field

10 patient's tumours will become inoperable

11 Mostly involving follow-up and diagnosis.

12 No details

13 Our Hospital is just Oncology meaning that we were not treating any Covid19 patients. This allowed us to keep treating patients. Some of the older ones canceled treatments by fear of hospital environment

14 Mammographic screening should not have been stopped

15 move to higher stages and outcome of therapy

16 Diagnosis, surgeries and follow-ups were canceled or delayed.

17 Medical Oncology treatments have continued as near to normal as possible. Some decisions made not to pursue [pursue] SACT in line with the change in the environment around us.

18 The lack of some drugs

19 palliative care is non-existent in Greece there are important inequalities in access especially for surgery

20 N/A

21 We are storing up a huge problem which will hit us only once patients are able to come back for routine cancer care

22 A cancer cases explosion which were strained by the delay in diagnosis and treatment caused by the pandemic situation.

23 most of the hospitals and specialists (surgeons, anesthesiologists, radiologists) are prepared to be mobilised (if needed) for Covid patients. Delaying diagnostic procedures and operation treatment except for urgent indications. General hospitals cut hospital beds for palliative and supportive care.

24 some changes came to stay to stay particularly in NHS

25 Palliative patients not prioritised causing high distress

26 Delays are mainly due to patients not visiting the hospital or GPs not referring

27 many patients will be diagnosed in metastatic stage instead of local disease...

28 Anxiety in patients waiting for treatment

29 Lack of palliative care support in the home and severe restrictions in visitor to hospice setting Delayed surgeries for upper GI patients

30 In my hospital breast Surgery regularly worked during the pandemic lockdown

31 Screening programmes were stopped for 2-3 months with delay of diagnosis and women didn't go to Mx also in case of symptoms

32 delayed treatment start, lack of follow-up care, increasing fears/uncertainties among patients

33 During quarantine we have postponed a lot of therapy, also our patients are really scared from this situation and are not presented in the hospital especially during March and April it was a strong quarantine in Albania and every medical step was 'frozen' except Covid cases investigating.

34 Referrals not made or delayed so diagnosis delayed. Surgical treatments are more complicated to arrange and neo adj chemo and Herceptin treatments avoided in favour of surgery.

35 In Germany this Covid crisis has had no impact on any medical, surgeon or radiology therapy for cancer due to excellent Organisation!

36 We had no delays and cancellations in my hospital

37 Medical Oncology treatments have continued as near to normal as possible. Some decisions made not to pursue SACT in line with the change in the environment around us.

38 Prevention, diagnosis, therapies

39 At least in Berlin, no delays in cancer care due to Covid

40 Cancellations of inpatient family visits... many die without goodbye

41 bad impact on quality of life and survival

42 Loss of curative opportunity window

43 Delays on diagnostic tests will obviously delay treatment with negative risk for the prognosis of patients. Also very worried about referral, patients are not being referred to units

44 Particular concerns are related to delay of surgery after neoadjuvant therapy for breast cancer

45 As the treatment of cancer patients has not been delayed in our center, my main worry is the delay in the diagnostic tests of not yet diagnosed patients since we have noticed a decrease in this number during the pandemic time.

46 People are at risks of dying at home as a result of total failure of our health system, delays of diagnostics, interventions, basic therapy...

47 We will see more Stage IV-Tumours because patients avoid diagnostic

48 To do diagnostic late and worse physical conditions

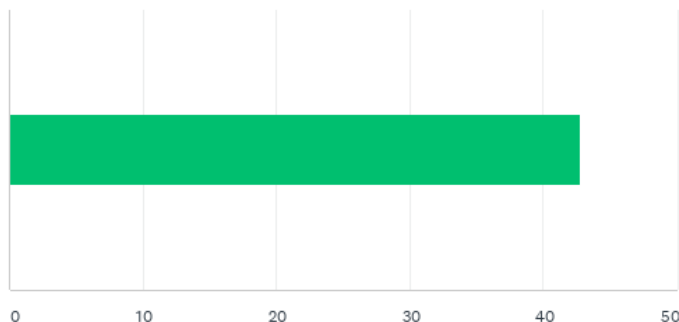
49 They should be evaluated on a case by case analysis.

50 disease progression

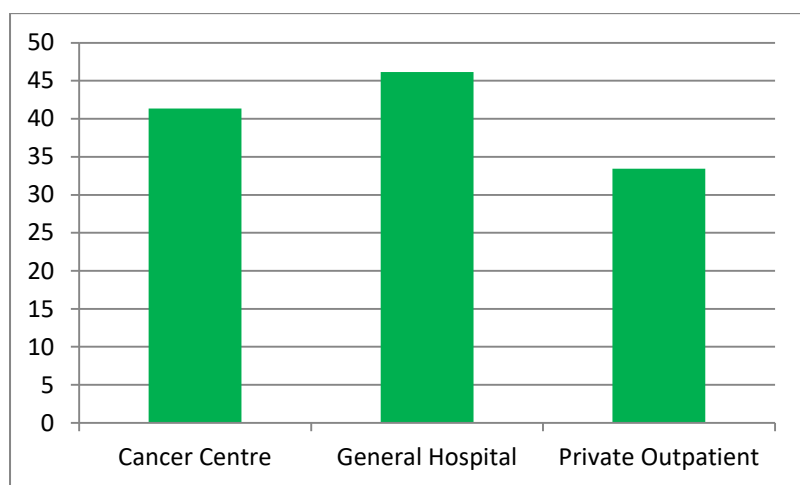
51 We did not have any important delays in Greece concerning cancer treatment

