Mr Paul Gallagher, Mr Alex Philips, Mr Alex McCulla and Miss Aya Musbahi

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Surgical Training during COVID times – Is this the Age of the Generalist?

Transcript of podcast:

ALEX McCULLA So, hello everyone and welcome to our ASME podcast. My name is Alex McCulla and I'm a core surgical trainee here in the North East. Today I'm joined by Mr Paul Gallagher, Head of School here. Mr Alex Philips who is Deputy Training Programme Director in the region and Miss Aya Musbahi a Senior of the GI training in the region. First of all, I'd like to thank Aya for organising this podcast and our guests for joining us this evening. Today our topic for discussion is surgical training during Covid times, is this the age of the generalist? Aya, do you want to tell us the reason that we're discussing this today?
AYA Thank you, Alex, for the introduction. I think the topic that we're discussing stems from experiences that a number of trainees have had during the first wave of the pandemic. As everyone who works in healthcare knows the pandemic has affected us in ways that we couldn't predict. So, about 18 months ago we didn't know what was going to be in store for us and especially in surgery we've had to cancel elective operating. Some trainees have had to be re-deployed to other areas and we've had to scale down workforce and maybe just focus on emergency work and I think that has really affected training. A lot of people have found that they've gone back to being generalists again, general surgeons. The distinction between some specialties is blurred during emergency times and seems to have highlighted the fact that we have become quite specialised. And we're so used to deferring for specialist opinions that when actually we're forced to be the sole healthcare provider for a patient sometimes that can be quite difficult. And as a trainee I think it's highlighted particularly that our training is more and more focussed, and perhaps that we're encouraged from an early stage to decide on sub-specialty and not just specialty. And that raises a question about whether we are neglecting an ability to provide a general workforce and is the generalist what's needed in the future?
ALEX McCULLA So, I suppose the more experienced consultants are very specialised generally and as the structure of healthcare delivery has changed over the last decade or so consultants have been forced really to sub-specialise but they still have the training to go general if required. Is that fair Mr Gallagher?
PAUL It's interesting. Historically at the end of the last century consultants would care for patients with a wide variety of conditions. I remember when I was a medical student, I attended an all-day operating list where the consultant general surgeon undertook operations on different patients including a gastrectomy, colectomy, aortic aneurism repair and a prostatectomy. So, they had a very wide range of a general interest. Over

the last 20 to 30 years there's been a progressive service re-organisation in the UK, with the emphasis on elective sub-specialisation in centres with the anticipation of improved patient outcomes. Larger hospitals may have all the services under one roof but smaller hospitals may need to refer some patients to specialist centres for ongoing management. However, this can be difficult to replicate in the urgent setting for a variety of reasons. Our current surgical curricula, and there's a new curricula implementing in August this year, recognises that competence in all aspects of emergency presentation as well as the common elective conditions is required to obtain certification at the end of training. This may not mean that the surgeon is undertaking all of the procedures but they know how to assess and arrange a referral if appropriate to a sub-specialist colleague. So, all surgeons will be trained to be competent in the management of all common and emergency general surgery conditions, but may not always do the operating. And just to go back to Aya's point, the Covid crisis has put something in focus that never mind in terms of surgery, first of all we are doctors and may have to use the general knowledge that we have as doctors unrelated to surgery to treat for patients in this crisis, but certainly, it's put a focus on surgeons having to do things that would normally not be in their realm of everyday experience.

ALEX McCULLA
Is that something you agree with Mr Philips?

ALEX PHILIPS
Yes. So, there's no doubt that Covid has been a real game changer in the way that we work. There's been unpredictability to the workload and a real emphasis on team work and adaptability. I think that consultants that have been working in their own silos will have found the whole Covid situation the hardest. So, if I take myself as an example, I work as part of a specialised team that deals with upper GI cancers but we do a lot of general surgery work too such as hernias and gall bladders in our elective practice. We're well-used to working as a team and I think our strength is excellent communication which means none of the cancer patients had delays and we had excellent results that we've even published. But the general component to our workload certainly has slowed and we simply weren't doing these cases for a certain period of time due to concerns about pressures on the system. From an emergency point of view most general surgeons are prepared to deal with what comes through the door and that's the prerequisite that you need for your CCT. But having a good team around you and knowing that you can call on a friend is always reassuring. I think there's certainly been some change to what we're seeing as emergencies as well. So, as an upper GI surgeon I think I've dealt with more colonic cancers in the last two months than I probably have in the last two years but I think that the training that was, and is, provided equips us well with dealing with this unpredictability. The biggest problem with dealing with clinical situations that aren't your bread and butter is frequently not the operating but the decision making. Often there's more than one option that seems sensible but picking the right one can be a combination of experience, gut instinct, and luck.

