

Position paper

Trainee redeployment during the COVID-19 pandemic

The Royal Australasian College of Surgeons (RACS) recognises the issues facing our trainees during the COVID-19 pandemic are far reaching and encompass numerous considerations including training opportunities, progression, exams and the possibility of work in new or unfamiliar departments.

This paper outlines the considerations regarding specialist trainee redeployment and draws upon the phasing model proposed by the Academy of Medical Royal Colleges in the United Kingdom.

Executive Summary

RACS expects that trainees should:

- Work within their existing specialty skill-set wherever possible;
- When working in a setting outside of the trainee's recognised roles, receive a focused induction. This induction should concentrate on clinical considerations to deliver safe patient care, life support and personal protective equipment (PPE) training. Induction should occur as a priority so that staff are prepared for redeployment;
- Be appropriately supervised when delivering clinical care. Supervision should be provided by senior doctors who routinely work in this service;
- Be utilised in a phased (Consolidate, Mobilise, Repurpose and Redeploy) and stratified manner, recognising different skill sets and experience. Not all competencies are transferrable or upskillable.

Welfare and wellness issues must be anticipated, planned for and mitigated where possible.

Introduction

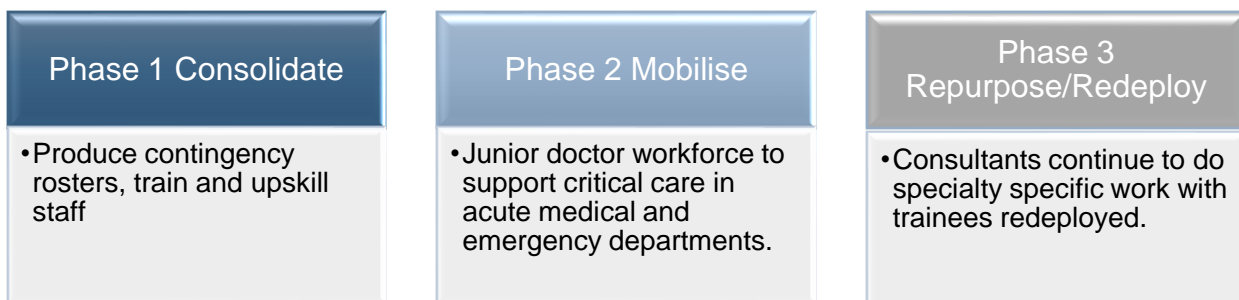
The trainee workforce is not homogenous and skill sets are diverse.

RACS values trainees as a key resource in the Australian and New Zealand health care systems. Trainees themselves recognise the need to be supportive and adaptive in the rapidly changing COVID-19 pandemic environment.

All trainees will possess a broad skill set and context-specific knowledge of their workplace which enables them to work across different specialty or healthcare team, if provided with adequate supervision. These skill sets grow as they advance throughout their training. Skills sets should be recognised and utilised appropriately at this challenging time.

All trainees can work at a lower level of the training path they have been through, including working as basic trainees in another specialty, but they are unlikely to be able to work at a level above. When considering the movement of staff, RACS cautions against shifting trainees into lower level roles because it can have a deleterious effect on the efficiency of the system and it is not utilising personnel at their level of proficiency. Trainees should still be working within their competency with the appropriate supervision provided to them wherever they are mobilised to. It is for this reason RACS have endorsed a phased utilisation and deployment model reflecting three stages in redeployment.

Figure 1: Stages in a phased utilisation and deployment plan



Phase one reflects the consolidation of available resources noting the likelihood that trainees will have to move into a different setting. Planning of future steps includes the implementation of contingency rosters and where necessary, undertaking early training and upskilling of staff. There is merit in shifting trainees out of their training environment early to allow time for trainees to acclimatise and upskill as required.

RACS recommends consideration is given to the ways in which patients are allocated and assessed to free up those services most affected and to help utilise trainee skills more efficiently. Assessment should be from the most senior decision maker available in order to expedite care and facilitate discharge if possible.

Phase two resembles the mobilisation of the doctor-in-training workforce to support critical care, acute medical and emergency department services, with predominantly senior staff remaining in specialties less affected by the pandemic, so as to provide ongoing continuity and emergency care.