SECTION 3: CLINICAL DECISION MAKING

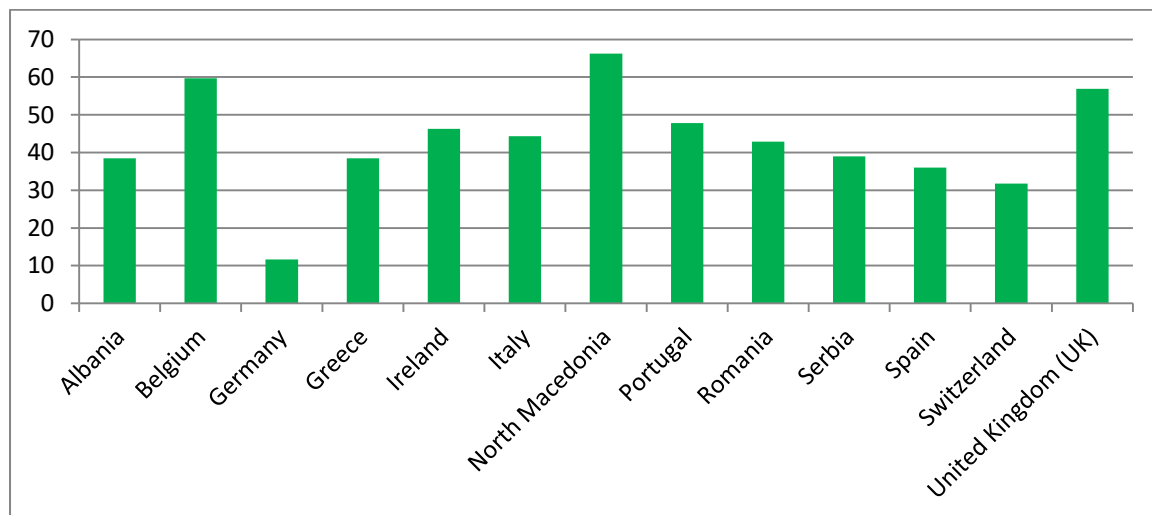
Q12 How often have you had to change the normal course of diagnostics and treatment on account of the pandemic?



Q12 Changed normal course by workplace



Q12 Changed normal course by selected countries



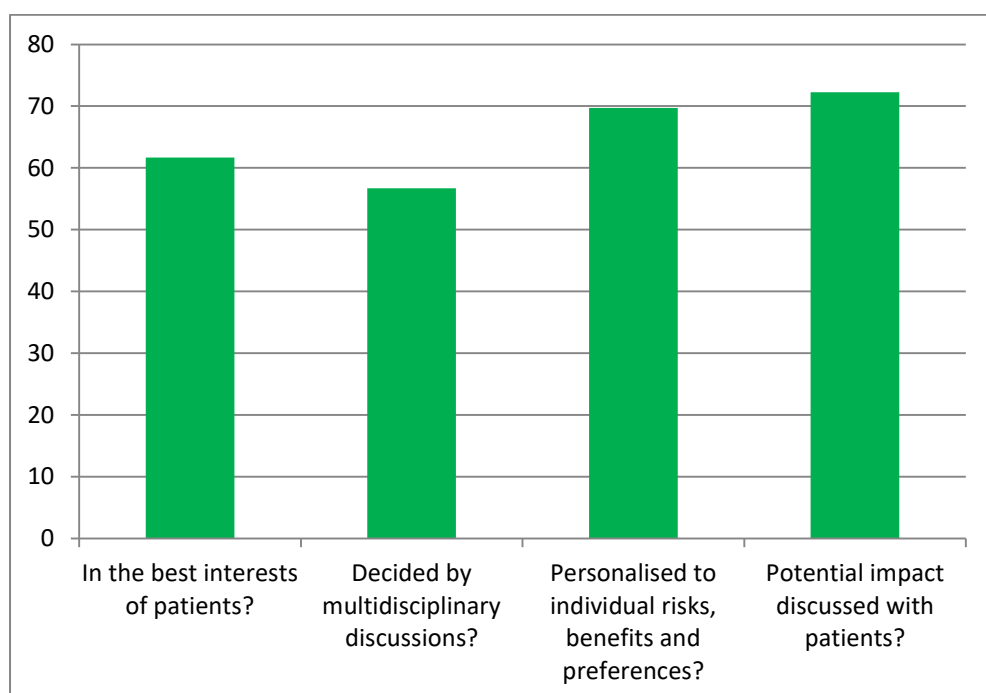
Q13 How confident are you that any changes to standard diagnostics, treatment and care practices are being implemented consistently in the best interest of patients during the pandemic?