ALEX McCULLA
And I suppose has it been a welcome change to go back to being more of a general surgeon again, and dealing with these general emergency presentations? Or have you found it quite difficult as senior consultants going back to do very general emergency work?

PAUL

I mean for myself the range of procedures that I undertake hasn't really changed but it's the challenge of the altered team structure. So, with potentially re-deployment of our surgeons in training and middle grades there's maybe a greater need to be more involved on a shop floor level. So, it's been very stimulating in certain ways. Obviously, I think we're all sick to the back teeth of Covid at the moment and want it to disappear. And that initial excitement almost at the start of the Covid pandemic of what it all meant in conjunction with the discomfort about it, that's certainly fading as it were now and I think for most of us we're now in a structured pattern of delivery of urgent surgical services that's safe. What will be interesting is the pause that's happened in many hospitals throughout the country on elective surgical services that are non-urgent, non-cancer that when we come back to doing those operations again, we may not have done operations like that for 12 months or so.

ALEX PHILIPS

So, I would agree that actually the range of operations that we're dealing with has not really changed and I think most people that do general surgery on call are exposed to a wide variety of things that come through the door. What I found that has changed is that the frailty and the level of illness has changed and that patients are presenting at a much sicker stage which gives you a much larger challenge. So, it's not your 50- or 60-year-old that's coming in with an obstructing cancer which doesn't happen very often because often people are picked up through various other ways, it's your 80-year-old who has been shielding for the last nine months and didn't really want to come and see anybody anyway but is now presenting in a really sick state with an obstructing cancer that needs something done very urgently. And the risk of morbidity and the risk of mortality associated with it is much harder. So, I think that the challenge is not just us in the operating but also it relays on to our critical care colleagues and they're having to help out and deal with sicker patients that we're operating on. So, I agree I don't think the range has changed much but I think that the level of challenge with the patients hasn’t got worse.

PAUL

I think that's a very fair point Alex and even what we'd normally term simple conditions such as in general surgery, appendicitis or abscesses, infection in gall bladders or obstructive hernias presenting as an emergency the patients have been scared to come into hospital at the start of the pandemic, and we were seeing patients with a very advanced stage of pathology because they were presenting so late. I think to a degree now that's settled but it can be difficult sometimes for patients to access healthcare services or know how to present particularly with an urgent condition. But yeah, it's provided different challenges, not so much technical but as you say Alex in terms of team working and decision making.

ALEX McCULLA

That's all very interesting. I think from my personal experience I've had the same thing. We've seen patients come in a lot sicker and needing a lot more urgent surgery than maybe we did in the past. Mr Gallagher you said that a lot of the juniors in the team had had to be redeployed or potentially off, or self-isolating, or indeed themselves unwell with Covid; has it been difficult being back on the shop floor, a bit more present? Or is it something that consultants of today are expected to be doing in their day-to-day practise being there and around on the shop floor?

PAUL

We've been relatively fortunate in the North East in the first wave of Covid there was relatively little redeployment, but there was an emphasis on covering colleagues who

were either isolating, or shielding and the rotas became much tighter. So, I think we've all been a lot more involved in the initial assessment of patients in ambulatory care units for instance. Making very quick decisions at a relatively senior level to decide whether the patient could leave the hospital to reduce their Covid risks. We haven't been so much involved, myself directly, with the basics of what the foundation doctors would be doing on day-to-day ward care but certainly the team has thinned out, and again just to emphasise that communication and team working is the thing that holds it together and provides good patient care. At the same time, we have been able to continue training of surgeons and that is really important because the effect of the Covid pandemic is undoubtedly going to delay the progress of training for many surgeons in training at the moment.

AYA

Can I just add Alex one of the things that was quite interesting that Mr Gallagher mentioned was about consultants being present as senior decision makers and that's something that I think a lot of the NCEPOD report in the past and Royal Colleges did produce a lot of guidance regarding this. But I remember when I was more junior there wasn't a lot of appetite for this kind of level of involvement from consultants and also, I think there wasn't a lot of appetite for the emergency general surgeon; do we think that Covid has increased perhaps interest in emergency general surgery as a specialty or a sub-specialty in itself? And do we think that that should be treated in its own regard like upper GI, colorectal, endocrine etc.?

