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Principles for the re-establishment of medical training in the UK
The Academy Trainee Doctors' Group

Introduction

In the wake of the initial phase of the coronavirus pandemic there is an inherent and understandable desire for medical training simply to return to 'normal', and the stability that 'normal' represents. However, COVID-19 may have an impact on society and on the health service for months or years to come. It is, therefore, crucial that we identify and embrace deliverable principles for the reestablishment of training, accepting that this will need to be done in a stepwise fashion over a period of time. It should also be seen as an opportunity to develop training as opposed to simply reinstituting it.

Prior to the onset of the COVID-19 pandemic in February 2020, it was already widely recognised that trainees were experiencing extreme levels of pressure, stress in the workplace and burnout.[1] Concerns that this way of training, working and living was unsustainable had been expressed by many areas of the profession, including the GMC,[2] the BMA,[3] and several of the Medical Royal Colleges.[4,5,6] Understandably, the emergence of COVID-19 led to concerns that the system, and the people in it, would buckle under the pressure, and that this would cause training, growth and progress, in all senses, to stall. Whilst this has been far from the case (in the clinical context), the impact on training has been significant, the extent of which is only just becoming apparent. All trainees have been affected by the pandemic, though the manifestation of this is varied depending on their personal circumstances. Change and uncertainty, especially unplanned and rapid change, is stressful and the deleterious effects of the pandemic on training should not be underestimated whilst recognising that some developments actually represent positive change which we should look to continue.

It is increasingly clear that the likelihood of things 'returning to normal' in the immediate future is not realistic, nor desirable, and we need to move towards a 'new normal', where training is a priority once again, the lessons of COVID can be implemented and, perhaps more importantly, the shortcomings of the previous systems are identified and not reinstituted. Here, we outline eight principles to support the reestablishment of exemplary training programmes for current trainees and trainees of tomorrow which will facilitate the optimisation of patient safety in the post-pandemic era.

Principle 1: Maintenance of training standards is a priority

Training standards are crucial to optimise both the training experience and quality in healthcare. We have already had to consider how best to change elements and requirements of training curricula. Maintenance of standards does not necessarily mean a return to a previous model of training. There has been increasing recognition during COVID-19 that training away from the 'shop floor' can be and is effective and protection of training time should be given renewed focus. Changes made should seek only to improve standards and outcomes should not, and must not, be compromised. Additionally, specialty, subspecialty and generic elements of training are all required for effective training and one cannot replace another. The UK is proud of the standard and product of UK training and the skills it equips doctors with. We have no desire to see that change.

Principle 2: Trainee wellbeing must remain a focus

It is a certainty that trainees (and trainers) are going to emerge from this period changed, as people and as doctors. This should be recognised, identified, supported and embraced. It is expected that all individuals will have experienced adverse outcomes as a result of COVID-19, be they clinical, emotional or practical. This cannot, and should not, be perceived negatively. It is imperative that renewed focus on pastoral and peer support is instituted. Measures which have been taken to improve wellbeing during the pandemic and seen to have been successful should be continued. Trainees should be encouraged to reflect and learn from their experiences during the pandemic. Discussion of any challenges this reflection highlights should be encouraged, and support should be proportionate and readily available without judgement or expectation, as well as entirely voluntary. Making sure trainees have access to mentoring and coaching opportunities, not just for stress or emotional support, but also for career support and progression is of key importance.

Principle 3: Iterative review and evolving evidence should underpin training decisions

Recent changes to training (including ARCPs, recruitment and exams) have been adopted through necessity and a need to make compromises (with the aim to detrimentally affect the smallest possible number of trainees). As formal training is recommenced, an iterative programme of review and revision, involving rigorous evidence-based evaluation should be adopted. Discrepancies, deficits and any benefits, compared to previous processes, must be identified, evaluated and alterations made to ensure that each implementation is an improvement on what has gone before. Quality assurance of the processes adopted should, as always, be prioritised.