Q14 In your experience, how often are changes to standard diagnostics, treatment and care decided by multidisciplinary discussions?

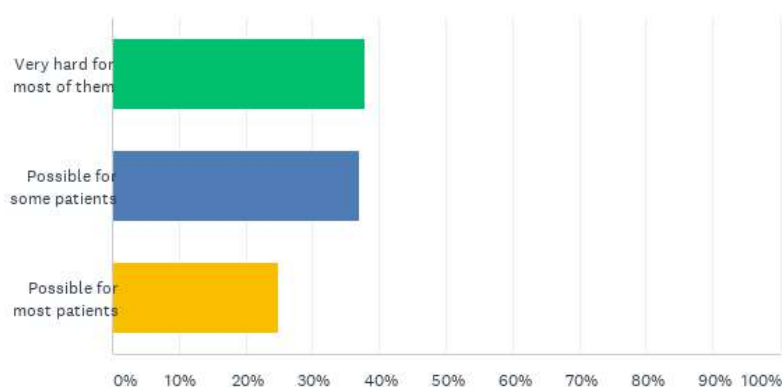
Q15 In your experience, how often are decision on changes to standard care being taken on a patient-by-patient basis in the light of their individual risks, benefits and preferences?

Q16 Is the potential impact of diagnostic and treatment delays being discussed with patients?

Q13–Q16 Were changes to standard diagnostics and care...



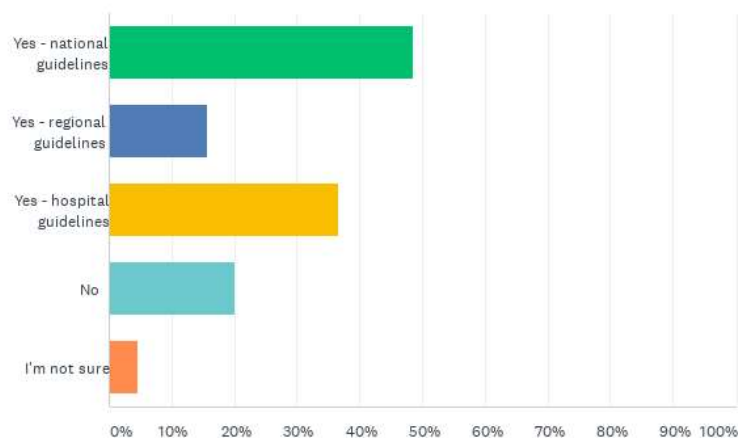
Q17 In your experience, how hard is it for patients to make informed decisions on what is best for them during the pandemic, in terms of weighing up the risk of infection against the risk to their cancer outcome of delays/changes to their diagnostics and care?



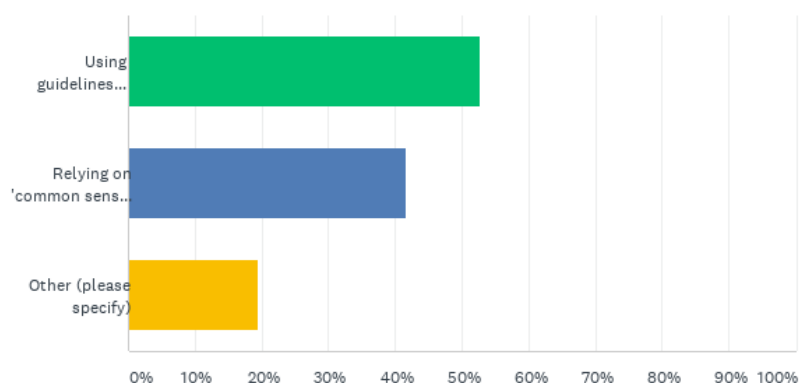
Q18 Please let us know of any particular issues that concern you about clinical decision making during the pandemic