PAUL

If I could take that maybe first of all Aya. It's been in the last decade or so there's been an interest in emergency general surgery as a dedicated career. But it depends what that means on a day-to-day level for the surgeon because if it's just assessing patients in an assessment unit or just being on call overnight and dealing with relatively straight forward operations, probably that will satisfy somebody for a few years but they'll want to then progress through their career. So, for much of UK practice it's combining a daytime interest in an elective specialty but then also staffing the rotas to provide 24/7 cover throughout the hospital. There are perhaps some very large centres where emergency surgeons have developed their own niche and will be dealing with the majority of all operative as well as clinical aspects of emergency care with the occasional need to bring in their sub-specialist colleagues. There are some smaller hospitals again that they've come up with a different structure where surgeons have a predominantly emergency-based job plan with very little elective work, but that then frees up the other consultants to continue that elective work. They are finding a very rewarding career in emergency surgery so; I think certainly it's something that's going to develop. And certainly, it's something that our Trusts, our employers will be looking to point people to these jobs as the years go by. Covid, I think to put it into focus the advantage of having a quick high-level decision made on patients presenting as an emergency both to see whether they need to stay in hospital but also the appropriate allocation of resourcing. Do they need a scan do they need an operation or can they be managed as an outpatient? But yeah, I think in the future very much so, Covid will change the way that we deliver urgent surgical care.

ALEX PHILIPS

So, I'm not sure that Covid itself will make emergency surgery more attractive or more required. I think what Covid has done from an emergency point of view is highlighted the need to work in teams and to be prepared to be flexible in the way that you're working. And certainly at the time of the first lockdown we had an on-call rota but there was a back-up tier going to four or five levels with the expectation that people

would be off sick. In the end I think there was only one shift that needed to be covered because somebody was isolating and then another because someone had Covid which was actually me. So, whether emergency surgery needs to be recognised as a specialty in its own right I think the answer is yes, but as Paul says it's very difficult to know what the long-term plan or what the job will be for somebody that enters an emergency surgery job. And is that going to be their career for the 25 years or 30 years they spend as a consultant? Or, is it going to be something they do in the more junior consultant years but they actually have a sub-speciality behind that they're going to fall onto? And I think that that can be a difficult question to answer and the concern that I would have with emergency surgery jobs is that firstly it can be difficult to make the job attractive because it's quite intense to have a large proportion of your job being on call or dealing with unpredictability and emergencies. And secondly there is a sort of slight historical stigma attached to these and what you don't want is the people who take these jobs to feel that they are less good as consultants than those that are specialists as such. And I think it almost sounds a bit derogatory to say well they're the specialists and I'm the emergency surgeon but actually being an emergency surgeon, and being a good emergency surgeon can be extremely demanding and the decision making there is very difficult as well. So, I think you're right it probably needs to be recognised in its own right in order to make it more attractive and more accepted but it's by no means an easy option to go down, it's very challenging. So, if you want good people to take those jobs you need to make it attractive somehow and the question is how do you do that?

ALEX McCULLA

Mr Gallagher you raised before about the change in the curricula and I suppose it sort of leads onto the Shape of Training review which in my understanding wants to lead to more a broad-based general surgeon that can dip in and out of their specialty when required and it sounds like Covid has sort of gone against that in a way because really, you've pretty much stuck to your specialties which is providing the great upper GI and colorectal service you do but then also being the emergency general surgeon. How do you think Covid may alter the shape of training review plans or do you think it will change them at all?

PAUL

I think not in certain ways. The thrust of Shape of Training was to be able to provide the workforce of the future to provide quality care on an emergent as well as an elective basis. And if we think of the journey of a trainee coming through from foundation years into core training it's very much essential that they have exposure to common conditions both for their own development clinically but also operatively because it's better off probably that they're acting as the first operator on relatively straightforward common conditions rather than spending their training time holding retractors and being second or third assistant in a very complex operation. Saying that it's also important that they do get exposure to more specialised procedures during their training to see if that's what they want to do, and then also to understand the clinical care of those patients. And as they progress through into specialty training in the third and fourth years when they are developing the early years specialist skills, they'll get the opportunity to select their specialty if that's what they want to do and at the same time they're continuing with their training in the generality of surgery so that they are able to provide that overall care for common conditions and emergency conditions. Now, the length of training may for some select specialties require further fellowships after certification after CCT if the procedures that the trainee's undertaking are going to very complicated or for uncommon conditions. So, I think the Shape of Training will be fulfilled or is being fulfilled with the new curriculum. It will deliver us

trainees who can become consultants with the ability to manage a broad range of conditions but still allow that sub-specialist interest.