Principle 4: Flexibility in training as standard

Flexibility in training has been a buzz term over recent years despite proving difficult to achieve. Progress was being made prior to COVID-19, with the introduction of OOPP and this progress should not be lost. Consideration must be given to how experiences within COVID-19 will count in a competency-based framework, alongside a more global acceptance of the fact that innovative methods of working and experience can represent novel, relevant opportunities. Changes to training decision matrices must be considered in an effective time course by the regulatory bodies and there must be an effective gap-analysis, not just in current ARCPs, but in future ARCPs. Improved access to Less Than Full-Time (LTFT) working was increasingly recognised, prior to the pandemic, and must be further supported. There must be a system-wide understanding that trainees may not be able to pick up their training where they left off, may need appropriate adjustments (e.g. OOP trainees/ trainees on parental leave who returned to clinical practice), may not be able to entertain sitting exams and may not feel able to rotate into new workplaces/rotations/environments.

Principle 5: Strengthening of supervisory relationships is a priority

There has always been significant variation in the supervisory relationships between trainee and trainer. This is a key support system for trainees and finding a pairing that is beneficial for both parties has never been more important. The remit of the supervisory relationship is evolving and not just focused on clinical issues. Trainees should be encouraged and supported to meet (including through virtual platforms) with their supervisors more regularly and if the professional relationship is not working for either party, switching to alternative supervision should hold no stigma. COVID-19 has highlighted that a key aspect of quality healthcare is the presence of a respectful team and the supportive environment this affords. Focus should be placed on recapitulating the team environment, even if a team is not physically present.

Principle 6: Training challenges should be actively identified and systematically addressed

Many of the questions that have arisen as a result of COVID-19 have simply led to more questions. There are numerous challenges to be faced regarding training. The input and work done so far to support trainees is not underestimated and we must work together to create effective solutions, with a focus on learning, for the ongoing issues the disruption the pandemic has caused. There are multiple areas that need to be addressed which need to continue to be broached in a systematic fashion with key stakeholders with ongoing robust and systematic trainee representation in both consultation and decision-making.

Principle 7: Change and novel solutions should be embraced

Human nature is to be suspicious and distrustful of change. Without change, however, there cannot be improvement. Whilst many of the changes made over the past few months have been borne out of necessity, some have resulted in positive outcomes. New interview processes, new examination formats, a deeper consideration of the evidence base behind self-assessment, new 'no fault' ARCP outcomes. All have the potential to bring lasting positives to postgraduate medical training. Clearly the impact of innovations needs to be carefully considered and evaluated but the 'new normal' is likely to consist of a hybrid of traditional training and novel approaches. The digitalisation of the NHS has been long-winded and costly. However, during this pandemic, multiple innovative solutions have been implemented in short time frames with good outcomes and should become standard practice. These include the utility of digital consultation platforms and a rapid expansion of digital resources – both as static content and interactive multi-professional meetings. However, the requirements for appropriate time apportionment, study leave, funding and developmental support for these new modes of learning should not be overlooked.

Principle 8: Short-term solutions must be part of a longer-term plan

Through necessity and uncertainty, many decisions affecting trainees have been made at short notice and long-term planning has been difficult. However, the training family (trainees, trainers, Colleges/Academy, Statutory Educational Bodies (SEBs), local education providers) aspire to develop increasingly robust contingencies. How long acutely implemented solutions may last, how different diets may look, how trainees return to a more familiar working pattern or location are all reasonable questions which must now be considered. Ongoing and indeterminate uncertainty reduces trainees' sense of control, safety and emotional/psychological wellbeing. Determining a longer-term plan should be considered a primary focus over the coming months.

Conclusion

The COVID-19 pandemic has put excess pressure on an already highly pressurised situation. It is humbling to see how the medical profession has responded to this situation but one of the casualties has been the maintenance of training. The educational and regulatory bodies have been working tirelessly alongside representative bodies at both senior and trainee level to limit the impact as much as possible and optimise a difficult situation. However, as a period of recovery and reestablishment begins, it is key to identify the challenges that need to be addressed, robustly evaluate the implemented processes, maintain positive changes and define the 'new normal' in training whilst maintaining and improving standards.

References

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