1. because of the social distancing rule, only the patient may come into the doctors cabinet. This disturbs me highly on ethical grounds. nobody should hear bad news about their health on their own; in those moments everybody needs their partner or family/friend
2. My reality is very different from the rest of the country and of most countries. I am very worried about the consequences overall and specially for national health systems
3. staff safety
4. Go to Hub Center to make operations
5. Families are left out. Constantly changing regimens make patients feel unsafe
6. We decided to transfer 50% of breast Surgery in a non covid hospital instead of cutting some interventions
7. We should have more simple standard protocol treatment in emergency like Covid to help us adapt quickly and efficient in help of our patients.
8. Encouraging or discouraging high risk patients to attend hospital for diagnosis due to risk and high mortality rates from covid 19. Moving away from neo adjuvant strategies due to concerns about risks of chemotherapy
9. the limited test of covid19.
10. no one, all the parts of the cancer treatment were to any time possible with no restrictions
11. The aberrant decision of medical authorities to prioritize COVID patients against cancer patients
12. no concerns
13. Lack of consistency or equity
14. In my personal experience most patients were treated as usual despite pandemic. Since screening activity was stopped we treated only symptomatic women (it is my greatest concern).
15. to continue with patient treatment besides the pandemic and not testing all the patient
16. Breast cancer treatment was over the risk of covid
17. Very cold environment discussing such issues. Lack of touch crucial.
18. none particular
19. In my experience there were practically no delays in treatment of already diagnosed cancer care. I fear a significant portion of cases are not being diagnosed right now because patients with symptoms are not going to seek medical advice or are not scheduled to necessary diagnostic tests (e.g. endoscopy) due to restrictions
20. Delivering of immunotherapy
21. neoadjuvant in high risk breast cancer young patients
22. Administrative decisions without hearing from professionals involved in patient care
23. lack of information, lack of access to internet, lack of knowledge how to cope with social media, teleconference, videocalls, e-mails
24. Sometimes changes in the sequence of treatments not discussed with patients in relation to pros and cons
25. Patients delaying treatment by themselves
26. length of previous treatment, prognosis, therapeutic response, previous toxicity of therapy, clinical stage, aggressiveness of the disease, associated diseases, age of the patient
27. lack of public transport
28. Decision making takes longer as we are all spread out at different locations - connecting for a team call just takes more time and effort for all.
29. Neglecting metastatic patients.
30. There is not much impact
31. Test for covid-19, test for hepatitis
32. Informed discussions should be based on evidence - but we miss evidence on the interactions between SARS-CoV-2, cancer and oncological treatments.

Q19 Do you have guidelines about how to prioritise/adapt cancer treatment and diagnostic tests during the pandemic?

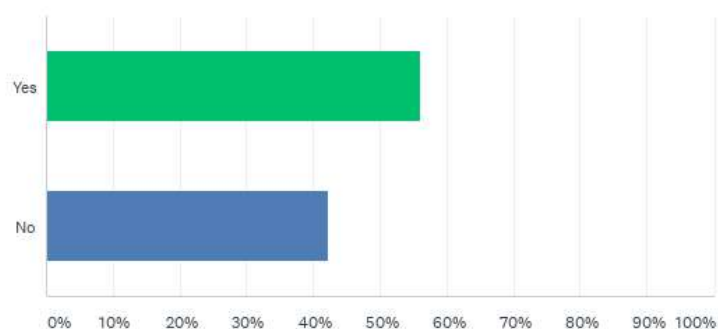


Q20 If NO, are you



Legend: Using guidelines developed by other professional bodies, eg European oncology organisations
Relying on 'common sense' and basic principles

Q21 Do you feel any of the changes to standard protocols and pathways adopted during the pandemic improve the quality and efficiency of care, and should be maintained moving ahead (eg more streamlined ways to deliver care, a more critical attitude to the value of certain interventions or tests for a given patient?)

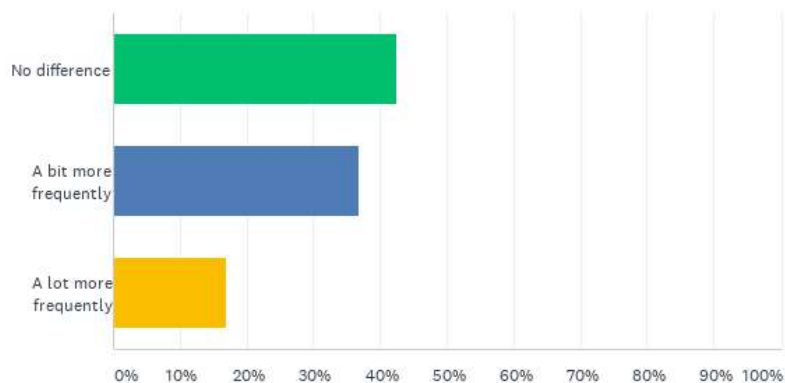


Please give details [of changes to standard protocols and pathways that should be maintained]

