Introduction

The COVID-19 pandemic has had far-reaching consequences for the provision of NHS services, staffing and capacity. Surgical training has been severely disrupted since the beginning of the pandemic and the Joint Committee on Surgical Training has provided a statement that takes into consideration trainee progression during this challenging time. (JCST, 2020)

The UK government has taken the precautionary measure of including pregnant women in the list of clinically vulnerable people. (NHS, 2020)

The Royal College of Obstetricians and Gynaecologists (RCOG) have issued guidelines for pregnant women and their employers. (RCOG, 2020). However, there is limited evidence of the risks that COVID-19 infection poses to pregnant women and their babies. Despite the guidelines, being a pregnant surgical trainee can be daunting and this guideline seeks to shed some light on to the issues and highlight some considerations facing trainees who are pregnant and their employers and provide some case studies as an example.

An additional valuable resource for support and advice is a Facebook group called Pregnant Doctors COVID19 Support Group.

Summary of RCOG guidelines (Version 3.2 - updated Friday 22 May 2020)(RCOG, 2020)

- There is no evidence that pregnant women are more likely to become infected with COVID-19 and the disease causes problems with a baby’s development or miscarriage.
There is emerging evidence to suggest that vertical transmission is probable.

UK Obstetric Surveillance System (UKOSS) study of 427 pregnant women admitted to hospital with COVID19 infection, estimated incidence 4.9 per 1000 maternities. 69% were overweight or obese, 56% were black, Asian or other minority ethnicity (BAME), 81% were in the third trimester or peripartum, 21% had pre-term births, 10% required respiratory support and 1% died. 10% of babies required admission to neonatal unit and 5% tested positive for COVID-19. (Knight et al., 2020)

All pregnant healthcare workers should have a risk assessment with their manager, which might include occupational health.

- Before 28 weeks’ gestation. Risk assessment to guide whether worker can continue working face-to-face. Employers must remove any risks that are greater in the workplace than to what they would be exposed to outside of the workplace, limit the exposure to high risk environments and Aerosol Generating Procedures (AGPs). Pregnant women can choose not to work face-to-face and the employers should support their decision.
- After 28 weeks’ gestation or people with underlying health conditions should stay at home and work from home if possible.

Employers should modify their work environment to minimise the risk of COVID-19 infection. This includes:

- Finding suitable alternative duties to face-to-face working such as telephone consultations or administrative work.
- Where possible, pregnant women are advised to avoid working with patients with suspected or confirmed COVID-19 infection and in high risk areas (such as operating theatres, ITU) where greater number of AGPs are performed.

Training considerations

Before undertaking the risk assessment with your manager you should consider the potential impact of amending your working duties will have on your training.

Points to consider:
- All trainees, including expectant mothers, are likely to have a reduction of training opportunities due to the COVID-19 pandemic.
- Consider alternative training opportunities such as online teaching and conferences, simulation training and opportunities to get involved with audit, teaching and research. See AOT website for education opportunities.
- Common AGPs in ENT practice that you should discuss during the risk assessment:
  - In ENT clinic/ward: Upper airway endoscopy (ENTUK, 2020).
In operating theatres: intubation, extubation, tracheostomy, bronchoscopy, upper airway endoscopy, procedures that use high speed-drilling such as mastoid surgery (gov.uk, 2020a).

- Discuss early with your Assigned Educational Supervisor (AES) and Training Programme Director (TPD) the impact that alternative duties might have on your progression and whether you will need extension of your training. Be aware that the Statutory Education Bodies have issued guidance for ARCP progression and this includes two ‘No-fault ARCP outcomes’ (Outcome 10.1 and 10.2) that allow flexibility for future extension of training. (COPMeD, 2020)

- The surgical curriculum is competence-based and therefore it is worth considering what areas of your training could be affected by changes in your clinical duties (i.e. paediatric level 4 PBAs if you are currently on a Paediatric ENT placement). Moreover, it is important to consider if you are at a key stage in your training such as ST6 and ST8 where you are asked to provide competence checklists. Early discussion with AES will ensure you will be able to obtain the missing competences in future placements.

- Consider whether you will continue on-call duties and the impact of this decision on your CCT requirements.

- Consider the length of the maternity leave as you are likely to be off the on-call rota and clinical duties for a longer period.

- Several FRCS examinations have been cancelled or postponed during the pandemic and their format of them is likely to change. (JCIE, 2020)

**Pay for pregnant workers and maternity pay**

Employers should take reasonable action (such as alternative duties) to provide safe working conditions for expectant mothers. If it is not possible to avoid the risks by taking such action, they are entitled to suspension on full pay. (MaternityAction, 2020; gov.uk, 2020b)

Maternity leave and pay should not be affected by the COVID-19 pandemic.

