

Challenges in urology during and after the COVID-19 pandemic: a trainee perspective

BY MEGHANA N RAMACHANDRA

ONLINE
EXCLUSIVE

The COVID-19 pandemic has affected urological practice in many ways and at all levels. Social media has been set alight with the hashtag #NoTrainingTodayNoSurgeonsTomorrow highlighting the undesired consequences of the reduction in training opportunities. The impact has been considered by statutory education bodies including the General Medical Council (GMC), who have made it clear that the outcomes for training still have to be met and the bar for completion of training will not be lowered. It is therefore essential for training needs to resume safely and trainees should take opportunities where possible to maximise their training needs.

The Joint Committee of Surgical Training (JCST) and the Royal College of Surgeons in UK and Ireland have recognised the disruption to training caused by the pandemic. During final Annual Review of Competence Progression (ARCP), an outcome 10 was introduced in July 2020. This was a 'no fault' outcome that considered training disruption. An outcome 10.1 was awarded where a trainee was seen to be making satisfactory progress to date but had a delay in achieving competencies due to COVID-19. Outcome 10.2 was awarded if a trainee was at a critical progression point and needed additional training time [1,2]. Analysis by Clements et al. showed that one in eight trainees in their final year have had their training extended through inability to achieve required competencies and more than a quarter entered their final year of training below their expected training trajectory [3]. With the current rate of consultant retirement, extension of training for a large number of trainees will have consequences on workforce planning and service provision. This will affect the availability of training numbers for trainees progressing through within the regions and at the other end may have an ill-fated effect of having inexperienced trainees in consultant posts.

In March 2020, the World Health Organisation (WHO) declared the COVID-19 pandemic, which affected every nation. In accordance with the advice conveyed at that time by the scientific community, measures

were taken by government and public health bodies to control the spread of the virus. These ranged from social distancing to complete lockdowns. To accommodate for the influx of patients affected by COVID-19 on the healthcare system, medical, nursing and other allied healthcare professionals were redeployed to the departments most affected. These included ventilated bed spaces (HDU / ICU / theatre recovery areas) and multiple wards caring for patients affected by COVID-19, where in-patient care was needed.

All routine and urgent elective surgical procedures were initially cancelled [4]. Although COVID-19 did not directly affect the urinary tract, urological services, like other specialities, were affected due to redeployment of staff and shortages of hospital resources. The method of 'clinical prioritisation' of waiting lists was implemented (as per Federation of Surgical Specialty Associations (FSSA) guidance) and, in large part, procedures for benign pathology were discontinued. This included circumcisions, surgical procedures for urinary incontinence, benign scrotal pathology and benign prostatic hyperplasia [5,6]. Where possible, procedures under local anaesthetic were encouraged to avoid the risk of transmitting COVID-19 during aerosol generated procedures. Nephrostomy services were utilised, and a nephrostomy insertion was favoured over ureteric stenting under a general anaesthetic, in certain cases of obstructing infected stones.

Operative logbooks of trainees have confirmed a significant reduction in recorded operative experience in 2020 when compared to the same period in 2019. A further second dip was recorded, which coincided with the second wave of the pandemic in the UK. The JCST in conjunction with the Association of Surgeons in training (ASIT), the British Orthopaedic Trainees Association (BOTA) and the Confederation of Postgraduate schools in surgery have laid out a framework to address the training issues. These include minimising redeployment of surgical trainees, maintaining elective surgery and the delivery of training in 'COVID-light' sites as well as independent sites where NHS patients are being

treated. Regular meetings between clinical supervisors and trainees to identify bespoke training needs and action plans have been encouraged. Innovative simulation-based training has also been encouraged to regain the lost opportunities [3].

Face-to-face outpatient clinics were initially cancelled, but later reintroduced as 'virtual' clinics, where consultations were either telephone or video-led. In our department, all referrals were triaged by consultants. Telephone consultations identified certain patients requiring a further face-to-face appointment. Potentially difficult video-led or telephone consultations were identified (patients with visual and hearing impairments) and these patients were brought in for face-to-face appointments. Patients had their COVID-19 status pre-checked at the designated off-site testing centre and were told to isolate for 48 hours prior to attending their appointment.