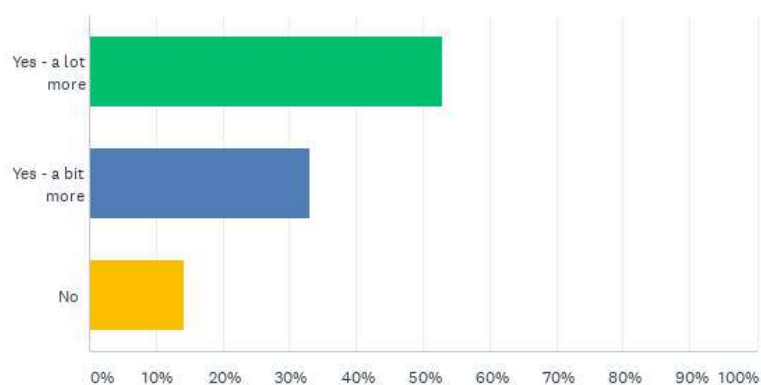
- 1 Use of hypofractionated RT schemes
- 2 The use of telemedicine for some situations; reduction on number of visits to the hospital; less bureaucracy in clinical trials
- 3 Our department moved off site to a university setting. Patients are telephoned 2 days before chemo and screened, attend bloods day before chemo and are screened again and on the day of treatment patients are screened again before entering the oncology ward (screening is a questionnaire and temperature check)
- 4 Electronic therapeutic plans are now standard of care for most of our patients
- 5 Web based discussions can be useful
- 6 Not sure really - my current practice is optimised around our own individual environment – we are making the best of v limited and suboptimal resources.
- 7 there were no changes
- 8 In some cases yes, but certainly not a blanket acceptance
- 9 telephone, e-mail and skype consultations, e-prescriptions
- 10 virtual reviews
- 11 teleconsulting
- 12 fast forward radiotherapy
- 13 N/A
- 14 More telemedicine - real one! - for ordinary complementary results; more hypofractionated radiation therapy schedules.
- 15 more use of telemedicine
- 16 Protocols during pandemic were focused to overcome problems, not to improve quality of care
- 17 we prepare for any other pandemic 6/8/2020 10:19 AM
- 18 Covid19 is not the only risk for a hospital patient
- 19 More realistic assessment of risks and benefits of adjuvant or palliative chemotherapy; better designed circuits for oncologic patients
- 20 Sometimes.
- 21 use of technology
- 22 No changes in standard protocols and pathways were adopted during the pandemic
- 23 Phone outpatient appointments
- 24 Videoconference with patients, daily phone calls to ask them about signs/symptoms, patients education on how to detect new symptoms
- 25 critical judgement of therapies and interventions
- 26 Follow-up made by phone in a number of cases has been very well accepted, has decreased the number of patients in waiting rooms and has given more time for more serious cases. We should maintain this policy.
- 27 Only some changes in follow-up may be of interest even in normal care
- 28 N/A
- 29 Even the applied measures that we have adopted, they created a real mess and confusion... Terrible
- 30 e-consults could replace most of the regular consults in my opinion
- 31 Telephone or video consultations to provide useful information before the clinical encounter. Careful risk-benefit considerations. Critical thinking about diagnostic and therapeutic procedures.
- 32 Some decisions are made faster - we need to think about keeping the pace of decision making post COVID-19
- 33 Reducing the numbers of hospital visits by using telemedicine for patients with oral treatment and no complications.
- 34 fast forward protocol breast irradiation
- 35 national guidelines
- 36 We are just "washing our hands" with guidelines and making sure about "legal implications" not aiming to provide best for our patients.
- 37 For some patients, the follow-up being done over the phone, paperwork that is sent via technology
- 38 adjuvant chemo not given post surgery, fewer RT appointments, fewer face to face appointments
- 39 Hypofractionation of radiation therapy; more selective use of chemotherapy by using predictive tests.

SECTION 4: COMMUNICATION WITH COLLEAGUES

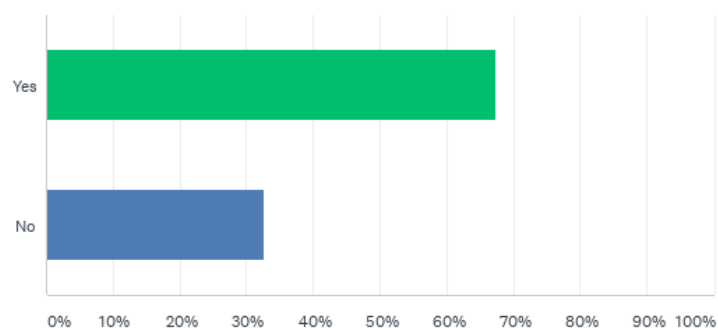
Q22 How have new ways of working affected how frequently you communicate with health professionals outside your immediate team (eg specialists at other hospitals, GPs, hospices, community palliative care teams)?



Q23 Are you making more use of "telemedicine" to minimise travel involved in multidisciplinary team discussions or accessing specialist advice?



Q24 Are there any changes that you have experienced in communicating with colleagues that you would like to see continue after the pandemic crisis is over?

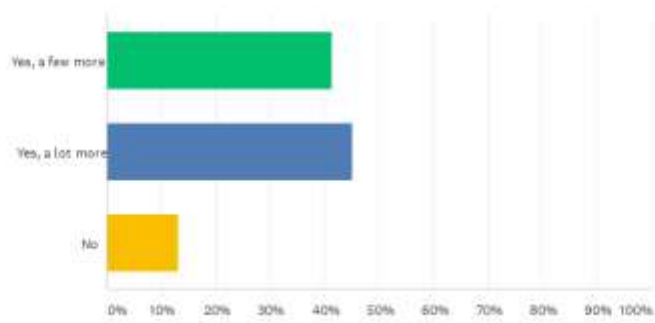


Q24: Please give details [of changes in communication with colleagues you would like to see continue]