ALEX PHILIPS
You're quite right the Shape of Training review emphasised that training doctors with generalist clinical professional capabilities is important for the future workforce and I think we have a training programme that still very much caters for this. Specialism isn't really focussed on until the final couple of years of training and in many cases not just with the general surgical sub-specialties people undergo specialist fellowships so that they can really enhance their skills. So, I think we have training programmes across different surgical specialties that do give people the foundation for generic skills that allow them to deal with problems and I think that those that want to have a specialist string to their bow then go on and do that in their final years of training and then usually go on and take fellowships and it's not unknown for people to do more than one fellowship in order to feel that they're completely comfortable in doing something very high-tech. So, I think at the moment we are meeting the criteria that Paul said and that the training programme is very much fit for purpose.

PAUL
And just to emphasise that for most consultants who are appointed nearly all of their training will have occurred during the training programme so a fellowship is certainly an option after CCT but by no means necessary so when somebody reaches the end of training they'll be assessed as being competent and then ready to take up the consultant post. But for a small number of trainees that extra time after CCT to obtain additional experience through a fellowship will be useful for their sub-specialty interest.

ALEX McCULLA
As a trainee coming through it's reassuring that you both think that the pathway that I'm going on, and a lot of the people listening will be going on, is fit for purpose and that Covid hasn't highlighted a major flaw in the training programme and that it's actually quite robust. Mr Philips have you had much involvement with the IST trainees coming through and the run-through trainees coming through? And what are your thoughts on the training pathway that that provides?

ALEX PHILIPS
I think it's important to remember that the IST run-through trainees will still have had a very broad-based curriculum and have generic competencies that they need to achieve. The newest addition of the curriculum that was released towards the end of last year and is coming into force later this year has tried to emphasise the importance of it being a competency-based curriculum rather than a time-based one. Interestingly this was exactly what was said when the Intercollegiate Surgical Curriculum Programme, the ISCP to you and me, was released more than a decade ago. Then ISCP was replacing a syllabus rather than a curriculum and it took a much broader view and was more prescribed than its predecessor which was essentially just a list of topics. I think there are pros and cons to having a run through pathway. In the past trainees could almost build their own training programme which was bespoke and they'd have experience in a breadth of surgical specialties; plastic surgery, ENT, orthopaedics, and I think this was really great for developing skills and helping individuals decide on the best specialty for them but it also gave them a background to draw upon that enabled them to perhaps deal with unpredictability better and perhaps combine the features of generalism and specialism. I haven't had a great deal of experience with the IST trainees that are coming through. But I have witnessed a couple of them and they did

seem to be quite advanced or quite able. And it's difficult to know, when we originally had MTAS back in 2007 and we were designed to have run-through training there I think it was all organised in a slightly chaotic way, and I don't think it was thought through very well. You could argue that if you go to other parts of the world people choose their selections or their specialties at a very early point in their career. But I'm not necessarily sure that that's the right thing or the best thing. And I often say to trainees there shouldn't really be a rush to get to the end and being a consultant. I think there's two things that you want from your training. I think you want to enjoy it and I think that's really important, and I think you want to feel at the end of it you're prepared for the rigours and the demands of being a consultant. And I think that's the advantage of having an un-coupled system where often people have a bit more opportunity to sometimes take time out of the system and do other things. So, I have a little bit of reservation about run-throughs and we'll just have to see how it pans out.

ALEX McCULLA
Mr Gallagher is that something you've also thought about?

