

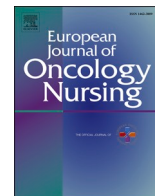


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# European Journal of Oncology Nursing

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## Guest Editorial



## How did SARS-CoV-2 changed the landscape in cancer care

A global threat to public health began in late 2019 with the onset of the COVID-19 pandemic from the SARS-CoV-2 virus. In January 2022, 373,229,380 cases were reported worldwide. Acute respiratory failure caused the death of 5,658,702 people worldwide ([WHO Coronavirus \(COVID-19\) Dashboard, 2022](#)). Vulnerable groups of patients such as the elderly, patients with chronic diseases (heart and lung diseases, cancer), immunosuppressed and others were disproportionately affected by the virus compared to the rest of the population. The implications for health systems were detrimental as the systems were unprepared to effectively deal with the increased demand placed on them, revealing their vulnerability to manage such an acute crisis. The complex implications of the pandemic were expanded to include the overall health status of the people, the poor economic progress (on a global scale), the lack of trust in governments (partly due to poor pandemic management), and the threats to the social cohesion, to report but a few ([OECD, 2022](#)). Health systems are constantly adjusting throughout this period, adapting their philosophy to life-saving, enhancing specific services such as emergency, SARS-CoV-2 units and ICUs, and redesigning staff allocations; with their resilience constantly being challenged ([Sagan et al., 2021](#)). At the same time the resilience and wellness of health professionals are also tested, given their physical and mental exhaustion, the need to make of difficult decisions concerning patients' lives, the management of frequent contact with death and their personal isolation from their loved ones ([Baskin and Bartlett, 2021](#)).

Cancer patients throughout the disease continuum are a high-risk group due to the severe outcomes of SARS-CoV-2 infection ([Alom et al., 2021](#)). In terms of cancer care, the consequences of the pandemic are multidimensional and primarily include limited or no access to screening and diagnosis (e.g. appointment cancellations, late diagnosis), and diminished access to treatment and care (e.g. cancellations, delays, drug shortages, changes in nursing practice) ([Dhada et al., 2021](#); [Lawler and Crul 2022](#)). The numbers are indeed staggering on the impact of the pandemic on access to treatment and access to screening and diagnosis. Even with modest estimations, some 100 million of diagnostic tests have not been performed in Europe ([Lawler and Crul 2022](#)). This means that potentially as many as one million Europeans may be walking around with an undiagnosed cancer, while one in two Europeans with cancer did not receive the surgery or chemotherapy that they needed in a timely fashion ([European Cancer Organisation, 2021](#)). This diminished access to screening and care poses a great threat to the already existing and widening inequalities in cancer care. A recent Action Report by the [European Cancer Organisation \(2021\)](#) “*It Can Be Done – Beating Inequalities in Cancer Care*” shines a much-needed spotlight on inequity that exists in all parts of cancer care, in all countries in Europe and highlights that with the SARS-CoV-2 pandemic the need for mitigation measures is now more than ever necessary. The report identifies readily available policy mechanisms that can be deployed immediately to bridge gaps and raise standards and outcomes in cancer care.

The barriers to access are not only organizationally-based but are also driven by the fear and anxiety of contracting SARS-CoV-2 that the patients are often experiencing (for oneself, family, etc.). At the peak of the pandemic, many patients often found themselves struggling between poor communication and misinformation about cancer and SARS-CoV-2, which limited their ability to make informed decisions about their care. This exacerbated the burden experienced by informal caregivers who had to manage the consequences of COVID-19 on their personal and family life additionally to the demanding care that cancer entails. This impacted them emotionally and socially limiting their resilience and coping mechanisms that in turn negatively influenced their ability to meet the requirements of their caregiving role. These accumulated consequences of SARS-CoV-2 resulted in patients becoming prone to poor health-related outcomes.

Organizational issues related to the care of cancer patients added to their vulnerability. These organizational issues go beyond the issues of access and include staff shortages and lack of protective equipment, the limited capacity of hospitals, the need to reduce the physical contact of staff with patients, or treatment modifications. (e.g. treatment delays and interruptions).

The need to maintain distances (i.e. social distancing) for the safety of every human being in the period of the pandemic, in all aspects of his/her life, such as distance in education, distance in entertainment, distance at work, as well as distance in health care, in the general public and also in the care of cancer patients was also deemed necessary. Consequently, there was an urgent need to develop alternative methods of care and monitoring for cancer patients ([Mohseni Afshar et al., 2021](#)). This required in many cases a service transformation to ensure that there was a required safe distance between patients and health professionals and between patients themselves where physical presence was compulsory ([Leung et al., 2020](#)). Community care with the use of technology has gained ground in the effort for transformation in the provision of care to cancer patients, in the post-COVID-19 era ([Laughlin et al., 2020](#)).

Clinical applications of technology including telemedicine, telenursing, virtual consultations and generally remote interaction seemed to replace in-person visits, in the fields of diagnosis, triage, treatment, patient monitoring, and palliative care depending on the type of cancer and its severity

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(Kaye et al., 2020). This emerging need has been embraced by National, European and International professional organizations (Tartarone and Lerose 2020). On the basis of this technological framework, a large number of outpatient visits can be replaced by tele-visits, the treatment of patients is moved to the home as oral chemotherapy and intravenous therapy at home replace the traditional intravenous treatment in the hospital. The utilization of mobile applications gives the opportunity to monitor and support patients at home, as well as a means to provide patient e-education and information. Similar transformations occurred in the home and palliative care settings where mobile palliative care units can take care of patients at home by adhering to safety protocols, while end-stage care and bereavement support are indicated to be done at home using technology as well as day care for which home activity videos were developed (Fadul et al., 2021).

The conditions imposed by the pandemic and the global care crisis that followed opened up new horizons for both patients and healthcare professionals when it comes to the most appropriate place of care for patients. The pandemic has demonstrated the high potential of remote monitoring and caring of patients when conditions do not allow their physical presence but it is also an aspect to be considered and evaluated on a routine basis. The pandemic has caught the healthcare systems by surprise; however, we can be certain that it will not be the last pandemic we face. We therefore need to be initiating a wider transformation at an organizational level to allow the restructuring and financing of these new models of care towards a more resilient health delivery system. The development and implementation of new care protocols and the appropriate increase in the digital literacy of those involved in the care along with other sustainable measures are the way forward.

### Declaration of competing interest

The authors have no conflicts of interest to declare.

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