- 1 telemedicine
 - 2 more conference calls through canals as ZOOM, etc
 - 3 Having any adjustments to prescriptions completed before the patient is due
 - 4 Some carefully considered use of web-based conferences and telemedicine use improves daily routine
 - 5 Teleconferenecs
 - 6 Web communications
 - 7 Webinar are very interesting to communicate with colleagues of others hospitals
 - 8 more focus on patient safety
 - 9 More online discussions ,conferences ,courses
 - 10 Capacity for remote attendance at MDTs and conferences - increases ability to attend these
 - 11 more frequent communication
 - 12 telemedicine
 - 13 teleconsulting
 - 14 Multidisciplinary meetings online
 - 15 common priorities
 - 16 Restricted access to hospitals for the general population: one patient, one caregiver (on a general basis!).
 - 17 MDM meeting work well as e-working, nonotheless MDM in presence remain important even if can sometime be substituted by online meeting
 - 18 we can understand the different problems according to level of radiotherapy - oncology center and how to use some other experionce in aim to avoid mistakes and have better practices
 - 19 Maybe some more on-line meetings.
 - 20 Better ahead of meeting preparation of cases to be discussed in multidisciplinary meetings that was needed in this context should carry on
 - 21 call meetings
 - 22 All these new webinars should keep going, for more subjects
 - 23 Smarter use of telemedicine
 - 24 Most of them are more open-minded...
 - 25 call conferences
 - 26 telemeetings instead of physical presence
 - 27 Videoconference and webinars should be continued and should be an option for when we can't be present in seminars or similar
- 6/5/2020 10:30 PM
- 28 Virtual meetings we don't have before pandemic crisis, now it would be one of the. new ways in our communication
 - 29 The use of telemedicine
 - 30 more video conference
 - 32 Web meetings
 - 33 Multidisciplinary conferences with video platforms
 - 34 Generally more collaboration
 - 35 Telemedicine for multidisciplinary discussion and for patients who live far from the centers and are taking oral medications with no complications, for example.
 - 36 Meetings by zoom
 - 37 teleconferincing for tumour board
 - 38 everybody had more time during pandemic
 - 39 On line platform for conference meetings (example zoom)
 - 40 virtual meeting
 - 41 e-consult with colleagues
 - 42 reduced travelling and meeting time when doing things online but reduced informal discussions
 - 43 Teleconferences can absolutely not replace life meetings. However, less routine follow-up of patients is a great benefit.

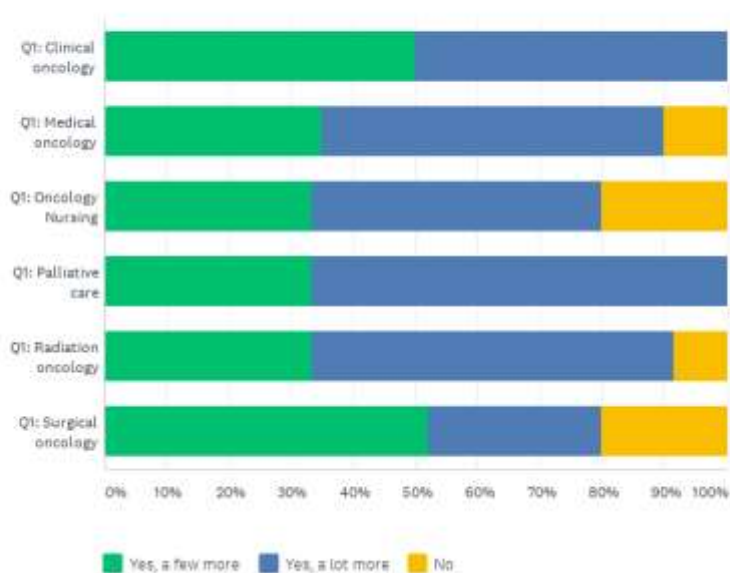
SECTION 5: COMMUNICATIONS WITH PATIENTS

Q25 Are you conducting more patient consultations over the phone/internet?



Q25 by discipline

Q25 Are you conducting more patient consultations over the phone/internet?

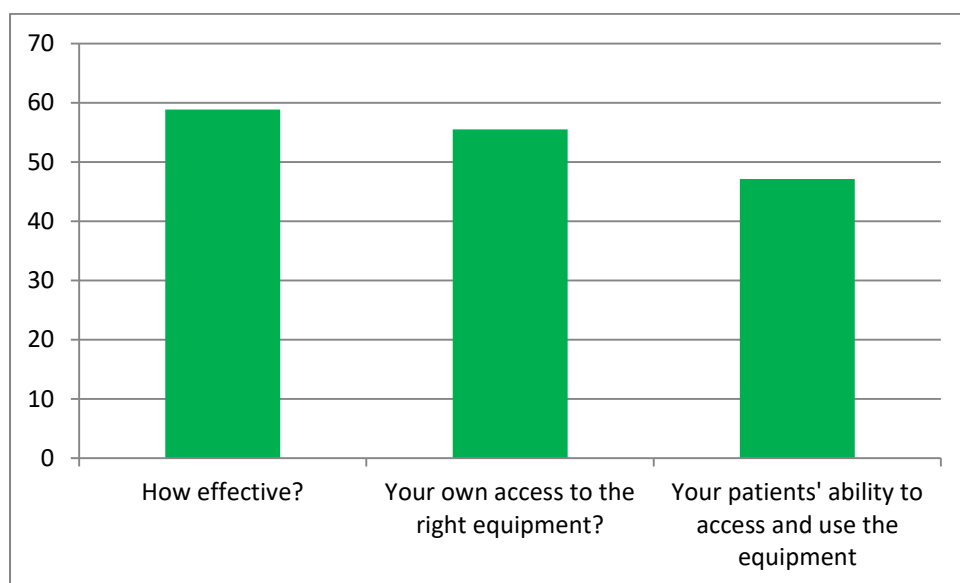


Q26 If you answered Yes, how satisfactory have you found this in terms of effective communication between you and your patients (discussing treatment options, breaking bad news, etc)?

