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Editorial debate: Challenges an oncologist has to face during the SARS-CoV-2 pandemic within a universal healthcare system

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In these dramatic days of the SARS-CoV-2 pandemic, what is our role as oncologists in a country like Italy, characterised by a very high prevalence of the Covid-19 infection and high mortality rates, and a universal healthcare system?

The answer looks easy: continue to guarantee the best care to cancer patients in order to avoid leaving anyone behind.

True, but it's not as simple as it looks.

Our healthcare system is overwhelmed by the number of critically ill patients, by the need for beds and ventilators in our intensive care units (ICUs),[1] not to mention the very serious situation facing many physicians and nurses working in war-like conditions, becoming infected and sometimes dying from Covid-19.

Yet, almost no one is allowed to mention the word "triage" in the media; we simply cannot induce panic by suggesting that we are unable to continue treating all patients coming to the ICU the same way. It is hard to admit, but triage is still a cornerstone in the management of catastrophes such as the current pandemic, although it will always be an unresolved ethical issue.[2]

Should we do triage too, as oncologists, in our wards?

I think the answer is yes, although this is a tough decision for all of us, especially in a universal healthcare system like ours.

Right or wrong, too many cancer patients still receive treatments which won't have any impact on their survival[3 4]; indeed, the survival gain of many later-line therapies is extremely limited, at best.[3] Furthermore, we know that mortality within 30 days from chemotherapy is as high as 8.1%, even in a top European institution such as the Royal Marsden in London.[5]

However, many of us are used to administering relatively useful anticancer treatments, because ultimately these treatments are reimbursed (at least in a country such as Italy); this is because patients often ask for further therapies (especially when not adequately informed about their prognosis), and because it is definitely easier to prescribe a new agent, instead of trying to explain that end-of-life care is sometimes the most ethical, although tough, choice to pursue.[6]

Now, in order to protect our patients from the unnecessary harm that may result from being admitted to hospital during a pandemic, as well as to preserve valuable resources for the management of Covid-19 patients, we should start revising this attitude.

After having consumed a very large amount of research resources, at the expense of other disciplines such as infectious diseases, it is now time to reconsider our role in medicine, and go back to the roots of a close and personal relationship with our patients. Furthermore, we should cease to consider patients as a source of economical income for our institutions, and instead do what is best for them and not what is economically convenient.

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