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Impact of COVID-19 pandemic on training of junior doctors in the UK: Implications for BAME trainee doctors

Abstract

The recent coronavirus disease (COVID-19) pandemic has caused detriment to all factions of society on a global scale. This article aims to examine the impact of COVID-19 pandemic on trainees, particularly from ethnic minorities and the steps that employer and educators can take to support them.

Keywords *COVID19; medical training; junior doctors; BAME*

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Background

Coronavirus disease (COVID-19) is a recently discovered virus. The ensuing pandemic has led to mass disruptions in countries around the world. From curfews and lockdowns to a near shutting down of economic activity, it is clear that COVID-19 has had a huge impact on all members of the community.

A striking feature of the recent pandemic has been the increased risk of mortality and severe morbidity faced by Black, Asian and Minority Ethnic (BAME) communities in the United Kingdom. A comparison carried out by the Of9ice for National Statistics (ONS) (1) showed that even when factors such as age, socio-demographic factors and disability were accounted for, risk of COVID-19 related deaths in the BAME community was higher than those of white ethnicity. A seminal report by the Royal College of Psychiatrists (2) examining the impact of COVID-19 reported that around two-thirds of healthcare staff who have died are from a BAME background despite representing only

one ϑifth of the workforce. This discrepancy has prompted several organisations to study wider factors that could explain the higher risk in BAME communities.

A recent review by The Lancet (3) associated quarantine with a negative psychological effect, even months and years after the outbreak has passed and quarantine has ended. A study in Singapore (4) evidenced the prevalence of depression, stress, anxiety and post-traumatic stress disorder (PTSD) among a large section of healthcare workers who were at work during the pandemic. A host of factors have been implicated - the loss of social interaction, confinement to a single place of residence and stress about the health risks for oneself and family can all contribute to the psychological impact of quarantine.

Why are BAME healthcare workers at higher risk?

The ONS findings mentioned above indicate that a BAME background is an independent risk factor regardless of other characteristics such as age, gender, socio-economic status, etc. This is further supported by the analysis carried out by Goldacre et al. (5), who found that people of Asian and Black ethnic origin were found to be at a higher risk of death. It is pertinent to note that the majority of the Healthcare Workers (HCWs) who succumbed to COVID19 were international HCWs. The study goes on to suggest that higher prevalence of medical conditions such as hypertension and diabetes accounts for only a small portion of excess risk, further supporting the idea that BAME background is a risk factor independent to any others.

It is difficult to pinpoint the reason(s) for this discrepancy. Different theories have been postulated, one such being that of overcrowded housing. According to government data on overcrowded households (6), 30% of Bangladeshi households, 16% of Pakistani households and 15% of Black African households were classified as overcrowded in 2014-2017. This is compared to 2% of White British households. Goldacre et al. (7) also suggest that over-representation on the front-line may also play a role in the increased risk for BAME communities. This is demonstrated in government data (8,9) which reports that 29.7% of medical staff working for the National Health Service (NHS) in England are of Asian ethnicity as of March 2019, despite representing 7.5% of the overall population in England and Wales at the time of the 2011 census. The Workforce Race Equality Standard (WRES) report in 2019 (10) also unveiled several reasons why BAME healthcare workers may be at higher risk for reasons pertaining to the work environment. BAME workers were less likely to report personal experience of discrimination and less likely to raise concerns, for example with regards to lack of Personal Protective Equipment (PPE). They may also face discrimination around ϑit testing for PPE due to cultural reasons such as keeping a beard or wearing a veil or turban. Chakravorty et al. (11) found early on in the pandemic that almost half of BAME hospital doctors reported that they did not have access to appropriate PPE in accordance with Public Health England guidance. The same report also showed that 75% of BAME doctors were not able to comply with social distancing guidance when at work or commuting to work. Surveys conducted by the Royal College of Psychiatrists (12), British Medical Association (BMA) (13) and British Association of Physicians of Indian Origin (BAPIO) (14) suggest that doctors were not equipped with an appropriate level of PPE. Big proportions of Foundation trainees were not provided with any formal training or support for their personal safety during the COVID-19 outbreak. (15) BAME doctors are overrepresented in Specialist and Associate Specialist doctors and may be overrepresented in on call and frontline rotas (16), which worrying contributory factor for the disproportionate death rate in IMG and BAME staff.

Trainee specific issues during COVID-19 pandemic in the UK

Due to COVID-19, a number of changes were implemented across NHS, which meant a change in learning environment and opportunities. Some doctors were being asked to serve in different roles and tasks that are non-related to their primary specialty (17). They have been asked to cover gaps and shortages in personnel in other specialty as other colleagues are being isolated, shielding or infected with COVID-19.

(18) According to a survey, training in the new clinical areas had its own demands with some anxiety in their new role and requirements. The varying level of demands on the department resulted at times some doctors felt they were not needed in their new role and placement. (19) More than 20,000 doctors were supposed to be rotate to their new placement area during the pandemic, but these moves were paused to

avoid disruptions to services. With scheduled rotations paused, trainee doctors may experience a reduction in learning opportunities due to a shift towards unscheduled, acute care and lack of availability of senior staff capable of supervising learning activities. During the pandemic most elective surgeries were cancelled, and only small number of procedures were undertaken (mainly cancer procedures, emergencies, and obstetrics). Because of lower needs, junior surgical trainees lost opportunities for solo lists and hands-on experience. Only senior trainees had access to emergency procedures with limited number of theatre staff, so they had pressure to perform all procedures with minimal or no supervised learning environment.

