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### Multidisciplinary tumor boards as videoconferences — a new challenge in the COVID-19 era



The coronavirus disease 2019 (COVID-19) pandemic mandates reduced direct personal contact. In oncology, multidisciplinary tumor boards are considered best practice in management and decision making for cancer patients worldwide.<sup>1</sup> However, their performance is variable and depends on four factors: holistic and clinical inputs, radiology, pathology, and meeting management.<sup>2</sup> Videoconferences as an alternative form of communication among medical professionals carry the risk of loss of relevant information and decreasing meeting discipline, thus enhancing the risk of wrong decisions or recommendations.<sup>3</sup> Therefore appropriate technical solutions and regulations for participants are of crucial importance to maintain high quality in oncological care.

#### Technical issues:

- Appropriate conference software concerning data protection and communication options, such as presentation of individual participants' screens.
- Capable and rapidly available information technology support.
- Internet access with sufficient and secured bandwidth, especially in wireless settings.

#### Participants' issues:

- Definition of a 'videoconference environment', that is, avoidance of group workrooms, adequate illumination in individual workplaces, and high-quality 'radiology-grade' computer screens.
- Use of headsets for optimized speech transmission and avoidance of acoustic feedback.
- Briefing of participants who are not familiar with the conference software.

Potential limitations affecting the interactions between decision makers:

- Distraction by external stimuli such as incoming emails or telephone calls, colleagues, smartphones, or other activities.<sup>4</sup>
- Unusual 'conference atmosphere' in the participants' own workplace or at home.
- Loss of individual concentration in longer sessions.
- Comprehension problems if more than one person speaks at one time.

Consequently, regulations for videoconferences need to be defined:

- Definition of a moderator.
- Strict 'communication hygiene'; that is, only one participant speaks at one time.

- 'Videoconference dedication': no parallel routine duties/distractions.
- Permanently visible and audible participants: unmuted microphone and camera.
- Consider breaks in longer videoconferences (>60-90 min).
- Meticulous radiological demonstration of imaging studies.
- Common consent at the end of every individual discussion and online written documentation of this consent.
- Common sign-in at the beginning, with confirmation of attendance of decision makers.
- Common sign-out at the end.

Radiology carries particular significance because usually radiological findings are demonstrated using dedicated rooms and screens to show even discrete changes.<sup>2</sup> Inadequate workplace illumination and low-quality computer screens may compromise the perception of such changes. This necessitates a meticulous preparation and demonstration of imaging studies, partly in enlarged images to overcome poor screen resolution.

When introducing videoconferences in routine multidisciplinary tumor boards, the essential regulations should be summarized and distributed (e.g. as a leaflet). During the introduction phase of videoconferences it needs to be accepted that the time efficiency of the conferences may not reach the usual level.

In conclusion, the introduction of videoconferences is challenging and needs cooperation of all participants. Prospectively, videoconferences may become a standard due to the absence of traveling times to conference rooms, the option to share comprehensive diagnostic findings online, and the opportunity to involve subspecialists, who are only occasionally needed or who work in remote institutions.

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