PAUL
Well, we've only just started the Improving Surgical Training pilot project in our region three months ago whereas it's been up and running in the rest of the UK for a couple of years. And that was because of the stringent requirements to make sure that we were going to be able to deliver that in terms of the amount of supervision required as well as the structure of rotas and on-call patterns. So, one of the advantages of the Improving Surgical Training pilot is that a trainee will be appointed at an ST1 level and then will have a guaranteed rotation all the way through to ST8. And that appeals to a lot of trainees knowing that they'll be in the same location, the same region. Alex is right and what you don't want necessarily to do is to commit at too early a stage if it's not right for you. And sometimes different pathways are useful so we would continue with what we'd call an uncoupled programme as well as a run-through programme so that people have choice at what level that they will come into surgical training in most of our specialties.

ALEX McCULLA
And I suppose you both mentioned there about not wanting to pick a specialty too soon but it's quite a more common thing now amongst trainees is to have had a few years if not three, four, five years before they even join ST or CT1. So, is there an argument to saying that in those years post foundation, pre joining a formalised training programme that that's the time that people are finding out what specialties they do and don't want to do and what areas you do and don't want to work in?

ALEX PHILIPS
So, I think that's quite a reasonable thing to expect but there almost seems to be a pressure on those that are coming towards the end of their second foundation year to find a rotation and then to move seamlessly into that. And it probably isn't helped by the fact that those that decide to perhaps try and enter at the slightly later stage at ST3 are quite heavily penalised if they've acquired extra years of experience on their CV. So, I think the problem there is that some of them have done very worthwhile things and gained lots of experience and are now very mature and know exactly what they want to do but they're getting penalised for doing that because they've taken more years to get to that point. So, I'm a bit concerned that there are very good people that potentially are missing out.

PAUL

I'd just take a slightly different slant that I think the majority of people who enter into surgical training have probably made that decision during medical school or foundation years from the experience that we've had and certainly as surgeons it's important for us to mentor and develop that interest at that early year's level. If you're then taking several years out to decide what you want to do there are avenues that you can go onto a formal surgical training programme. But the majority of people entering core training are coming through from foundation years and then the majority of people entering into specialty training have not usually had that big a gap, if they're UK graduates between medical school and actually application. But there are different ways through. And also, to emphasise there are other opportunities once you're on a specialty training programme. Once you've made the broad decision do I want be a general surgeon or an orthopaedic surgeon, or a cardiac surgeon or a paediatric surgeon etc., within those specialties you will have different placements lasting 6-12 months in the sub-specialties to sample. So, you can decide what you want to do. There will also be the opportunities to pause your training and have an out of programme experience either related to research or teaching, or training or other aspects as well. So, within that you can pause because as we know some of us will just want to learn at different rates and other life events will mean that we might need some time out of training as well.

ALEX McCULLA

And Aya as a trainee in the region too how do you find that Covid's impacted your training? Sort of bringing it back to Covid, do you find that you've been able to become very general again or have you found that opportunity has been limited because of the outbreak?

AYA

I don't think it really affected me personally that much I mean where I was working, we still managed to keep elective lists going, I still had quite a lot of experience. But I think for those people who maybe have been affected I think it's important for us maybe to accept that the training doesn't have to stop when you stop being an ST8. And I think teaching and training your consultants that's something that I've seen senior consultants' mentor and take new consultants under their wing, and teach them new things or teach them a new technique, or a new operation. And that's something that should be allowed to continue, you know you don't suddenly stop being able to train once you finish your training programme. And just because it's not a formalised thing you should still be able to learn and expand the breadth of your experience. I'm sure old-school surgeons who maybe only did open, they must have learned laparoscopic surgery when they were consultants and somebody must have taught them that. And if the people who are learning robotics, they learned it when they were consultants, they didn't learn it as trainees. So, somebody must have taught them that and they were trained to do that. So, you know that training process shouldn't be just a fixed point in time when you're between ST3 and 8, it should be a continuous and evolving process. And perhaps in a way maybe that should be something that is formalised through fellowships or mentorship, or senior and junior consultant mentorship is another possibility I guess but these are just ideas of mine.

PAUL

I think that's some useful comment Aya. I suppose we'd redefine it as continuing professional development rather than training when you switch to being a consultant but all of us particularly in the early years of being a consultant will really lean on our other surgical colleagues and consultants for decision making as well as practical experience in the operating theatre and advice there. And really just continues through

lifelong, because there will be changes as you say in technology and I was on the initial laparoscopic wave when that first started and now starting to think about the implication of robotic surgery. Or there will be changes in the conditions that we deal with or the pandemic. So, we don't know what's quite around the corner. So, I think for a lot of us at the start of the pandemic we had to do an awful lot of revision about virology and public health that we hadn't really thought about for 20/30 years so, it's a lifelong learning process definitely.