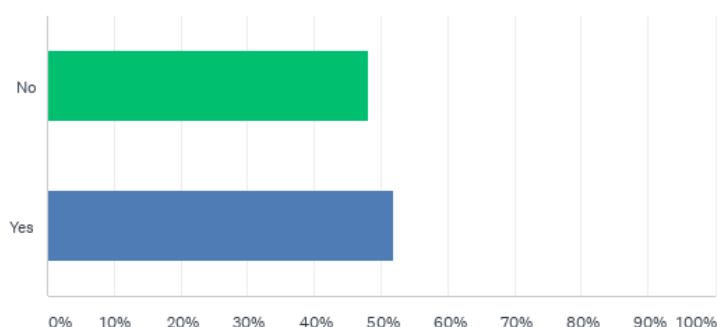
Q27 How satisfactory have you found this in terms of your own access to the right communications equipment?

Q28 How satisfactory have you found this in terms of your patients' ability to access and use the right communications equipment?

Q26–Q28 How satisfactory was using more remote communications?



Q29 Are there any changes that you have experienced in communicating with patients that you would you like to see continue after the pandemic crisis is over?



Q29 Please give details

- 1 elderly people should be more adapted and have more acces to/ knowledge of ZOOM, secured whats app,...
- 2 Less visits to the Hospital
- 3 Pre treatment screening
- 4 tablet therapy is giving in the local centers that is simplify the therapy proces for patients
- 5 Web communications
- 6 to also have time for telephone/internet-based consultation of patients
- 7 I have restrictedtelephone consultations to simple decisions and negative (benign) results. Still prefer face to face consults for complex discussion, bad news or diagnosis (malignant)
- 8 more telemedicine
- 9 facilities in tools for communicating
- 10 contacts by phone in some cases
- 11 We need real phone communication, access to patient image and real telemedicine. Internet communication has many legal obstacles - regarding to laws about personal data protection. A real barrier.
- 12 some communications with patiens could be done with telemedicine, but hospitals have to give the equipment to do it
- 13 more confidence between patients and doctors
- 14 More use of technology can (in selected cases) be a part of follow-up for some patients in some situations
- 15 phone and tablet instruments

SECTION 5: COMMUNICATIONS WITH PATIENTS cont/

16 Easiness of communication

17 Use of videoconference improves communication, it is better than phone calls but it depends on patients age

18 Some issues (e.g. control blood tests) can be discussed avoiding access to the clinic

19 Patients could stay less amount of time at hospital what will improve patients quality of life

20 more contact per e-mail

21 For some follow up consultation doing them by phone is excellent

22 The social network

23 Follow-up visits avoided

26 Telemedicine allows patients (and their families) to engage in the consultation process

27 The awarenesses of what is really necessary for their pathways

28 talking a lot more , even if it is on the phone

29 Telemedicine works quite well and can be used more often after pandemia ends

30 Nationwide equipment and platform for secure communication with patients (eg. Handset with data link and secure application that could be delivered to patient home in order to do teleconsultation)

31 More use of e-mail

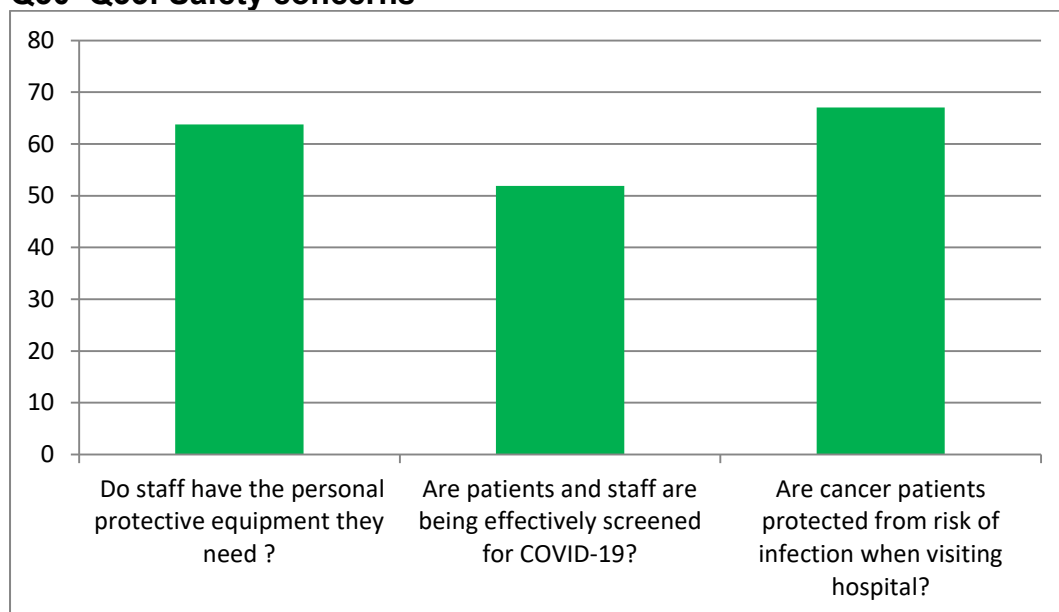
SECTION 6: PROTECTION OF PATIENTS AND STAFF

Q30 Based on your current experience, how confident are you that oncology professionals across your healthcare system have the personal protective equipment they need to deliver care in a way that protects staff and patients?