There was a significant reduction in number of cases trainees could record in their procedural logbook, for example in Orthopaedic specialty (76% reduction for core surgical trainees and 90% reduction for Specialty registrars) (20). In anaesthetic specialty, due to change in processes around airway management, some hospitals had set up specific teams managing intubation and extubation of most of the COVID – 19 patients. Though it helped in limiting staff exposure to Aerosol Generating Procedures, such specific teams didn't involve junior trainees. Similarly, airway skill exposure was lower as most of the elective cases were performed under regional anaesthesia. In cardiac surgeries, all operative procedure were high risks, so most of the surgical procedures performed by consultants, hence there was a greater diminish in number of cases and training opportunities for trainees. (21) During pandemic most of the outpatient face to face clinic were converted to virtual clinics, such as telephone or video consultation. Trainees were not allowed to be participate in virtual clinics, hence no learning opportunities for consultation in outpatient department.

A survey during the pandemic suggested challenges around Workplace Based Assessments (WBA) and reduction in confidence in practical procedures amongst trainees. Trainees did not have same opportunities to complete audit cycles compared to pre-COVID era. (22). The Academy of Royal Colleges (AoMRC) made the decision to cancel all exams in the wake of COVID restrictions. While examination fees were deferred, this was small mitigation given the level of disruption. Deferred exams mean renewal of subscriptions for preparation materials, an added year of stress, and more distraction during arduous times. These challenges were reflected in Annual Review of Competence Progression (ARCP) and various colleges relaxed usual stringent standards to allow progression to next steps.

What may concern training of BAME junior doctor during pandemic?

One specific group amongst healthcare professionals plagued with uncertainty are doctors in training from BAME doctors and International Medical Graduates (IMGs) (16). The WRES report in 2019 (10) findings suggests BAME workers are more likely to fear being reported or warned for raising concerns around risks in the workplace, or for requesting safer alternatives. Raising concerns may adversely affect job security if they are on a temporary visa, or adversely influence career progression and pay. The 'Fair to Refer' report (23) carried out by the General Medical Council found that BAME workers are less likely to receive constructive feedback, which can be a barrier to raising concerns. Furthermore, a report by Public Health England (24) found that BAME community stakeholders felt that racism and discrimination experienced by BAME key workers was a root cause affecting health, exposure risk and disease progression risk. Possible attributions included - fear of diagnosis, fear of speaking out and hesitancy in seeking help in early stages of disease progression.

A string of additional issues such as inadequate induction and support, difficulties accessing leadership teams and being heard, blame cultures that exacerbate feelings of being an outsider, lack of sense of belonging, bias and stereotyping were also found. All these issues can increase the likelihood of adverse outcomes due to reduced input into teams and rotas, less willingness to challenge what is given to them, and less confidence to speak out. Thus, due to prior inequalities and differential attainment in BAME or IMG doctors, the concerns of compounded effect of change in learning environment and opportunities is major.

Mitigation of potential risks to the trainees

At the centre of mitigating strategy is the need for clear, robust communication. The aforementioned Royal College of Psychiatrists report recommends a full risk assessment featuring an open collaborative conversation, with open questions aimed to give BAME workers a platform to voice their concerns without fear (11). Furthering this, a clear channel of communication could be by setting up BAME network at each NHS Trusts, to allow BAME colleagues to safely voice any concerns, take part in healthy discussion and work on generic issues such as stress, poor morale or inequality at work. One key driver for change will be the quality of equality and diversity training. Enhanced diversity training using simulation and incorporating the lived experience of BAME healthcare workers may address the criticism that such training serves to tick the political correctness box. Such training is particularly important for Educational and Clinical Supervisors and for Clinical Managers to equip them with the requisite skills to have sensitive conversations about ethnicity and culture. The need for such training was highlighted in the current pandemic with the requirement for structured risk assessments for BAME staff.

Another key change needed is greater diversity in leadership. WRES data has shown that BAME staff members are significantly underrepresented at leadership levels. The absence of visible role models is an important barrier to equity in the workplace. Diaspora organisations such as BAPIO and British Indian Psychiatric Association along with the BMA and Doctors' Association UK as representatives of doctors, are in a unique position to provide a voice to support colleagues who want to speak up about issues in their workplace related to adverse outcomes for BAME staff. Additionally, they can ensure that proposed solutions or policy changes are informed by the lived experience of BAME/IMG staff. With the right attitude, appropriate actions and engagement from across the employment spectrum, it is very possible for this pandemic to serve as a platform upon which a new, positive equitable environment can be built for IMGs and BAME colleagues.

With recovery plans been implemented with return of clinical services, educational supervisor and training program director needs to promote and safeguard training needs. Trainees should have dedicated time to catch up with WBAs, signing up other competencies, and other training needs to allow them progress in their career. Novel virtual technologies such as web-based teaching, virtual realities and simulations need to be used for training whilst we continue with safe social distancing and lack of larger seminar rooms. Similarly, trainee doctors should be trained to utilise virtual consultations with patients and supervised out-patient training. Measures needs to be in place to ensure trainees mental health and wellbeing is maintained, particularly with BAME doctors who may face uncertainties not only in NHS but also from home abroad with family members effected with COVID-19 pandemic. A BAME trainee specific representative or Training Programme Director for BAME trainees should be considered to develop further insights into complex issues. Regular anonymous surveys should be conducted to gauge challenges and progress in training needs by Health Education England (HEE) and training directors.

Conclusion

The COVID-19 pandemic has exposed deep routed inequalities in the society and healthcare settings across the globe. Junior doctors or trainee are main frontline medical doctors who are exposed to heightened risk of exposure to COVID-19 but also significant change in their work environment with lesser training opportunities. In addition to mitigating the risk of COVID-19 related morbidity and mortality, training needs are important to consider. These needs to be part of recovery and resilience planning as we move out of COVID-19.

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