ALEX PHILIPS

I agree I think it's always important to remember that a career in medicine or surgery involves lifelong learning so, I think we need to be very open to new technologies. I'm not saying that every new technology or every new technique that comes along needs to be embraced and is the right thing to do but I think it certainly needs to be considered because undoubtedly there will be some things that come along that allow you to do things better than you're doing them at the moment. And I think that robotic surgery is the obvious candidate at the moment. We've got robots here I think there's many around the North East and they're all round the country and what it allows you to do, the vision that it gives you, the dexterity that it provides you with makes I think some surgery certainly easier and I think it will be here to stay and I think it will certainly have benefits in certain areas.

ALEX McCULLA

It's very reassuring as we enter what is now our third lockdown here in the UK that as a trainee going forward it's reassuring to think that actually there is still some training hope at the end of the tunnel when as we go through what is still an evolving pandemic. Aya, have you had any experiences in your work where you as a senior trainee have been aiding and helping a consultant in operations or in decision making that maybe they haven't had to make in years because of the pandemic? Is that something that you've come across as a senior trainee in the region? Have you found that you've had sort of conversations with consultants about making decisions that maybe they're not too comfortable with and you've been the person they've leaned on for advice? Or in theatre have you been the person that said actually whatever consultant the current literature suggests doing this? As things have been coming up and consultants have been covering for colleagues and doing things that they may not have been doing in their day-to-day work?

AYA

Sometimes if you're, for example, experienced in a particular area like I for example have had a lot of years in bariatrics, if I'm on call say with a colorectal surgeon who's you know, never aspirated a gastric band, you know doesn't know how to remove one, something like that emergency situation or a specific upper GI issue and you're on-call with a colo-rectal or previous hospital on-call with breast surgeons, you can offer that advice. And I think you don't want to be a cheeky registrar who's telling people what to do but sometimes if you've come from a different kind of background or different area of expertise you can offer a suggestion or some advice and I think most people have the kind of maturity to take it and to understand where you're coming from. So, I don't think it's about, you know I've never had to take over from a consultant that's not appropriate but if you've got an area of expertise, that you can be of assistance in and help in or if you know how to do an upper GI scope or an OGD or whatever and that consultant perhaps can't do one then yes, your skills might be called in to help. But I guess that's probably the extent of it really.

ALEX PHILIPS

So, the flip-side Alex is I'm more than happy to ask my registrar for their opinion and for their help and I don't think that you should underestimate the importance of common sense as well as experience. So, if you're on with sensible team members then it's very good to have a registrar that you can ask their advice from. As an upper GI surgeon if I have a senior colorectal trainee with me, I regard that as being very fortunate because they will certainly have done more recently some of the things that might come up on an emergency take. And I think it's very reasonable to ask them their opinions on things. Ultimately the buck will fall to me and the responsibility falls to me, but I think you can use your trainees as a source of training and keeping up to date very easily. And I think it's important that you recognise their value as part of the team.

PAUL
One other point just to bring in on that is for any surgeon who's the lead operator we would emphasise non-operative technical skills. And that's not just the technical aspects of what you're doing but controlling your operating environment and controlling yourself in that environment and it's very useful having a trainee that you can just pause the operation and say this is what I'm thinking, do you have any other thoughts? Number one. Or a trainee asking you a question because they realise that you're heading on a trajectory that you normally wouldn't do because sometimes you can develop tunnel vision as the primary operator and are not aware of other aspects that you might need to consider so it's invaluable bouncing those ideas off another person, be that a trainee or another consultant colleague.

ALEX PHILIPS
Paul I completely agree I think you've summed it up very nicely there.

ALEX McCULLA
Mr Gallagher as Head of School you're really involved in how the training of junior surgeons has been developed. Have you been made aware of trainees that have had to defer their training, or potentially looking at deferring their training as an impact of Covid?

