Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Correspondence

The impact of despecialisation and redeployment on surgical training in the midst of the COVID-19 pandemic

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Dear Editor,

An outbreak of coronavirus disease 2019 (COVID-19), caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), was declared a pandemic by the World Health Organization (WHO) on 11th March 2020 [1]. According to the WHO there have been, to date, 334,981 confirmed cases across 190 countries, causing 14,652 confirmed deaths [2]. The number of cases are expected to increase rapidly. This global health threat has resulted in emergency legislation introducing measures attempting to contain the spread of the virus, most recently in the United Kingdom, where Prime Minister Boris Johnson has restricted all but essential travel.

Preparations for the expected rise in COVID-19 positive patients have been underway in hospitals across the country in all areas and departments. The public and others at our centre have responded and we have observed a 40% fall in emergency department arrivals. Other centres have also reported a significant reduction in emergency department attendances as well as a surge in National Health Service 111 calls, which may in part be attributable to coronavirus fears.

Staffing issues are also expected to worsen as many symptomatic healthcare workers are appropriately self-isolating, and others are forced to stay home due to unwell family members. The ethical and medico-legal ramifications of decisions around autonomy-limitation are often revisited at times of global health concern. Webb explores the mandated 21-day quarantine that was imposed by several US states on healthcare workers returning from West Africa during the Ebola virus outbreak [3]. The author concludes that policy-makers should take into account the “realities of the interdependent global community”, an idea to which I believe we should pay more attention. During the COVID-19 crisis, the NHS is doing everything in its power to expand treatment capacity. A deal NHS England made with the private sector has yielded nearly 20,000 healthcare professionals to join the NHS workforce, and the UK Secretary of State for Health and Social Care announced that within 48 hours of a governmental plea for retired healthcare workers to return to the NHS, 4,500 had signed up. Medical students have also been offered temporary work to help the national effort.

Another avenue to meet the needs of patient care in these unprecedented times is reconfiguration of the way junior doctor training programmes work in order to ensure effective cover for the mounting inpatient workload. In some trusts, this will involve de-specialisation of all junior doctors, apart from some ‘core’ specialties whose knowledge and skills are central to the COVID-19 response. Foundation programme trainees will not progress into the final rotation of the year to minimise disruption in the provision of patient care. Academic and other ‘out of programme’ trainees have also been asked to return to clinical practice to support the workload. The specifics of these changes will vary on a local level.

The surgical workforce will certainly need to adapt to this pandemic. The Royal College of Surgeons has published guidance which specifies four priorities in these challenging times which include maintaining emergency surgery provision; protecting the surgical workforce; and fulfilling alternate surgical, and non-surgical roles. How these priorities are met will depend upon local arrangements. The extent to which the pandemic may impact on the provision of trauma and orthopaedic care is as yet unknown. The implementation of major trauma networks across the UK in 2012 has been associated with significantly improved outcomes of patients with severe injury. In the 27 major trauma centres, it is thought that the burden of trauma care provision will now be undertaken by consultants while orthopaedic registrars in training will be providing general medical services to other patients around the hospital. The trepidation this is likely to cause many trainees has been summarised by the experience of an orthopaedic resident in Singapore, who was drafted to help in the emergency department [4]. The British Orthopaedic Association have released and are continually updating guidance on policies regarding trauma surgeries and fracture services during the pandemic [5]. The response to these new policies will of course depend upon the burden of COVID-19 in local trusts, and whether or not the workforce capacity can keep up with the disease.

COVID-19 represents an accelerating challenge that will pose countless uncertainties for surgical trainees and other healthcare professionals. The way in which this situation is best managed will continue to evolve at every level. Until effective antiviral medicines are developed, and immunity testing and vaccination become commonplace we will face unparalleled pressure and have a great deal more work to do.

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