RESIDENT VOICE

The Impact of COVID-19 on Radiation Oncology Department Workflow in the United States

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Oncologic care care is situated at a uniquely troubling intersection between the desire to safeguard a vulnerable patient population from COVID-19 while providing necessary treatment in a timely manner so as to not compromise oncologic outcomes. Cancer patients are deemed particularly susceptible based on age, performance status and, frequently, immunosuppression secondary to ongoing systemic therapy, among other sociodemographic and treatment-related factors. With about 50% of cancer patients receiving radiation therapy as part of their management,[1] radiation oncology departments across the country have rapidly implemented appreciable adaptations to workflow while contemplating major questions, including: What is the best way to prevent exposure? What is the optimal timing for delivering radiation therapy? How will changes in clinical decision-making affect the future? While some answers remain elusive, other solutions are effectively addressing concerns.

Extensive efforts are underway to minimize exposure and disease spread. Patients and health care workers are often required to use separate entrances and undergo separate screening. Upon arrival to the radiation oncology department, patients again undergo screening and further triaging,[2] with appointments at spaced intervals when possible to minimize prolonged overlap in the waiting room. For urgent clinical scenarios in which a COVID-positive patient must receive radiation therapy, all equipment is sterilized. Treatment breaks are another issue for newly diagnosed COVID patients, as Centers for Disease Control and Prevention (CDC) guidelines propose a 14-day minimum quarantine,[2] increasing treatment package time and sacrificing confidence in local control. To pre-empt these potential breaks and minimize health care visits even for COVID-negative patients, the American Society for Radiation Oncology's (ASTRO's) COVID-19 recommendations urge using hypofractionated treatment regimens when appropriate.[3]

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A paradigm-shifting adaptation to department workflow is the increasing use of telemedicine.[2] This transition has been absolutely instrumental in minimizing exposure for patients and health care workers alike while reducing workforce numbers. All the while, it is crucial that we ensure patients do not feel socially isolated or abandoned by their health care providers in a time of great uncertainty while already struggling to overcome the emotional turmoil inherently associated with a cancer diagnosis.

For now, as radiation oncologists are increasingly called to assist colleagues managing a seemingly endless number of COVID-positive inpatients, there has not yet been explicitly documented evidence of a strain on the radiation oncology workforce to the point of compromising throughput. If further deployment should occur, let us never lose sight of the supreme privilege in practicing the healing arts, whatever that may entail.

As country physician Dr. William Victor Johnson said in *Before the Age of Miracles*, “No one can do better as there is no one else here.”[4] Most certainly, we are here to fulfill our duty to patients across the world. Beyond being radiation oncologists, we will always be – first and foremost – physicians.

References

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