Teaching and training programmes have moved onto online platforms and this has been highly successful in keeping up with the prescribed syllabus. The British Association of Urological Surgeons (BAUS) and the Royal Society of Medicine (RSM) Urology Section have been championing novel techniques of remote learning via teleconferencing, webinars, up-to-date evidence-based online lectures and guest lectures from experts. These have mostly been free of charge to trainees. Having access to webinars and teaching sessions on demand, has allowed me to learn and re-visit at my own convenience. Regional teaching sessions were predominantly conducted through Microsoft Teams and Zoom. Travel and facility hire costs have been significantly reduced due to the utilisation of virtual learning, however the lack of human interaction and networking amongst trainees has been significant and much missed [7].

The negative impact on trainees' mental health and well-being has been reported [8-10]. A cross sectional survey of junior doctors' well-being during this pandemic highlighted increased fear of contracting the virus and increased levels of severe anxiety. This study identified that the majority of the surveyed junior members were experiencing

increased levels of depression and suffering from nightmares when compared with senior colleagues. The authors have suggested the need for establishment of robust psychological support mechanisms and provide resilience against long-term mental consequences amongst trainees.

As surgeons, we are becoming more aware of the interaction of human factors at work and the association with patient safety and medical errors [11]. Decision making and cognitive functioning are affected by tiredness and fatigue [12]. Hospital trusts are making every effort to ensure doctors and other allied healthcare personnel are given adequate time off to prevent tiredness and burnout. Virtual resilience training and well-being webinars have been rolled out to protect the workforce and in turn reduce clinical error [13-15]. Performing surgical procedures during the pandemic in full personal protective equipment (PPE) affected both verbal and non-verbal communication amongst team members. An awareness of the impact of these is crucial to the prevention of medical error and hence the Royal College of Surgeons of Edinburgh has made the Non-Technical Skills for Surgeons (NOTSS) course entirely free online [16-18].

Working together during this pandemic has flattened certain hierarchies within the workforce and has resulted in appreciation for colleagues and the expertise of different individuals. This period has highlighted that teamwork and focused goals are key to the delivery of effective patient care. Another critical proponent for development of surgeons irrespective of seniority is reflective practice (RP). It promotes excellence in patient care, and is a conscious effort, using a structured framework to think about an experience or an event to develop an insight. Reflective practice has a major role in making complex decisions with regards to service.

At the start of the pandemic, I was a first-year core trainee (CT1) based on my general surgical rotation at a busy university teaching hospital. I was deployed to be the doctor on the surgical high care (SHC) and intensive care unit (ICU). The rota provided on-call, standby and sick cover with all the core trainees (year one and two) on the same work pattern. As the routine essential elective surgeries were cancelled, I was not able to achieve my required indicative procedures (as per the Intercollegiate Surgical Curriculum Programme (ISCP) and the requirements for ST3 urology selection). The Membership of the Royal College of Surgeons (MRCS) part B was indefinitely postponed thus adding further stress and anxiety with no plan for career progression. However, there were other learning

opportunities whilst working in SHC and ITU departments – my clinical knowledge and understanding of management of critically ill patients improved. The surgical and intensive care consultants took time to go through case-based scenarios to prepare me for the MRCS part B examination. This was extremely useful and in a way was a substitution for the lost training opportunities.

At times, working in PPE and the uncertainties with looking after COVID-19 patients were extremely challenging both physically and mentally. Having to go home to young children and a husband was difficult. The fear of contracting the virus and then passing it on to my loved ones was emotionally draining and this was the hardest part of my career so far. I have realised the need for a strong family and peer support network, in allowing me to cope with the demands of surgical training in the current climate. I was fortunate to live by the seaside and take long walks by the beach, which was one of my coping strategies. When the Royal Colleges opened the examination diets for MRCS, I successfully completed my MRCS part B and completed Core Training 2. With, hopefully, the worst of the pandemic behind us, I am extremely motivated to progress in my urology training with the gained experience over the last two years. This global pandemic has changed the way we learn and practise urology. Following huge disruptions to routine practice, some unforeseen training opportunities have arisen; the ability to learn skills in crisis management, healthcare management and leadership skills creating a cohort of trainees who have developed an additional skillset.