PAUL
So, yes there are many trainees who have been affected by Covid. Different specialties have been affected in different ways so those with a predominantly elective workload, leading to elective curriculum requirements will have had their training extended already. Those that have a predominantly either emergency or urgent cancer basis will have been able to continue training and be able to progress through with their normal competencies and that they're assessed at the end of year that they're able to progress to the next level. The main issue with Covid has been the lack of operating experience, for most trainees that's what they've noticed. To a degree for general surgery for instance endoscopy training, other trainees for outpatients as well, although they will have gained a lot of different experience in the emergency setting. There are also other competencies that you'll be required to get through and that might be related to a course or other curriculum outcomes and of course, passing exams as well. Now, we're aware of all of this at a national level and that's why we brought in different outcomes to the Annual Review of Competence, the ARCP, to what we call an outcome 10 as a no-fault indication that your training will need likely to be extended. And that's been implemented throughout the UK over the last nine months now really since Covid started. So, your training programme directors, your supervisors and the health education authorities nationally you're aware of these issues and will be very sympathetic to just allow that when we do eventually return to normal service.

ALEX McCULLA

Mr Philips, I know you're interested in exams, do we run this risk of having trainees who are reaching the end of their training and don't have their exams?

ALEX PHILIPS

I think that's eminently possible. So, when Covid came certainly if you look at things like the FRCS exam it caused a delay to the part ones and the part twos, and that lead to a backlog of people that needed to take exams. I know that the part two exam that was scheduled for February has been deferred into the summer. The Part one that's due to happen at the beginning of February I think is still on but may have changes made to it. But it's very possible especially as the second part of the exam is patient dependent and they have made provisions for Covid and patients and how they would be dealt with but I think it's difficult to know whether you'll be allowed to or be able to get patients in for doing a clinical exam in the summer. And we hope that there's going to be a vaccination programme and we hope that Covid will be better controlled but it doesn't give trainees very much margin of error if they've not had an opportunity for most of the year to do an exam. They'll feel additional pressure at having to pass at that point otherwise they're going to have to extend their training because for the ST8s the next opportunity will be probably after they've completed that ST8 year. So, I think it does add the pressure on to the trainees and there is an uncertainty about whether exams will go ahead in the summer as well.

PAUL

Just to provide some reassurance on top of that Alex, if trainees are just needing to pass the exam already there would be the possibility to extent training and as I say because it's related to Covid it would be a no-fault extension to training. The exit exams, the FRCS, the intercollegiate exam if you like has adapted so that the round that we ran in November didn't include patients so that we could take the exam but the format of the clinical stations was changed and that's under review by the intercollegiate exam board just to make sure that we can run exams and I'm sure they'll be very flexible on the timetabling of when the exams are going to occur to get as many trainees who are at a critical progression point the opportunity to take the exam at the earliest possible time as well. So, be reassured by that.

ALEX McCULLA

I suppose sort of one last question then to you both it means a lot of the trainees now are facing having sat a lot of exams during Covid, whether it’s been MRCS Part A at home or FRCS or whichever exam, whilst trying to revise during what is a really difficult time for everyone, apart from the work side, people aren't able to see families, weren't able to go home for Christmas. Personally, it's been quite difficult for a lot of trainees. Have you got any advice or tips, or sort of any words of reassurance for those trainees that are trying to do what is already a difficult exam during an even more difficult period of time?

PAUL

So, we're still waiting on the final analysis but the word is that there's certainly been no decrease in pass rates with these professional exams. In certain ways it might have given more time and more focus for trainees who've been out the hospital environment to learn the knowledge-based aspects required for examinations. It's always difficult revising for exams and motivation is one of the hardest things as well as confidence. But again, be re-assured the exams are robust but they're fair and they have adapted due to the needs of Covid in order to run the exams.

ALEX PHILIPS

I think actually Paul's hit on a very important point there about motivation and it is very hard to get motivated. It's very hard when you're working in busy jobs it's very hard when you don't necessarily have the support and the other things to look forward to around it. And additionally, it's hard when there's a degree of uncertainty regarding to when the exams will take place and the content of the exams so, I think there are some reassuring words there regarding pass rates and knowing that jobs are likely to be extended as required in order to cover you while these things happen. So, hopefully trainees can take some solace from that and know that they've got some security there. But I think everyone appreciates that these things are challenging at the moment.
ALEX McCULLA Again, I'm sure Aya agrees, that it's really reassuring for them to hear too that people who are involved in our training so much acknowledge that not only are they difficult things to go through but they're being made even more difficult with everything else going on at the moment. That's grand. Thank you very much. So, I think we're drawing to the end now of what's been a really enlightening discussion. I just want to thank you all for joining us today I know obviously we've been particularly busy this week and it only promises to get busier, I guess. So, thank you very much for joining us.
ENDS