This phase may be split into separate parts: initially staff remaining primarily under their parent specialty but assisting by performing and following up jobs for medical outliers on their wards. Overall responsibility for the care and treatment remains under the supervision of the specialty consultants.

Moving forward teams will likely be restructured because of this. When moving trainees away from one specialty this must be in line with the relevant jurisdiction guidance. Initial staff movements should start at junior levels and gradually progress upwards. RACS notes some specialties have useful natural links (for example cardiothoracic, GI surgery / gastroenterology) and consideration should be given to utilising certain trainees with prior experience and with acquired skills for example in the emergency department. These trainees must be utilised as much as possible. RACS has noted that it may be appropriate for more senior trainees to also undertake leadership or supervisory roles in these contexts.

Phase three repurposes and redeploys trainees while the consultant body moves to maintain the specialty specific work. Consultants will continue to do the specialty specific work for as long as possible. RACS recognised the risk of consultant burnout so there may be a role for senior trainees to act up in locally identified cases. Additionally, in areas of practice where emergency services rely heavily on the work of senior trainees this should be factored into plans for redeployment.

Trainee stratification

RACS cautions against considering trainees based solely on current specialty. It is far better to identify suitable roles to move trainees into that are based on their actual skills.

Skills-based stratification

This is an important aspect of trainee redeployment as it involves those trainees who are airway trained and in acute medicine while also supporting the important general ward work. A skills-based stratification is recommended.

Airway Trained: Surgical trainees with airway training skills are likely to come from Otolaryngology, Head and Neck Surgery but other trainees may have specific experience and training.

ALS / Acute medicine Trained: Acute assessment and admission of patients including work on isolation wards with patients at high risk of respiratory collapse and cardiac arrest.

Non-acute Physician / Critical Care / Anaesthetic Trainees: Those trainees who do not work within the acute medical/critical care setting in their normal training program are best utilised within the ward setting to facilitate care and discharge. This will allow for greater flow of work within the hospital and bed utilisation, including any conversion to COVID-19 bed spaces more efficiently. Skill matching where the aim is to free up emergency department physicians through the utilisation of surgical / ophthalmic specialties is recommended. There is a need to consider extended or supplementary induction and training for those trainees coming from specialties or rotations where acute/secondary care medical emergencies are not a focus. There are multiple telephone and virtual based roles where trainees could be of assistance.

RACS recognises that a competency-based training system is not necessarily time based. There is no call for the pausing of training. Even within the craft specialties there will be opportunities during the pandemic to demonstrate competencies and professional capabilities including, albeit at lower volumes, technical skills.

The Medical Board of Australia recently issued a statement regarding its regulatory approach to the pandemic acknowledging the need for flexibility in CPD.

Health and Wellbeing

It is recognised that working outside usual systems is stressful and, sometimes, extreme circumstances will additionally impact on wellbeing and morale. Support mechanisms should be developed as a priority. A rotational plan where doctors move between a high intensity and mild intensity workload may reduce this risk and will support a more sustainable workforce in the medium to longer term.

All doctors including our trainees should be listened to if they feel out of their depth and unable to provide an acceptable level of care.

Welfare and wellness issues must be anticipated and mitigated where possible and planned for in anticipation of the fact that caring for our colleagues is as important as caring for our patients.

It is imperative that the medical workforce has access to appropriate support during this pandemic. RACS have pre-existing avenues of [support](#) for their members but also support the emergence of services specific to well-being needs arising in the context of COVID-19.

Conclusion

RACS will continue to regularly review the situation. Working alongside the other Specialist Colleges, Specialty Societies and other educational bodies, RACS is committed to providing the best possible care for Australians and New Zealanders while being mindful of the ongoing impact this COVID-19 crisis has on trainees' health and careers.

References

Academy of Medical Royal Colleges statement (March 2020): [Plans regarding trainee redeployment during the COVID-19 pandemic](#). [Academy of Medical Royal Colleges statement](#)

Medical Board of Australia statement 30 March 2020:

Council of Presidents of Medical Colleges [Position Statement 17 April 2020](#)