See Maternity Leave information document on the WENTS website for further details about maternity entitlement and other considerations. (WENTS, 2020)

**Case studies**

These case studies have been written by pregnant ENT trainees in the UK and illustrate the complexities of the decision making and the need for an individualised plan according to personal circumstances.
Case study 1:
I found out I was pregnant shortly after COVID arrived in the UK. My husband is a GP and got symptoms (and later tested positive) very early on so I had to isolate at home for 2 weeks. I felt I had to let my department know about my pregnancy, at 8 weeks, on my return as we were all due to be redeployed to ITU and occupational health had advised I shouldn’t be going to a COVID high risk area.

I had a risk assessment with my clinical lead and from 8-19 weeks I came off the on call rota and worked from home, doing tasks such as organising the tracheostomy service, keeping the department informed re COVID changes with daily updates, audits, increased number of clinics and organising our hospital tracheostomy referrals/ service.

At 19 weeks I had another risk assessment (requested by me) and have now gone back to seeing telephone screened symptom free patients face to face in clinic, elective operating where patients have had a negative COVID swab and on call (with a backup StR who is being paid for the shift and will see any COVID suspected/ positive patients).

I plan to continue this until 28 weeks when the RCOG guidance suggests working from home.

Case study 2:
I was only a few weeks pregnant when hospitals started planning to stop elective activity and redeploy staff. I had actually already told my consultant due to severe early pregnancy symptoms but had to tell the rest of the department earlier than I would have chosen to. Despite the early guidance stating that pregnant women were at no greater risk, my department took the view that I should be in the higher risk category and immediately took me off all face to face work, including the on call rota. I did carry out a risk assessment but never involved occupational health as I just couldn’t get through on the phone; they were constantly engaged, and no one responded to my emails.

My department set up remote working for me so I spent my time working from home doing telephone clinics, triaging referrals and doing other administrative tasks such as updating the departmental Dropbox. I have also used this time to write a paper and have joined many educational webinars.

Following a discussion with my consultant after my 20 week scan, I asked to come back and do some lower risk face-to-face work. I have been going to theatre for head & neck/skin cases (thyroid, parotid, etc) but no AGPs, so no scopes etc. Patients are swabbed and have been asked to isolate for 2 weeks prior to their op date. I am not on the on call rota as I would have to be the one to carry out AGPs on both the sites we cover. I will continue this way until 28/40, although I may choose to continue some theatre after this time as I do have one eye on numbers for ARCP!

Case study 3:
AB had just crossed her 27 week when cases started spiking in her local trust, and so was entering her third trimester. The department clinical lead acted as line manager, although the line manager for a trainee is usually the Educational Supervisor (or where the AES is on another site, the Clinical Supervisor). The local risk assessment process was completed by the trainee
and line manager (i.e. clinical lead) together. AB was sent home the same morning, as the general advice at that time was pregnant women should be isolated. As things were new at the time, there was an impromptu departmental meeting; a trust laptop was arranged for the trainee. It was established that AB should work from home and perform telephone clinics for the patients on the 2ww pathway. This role then evolved, so AB became the main contact for all Head & Neck patient queries and worked closely with MDT colleagues to telephone triage any patients they had concerns about.

Occupational Health were contacted. In AB’s case, the referral was made by the line manager (clinical lead); note that some trusts allow self-referral once the risk assessment is completed. They had little to add as trainee AB’s department had already created a safe working environment for her.

For three months, no trainees were operating so AB did not feel that she missed any opportunities and felt she had an important role to play in the management of at-risk patients during a difficult and anxious time for them. Trainee AB’s deanery have the ARCP in the early summer, so by the time she went on Maternity leave at 38/40, she knew the current planned extension to her training.

Over the weeks, the advice and departmental plans were constantly being adjusted and updated according to government advice and COVID load in the hospital. The RCOG guidance was clear regarding pregnant doctors after 28/40: they should stay at home.

Employment law supports that if it is possible to be arranged, then the trainee can work from home during that period until maternity leave starts; if it is not possible to take action to avoid the risks, the trainee is entitled to suspension on full pay.

Key points from Trainee AB’s case:

- Find out your trust’s process for Risk Assessment and referral to Occupational Health
- For those trainees about to enter this situation, present to the department options/roles for continued work.
- Consider your work in the context of your resources; trusts that use electronic notes will be more amenable to setting up working from home. If however work from home is not possible, then make it clear that employment law allows you be at home from 28/40 with no detriment to pay. Medical Staffing may need to be informed of this outcome.
- Think about and acknowledge that there will be an impact on training.
- Ensure you engage with your Educational Supervisor and Training Programme Director about whether you feel you have received adequate training opportunity, and think you would benefit from an extension to training in excess of what you were expecting to add for maternity leave.
- Communication was key: the trainee and the team were kept up to date via email and a pan-department Messaging group.
References

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