The clinical fallout of organizational resilience in oncology during the pandemic

It was October 2020 when we started thinking about this special series for the *Mediastinum* on "Changes in management of mediastinal tumours following the surge of COVID-19 pandemic". At that time, we were leaving behind us the first wave of the COVID-19. Although a second-wave was predictable, and further medium-size epidemic expected up to 2022 (1,2), it was still not clear to many that a return to the previous status quo, mistakenly referred as the normality, would not happen ever again. It was far from a nihilistic approach, actually, the opposite. We thought it was realistic to think forward how we could have championed a necessary change for our patients, moving from an early to a delayed phase response. In a managerial approach, this process implies an essential skill and attitude, namely organizational resilience, which could be defined as "*the ability to anticipate*, *prepare for*, *respond and adapt to incremental change and sudden disruption to survive and prosper*" (Denver, 2017). After the COVID-19 outbreak and its impact on people and systems, restoration could be supported only by myopic as much as unrealistic effort. Instead, we have been loudly calling by this pandemic to leave our comfort zone, make necessary changes to our clinical offer, monitor and verify if these changes could become long-term improvements, learn the lesson, and anticipate further possible adjustments (see *Figure 1*). Several practical examples of long-term clinical enhancements have been doing, particularly in oncology, include more extensive use of telemedicine (3,4); limitation to unnecessary diagnostic, as well as therapeutic, procedures; the triage of our outpatients and more attention to their frailty; a preference for more convenient, less toxic and long-lasting, but equally effective, treatments (5); the building of more effective international collaborations, for example, by creating disease registries to monitor and review facts and assess changes (6). Some new, or, in some cases, not very new challenges have been spotted and still need adequate solutions, include the inequity in the access to treatments, especially in non-universalistic healthcare systems (7). The criteria we need to use to refer patients to active although still palliative treatments or to acute escalation treatments; inadequate clinical spaces and organizations; the distraction of clinical research, business and resource deployments to other non-oncological areas of medicine.

With this view, we welcome each reader to consider the papers included in this series. Expert authors from high-volume and referral cancer centres shared their clinical experience maturated during the pandemic surge. They discuss those needed long-term changes and improvements in the diagnostic and therapeutic paths of mediastinal tumours.

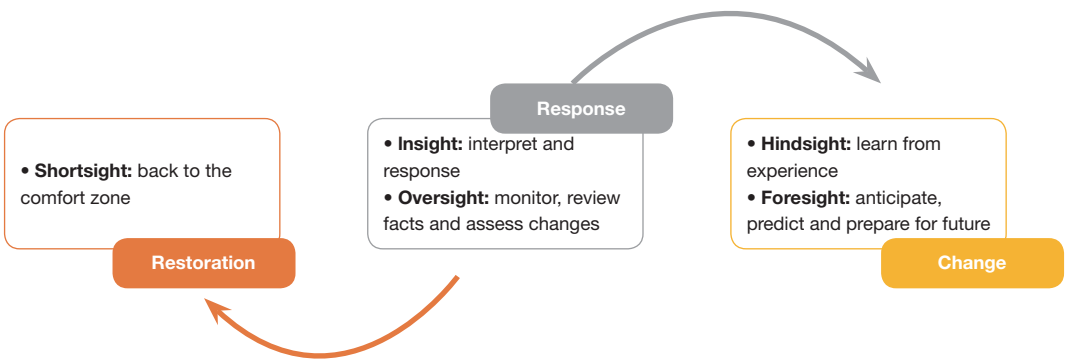

Figure 1 Clinical fallout of organizational resilience.

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