References

1. Conference of Postgraduate Medical Deans of the United Kingdom. *Implementing ARCP Outcomes 10.1 and 10.2 during COVID-19*. 2020. <https://www.rcoa.ac.uk/sites/default/files/documents/2020-05/ImplementingARCP/Outcomes2010-1%20and%2010%20during%20COVID-19.PDF> (accessed 11 November 2021).
2. Conference of Postgraduate Medical Deans of the United Kingdom. *Derogation to Gold Guide 8th Edition: 4.91 in Response to COVID Pandemic and Impact on Trainee Progression Assessments (ARCP)*. <https://www.copmed.org.uk/gold-guide-8th-edition/the-gold-guide-8th-edition> (accessed 11 November 2021).
3. Clements JM, Burke JR, Hope C, et al. The quantitative impact of COVID-19 on surgical training in the United Kingdom. *BJS Open* 2021;**5**(3):zrab051.
4. Ficarra V, Novara G, Abrate A, et al. Urology practice during COVID-19 pandemic. *Minerva Urol Nefrol* 2020;**72**(3):369-75.
5. Stensland KD, Morgan TM, Moizadeh A, et al. Considerations in the Triage of Urologic Surgeries during the COVID-19 Pandemic. *European Urology* 2020;**77**(6):663-6.
6. Chan M, Yeo S, Chong Y, Lee Y. Stepping Forward: Urologists' Efforts During the COVID-19 Outbreak in Singapore. *European Urology* 2020;**78**(1):e38-e39.

7. Doulias T, Thrikandiyur AA, Titus N, et al. Junior doctors' wellbeing at peak and post-peak pandemic: a repeated cross-sectional study. *Ann R Coll Surg Engl* 2021 [Epub ahead of print].
8. Coleman JR, Abdelsattar JM, Glocker RJ; RAS-ACS COVID-19 Task Force. COVID-19 pandemic and the lived experience of surgical residents, fellows, and early-career surgeons in the American College of Surgeons. *J Am Coll Surg* 2021;**232**:119-35.
9. Alhaj AK, Al-Saadi T, Mohammad F, Alabri S. Neurosurgery residents' perspective on COVID-19: knowledge, readiness, and impact of this pandemic. *World Neurosurg* 2020;**139**:e848-58.
10. COVID-STAR Collaborative Study Group. COVID-19 impact on Surgical Training and Recovery Planning (COVID-STAR) – a cross-sectional observational study. *Int J Surg* 2021;**88**:1-8.
11. O'Connor T, Papanikolaou V, Keogh I. Safe surgery, the human factors approach. *The Surgeon* 2010;**8**:93-5.
12. Parry DA, Oeppen RS, Amin MSA, et al. Sleep: Its importance and the effects of deprivation on surgeons and other healthcare professionals. *Br J Oral Maxillofac Surg* 2018;**56**:663-6.
13. McKinley N, McCain RS, Convie L, et al. Resilience, burnout and coping mechanisms in UK doctors: A cross-sectional study. *BMJ Open* 2020;**10**:e031765.
14. Maher Z, Milner R, Cripe J, et al. Stress training for the surgical resident. *Am J Surg* 2013;**205**:169-74.
15. Arora S, Sevdalis N, Nestel D, et al. The impact of stress on surgical performance: A systematic review of the literature. *Surgery* 2010;**147**:318-30.
16. Ellis R, Hay-David AG, Brennan PA. Operating during the COVID-19 pandemic: How to reduce medical error. *Br J Oral Maxillofac Surg* 2020;**58**(5):577-50.
17. Flin R, Yule S. Advances in patient safety – non-technical skills in surgery. *Surg News* 2005;**4**:83-5.
18. RCSEd. *Non-Technical Skills for Surgeons (NOTSS)*. <https://www.rcsed.ac.uk/professional-support-development-resources/learning-resources/non-technical-skills-for-surgeons-notss> (accessed 20 Oct 2021).



AUTHOR



Meghana N Ramachandra,
Urology Fellow, Department of Urology,
Royal Devon & Exeter Hospital.

SECTION EDITOR



Sarika Nalagatla,
Specialty Registrar, Queen Elizabeth University Hospital,
Glasgow.
E: Sarika.Nalagatla@ggc.scot.nhs.uk