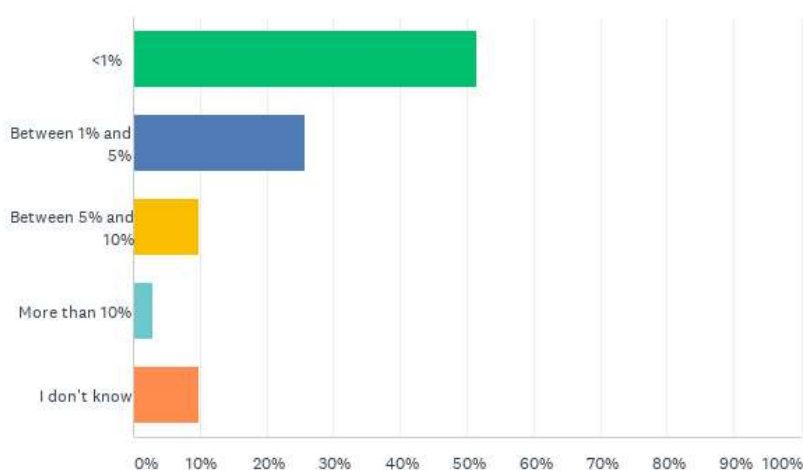
Q31 Based on your current experience, how confident are you that patients and staff are being effectively screened for COVID-19?

Q33 Based on your current experience are you confident that cancer patients on active treatment are protected from risk of infection when visiting hospital (eg through separate waiting rooms and entry/exit routes)?

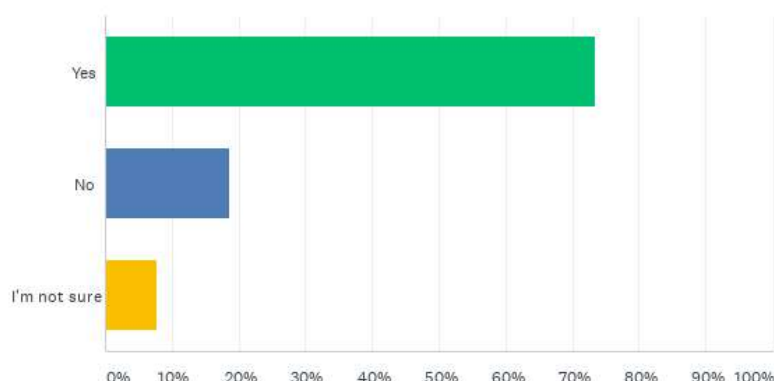
Q30–Q33: Safety concerns



Q32 What are the current rates of suspected COVID-19 infections among staff in your department?



Q34 Do you have protocols in place about how and where to treat cancer patients diagnosed with COVID-19 while on active treatment?



Q35 If you have particular issues/experiences relating to the protection of patients and staff during the pandemic, please detail them here.

- 1 its a shame that in 2020 health caregivers do not have enough personal protection materials!
- 2 We are not rated in a high level in the field of protection of our staff ,personel and patients because we are missing the equipments of protection
- 3 Here in Wales covid 19 testing for staff seems very difficult and I have been refused testing 3 times. Patients for surgery tested after 14days isolation - surgical teams NOT tested at all.
- 4 With more than 400 cancer patients/year we have had no one with Covid
- 5 "hygien and evaluation filter" at entrance, patients suspected of infection were evaluated at special office by entrance, febrile patients with cough and dyspnea were isoated at expectation ward, staff and patients were using masks
- 6 we are not a Hospital dedicated to Covid 19 treatment
- 7 during first period of pandemic patients were treated without covid screening as well as doctor and nurses. Now both patients and doctors/nurses are screened. Surgical pts make nasopharyngeal microbiology 2 times before surgery. If positive surgery is delayed if possible.
- 8 we have departement for epidemillogy which was involved all the time in protection of staff and patients
- 9 All elective admissions in the hospital are currently screened in regard to Covid right now. No scheduled surgical procedures during an active Covid infection.
- 11 If a patient has fever - he/she is no longer treated until COVID 19 is excluded. It is impossible to treat effectively like this
- 12 Using complete equipment as both the patient and the doctor are infected
- 14 We do not perform screening on cancer patients and between health workers, we usually do the testing acoording to already developed symptoms...
- 15 As far as possible see cancer patients in facilities where there are NO COVID-19 patients.