


LETTER TO THE EDITORS

## Reply to: "COVID19 and education: restructuring after the pandemic"

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Dear Editor,

We read with great interest Bellini et al.'s [1] article on restructuring education after the COVID-19 pandemic and found it both insightful and thought-provoking. The authors provide an accurate insight into the impact COVID-19 has had on education and training. With face-to-face sessions now becoming more and more limited, the pandemic has been quite a 'shock' and led to major disruption to the education system for medical students and postgraduate trainees.

We agree with the authors that the transition to a virtual platform has undoubtedly increased convenience and global connectivity [2]. Access to 'top' surgeons regardless of where you are is now possible, and this concept excites many of us. Moreover, such video technology has allowed national and regional teaching programmes' ease of delivery and participation from both the trainer's and trainee's perspectives, respectively. Nevertheless, there are several concerns particularly among surgical trainees about lack of adequate exposure to hands-on training within the theatre environment. Although some of the assessments can be done virtually as suggested by the authors in this paper [1], the actual hands-on operating and exposure for a surgical trainee is essential.

Indeed, many surgical trainees in Wales and UK have struggled to gain adequate exposure to training opportunities in theatre throughout the pandemic. Operating lists in many hospitals, particularly smaller general hospitals, have often been limited to emergency and urgent cancer cases only, with many of the procedures being performed by two consultant surgeons. Where operations were performed in other sites such as requisitioned private hospitals, often the hospital's own policies regarding consultant-led operating became a barrier to trainees gaining surgical exposure. Wearing

full PPE in theatre makes communication between colleagues difficult and proves to be an additional challenge to training.

The consequences of lost training opportunities have resulted in a large number of UK trainees receiving 'outcome 10' on their annual appraisal of competencies and progression (ARCP), which recognizes a delay in gaining competencies at the desired rate because of the pandemic. It is not currently clear whether this will have a long-term impact on progression towards completion of training and has undoubtedly led to a feeling of significant anxiety among the trainees.

As the authors mentioned, e-conferences are not only environment friendly but have also been more advantageous during this period. Although the potential for collaboration between doctors from high-income countries (HIC) and low-middle-income countries (LMIC) is evident, there is a reliance on excellent internet connection, for live streaming with videos often requires a large bandwidth. This may not be as easily available to doctors within LMIC and has the potential to further widen the research and knowledge gap between HIC and LMIC.

We found that the problems raised with scientific research during this period to be thought-provoking. The rush to publish and the uncertainty of the impact of the disease on various conditions have resulted in lower standards being held for scientific research. However, we feel that this problem is specific to COVID-19-related research, with non-COVID-related work being held at the same strict scientific rigour. With the recent news of the success of SARS-CoV-2 vaccine from various companies, it is vital that our standards for all research return to where it was before the pandemic. Retraction of COVID-19 articles could potentially damage the public's trust in science and vaccine, especially among anti-vaxxers. The over-publication of poorly written and researched articles has led to a large volume of clinically substandard information being available in the public domain. This can be unhelpful to clinicians at all levels and lead to confusion about the best ways to approach

treatment and care of patients, particularly those suffering from SARS-COV-2 infections. The number of articles published and then subsequently retracted is a cause for alarm. This coupled with the current amount of concern and levels of misinformation being circulated does not bode well for improving public relations.

The article stated that telemedicine and web technologies could result in a long-term lack of cost-effectiveness in terms of community health and educational meetings. However, we would argue that this is not the case. Studies before the pandemic have shown that eHealth is both efficient and cost-effective [3]. Transplant centres often have large catchment areas, and patients travel long distances. This can be inconvenient, costly and time-consuming. Additionally, with many transplant patients being at a higher risk of COVID-19

infection, telemedicine has proven to be an increasingly convenient temporary replacement for face-to-face consultation. Telemedicine in liver transplant patients has been shown to lead to increased quality of life, physical function and general health [4]. Perhaps telemedicine should continue as an alternative/additional mode of care, even after the pandemic.

Innovation thrives during a crisis. The pandemic has brought forward many new and flexible approaches to education and embracing these changes would allow us to develop novel education methods. Virtual learning may be the norm for many more months. The reduced cost, ease of access and availability to re-watch lectures at any time make them a powerful education tool, which could be used as an adjunct to traditional teaching in the future.

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## REFERENCES

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