EMERGENCY MEDICINE TRAINEES' ASSOCIATION

EMTA Report on Paediatric Emergency Medicine Experience during COVID-19

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Introduction and Purpose

This report has been produced following repeated concerns from trainees about their reduced exposure to paediatric emergency medicine during the COVID-19 pandemic. This has especially affected trainees doing PEM specific placements during ST3 and PEM sub-speciality years but trainees of all levels have reported reduced exposure to paediatric emergency medicine.

The reasons for this are multiple but include a reduction in the number of children attending emergency departments by around 50% during the first wave (1), redirection of unwell or injured children direct to the paediatric service, orthopaedic services and co-located primary care. In addition, the increased demand on adult emergency departments has seen emergency medicine trainees provide a greater proportion of care to adults.

This has been recognised as a risk to progression for emergency medicine trainees — who must be competent at managing the full spectrum of pediatric emergency medicine presentations — by RCEM, the statutory education bodies, by individual hospital trusts and emergency departments, and by trainees. Different organisations have responded to these challenges in different ways.

The aim of this report is to highlight areas of good practice that we have identified. Unfortunately we have also identified a number of practices which we feel are not acceptable. The information contained herein has been collected through the EMTA regional representative network, the EMTA committee and from feedback provided directly to EMTA via social media, email and the TellEMTA button.

Good Practice

One District General Hospital where trainees are placed during ST3 allocated trainees for 2 weeks on the general paediatric ward. This practice was in place prior to COVID and was continued during the pandemic and allowed for focused paediatric experience as well as providing perspective on what happens to the children referred from the ED.

Secondments to PAU/NICU/SCBU either in-house or other centres.

Sharing virtual teaching/journal clubs/meetings between sites.

Poor Practice

One trust has advised trainees to take study leave for protected shifts in paediatric emergency medicine. On the surface this might seem a pragmatic approach but PEM is core business for emergency physicians and a time spent delivering service in PEM is a poor use of study leave and will lead to gaps in curricular attainment elsewhere.

Several trusts have allocated trainees to PEM shifts but unfortunately trainees report that due to the demands on adult services they are more often than not allocated away from PEM to the adult department.

“Paediatric training is not ring fenced, trainees are allocated to ‘cover paeds’ during their in-hours shifts however trainees are often ‘called back’ to cover the adult EM department as service provision. Trainees cover adult EM for night shifts.”

Other considerations

Problems that existed prior to COVID remain and some reports suggest that these unwarranted variations were exacerbated during the pandemic.

Some departments lack suitable expertise to act as supervision for ST3 trainees on PEM placements.

The growth of the workforce who specialise in seeing certain presentations at the front door has clear arguments in terms of the growth of the emergency department and quality and sustainability therein. In departments that have developed this workforce in PEM the reduced number of paediatric presentations to the ED can be managed by this group who are not able to practice in the adult setting. EM trainees work across the spectrum of age and acuity with clinical priorities leading to redeployment. Prior to COVID this could be a barrier to gaining PEM experience and competencies — COVID seems to have exacerbated the problem.

“At [Major Trauma Centre], aside from those doing their ST3 paediatric block, there is no opportunity or training at all for any trainees to see paediatric patients. This is severely affecting our training, experience and confidence. We have already lost ANY exposure to minor injuries at [this trust] due to the ENP rollout (very occasionally a doctor is sent to minors to 'queue bust') and now we have no paediatric exposure. This must be addressed. It has been raised locally and it appears service provision in adult majors is their only concern. The excuse of covid is no longer valid.”

Formal Recommendations

ST1 and 2

In some locations trainees can complete ST1 and ST2 with minimal exposure to paediatrics, being placed in adult only emergency departments and departments of anesthesia. The transition to ST3 is especially challenging for this group and requires high-quality and proactive educational supervision.

ST3

Time allocated to an acute paediatric service, even in a supernumerary role, can help with both competence and confidence. A 2-week period, organised however practical locally, has

proved successful in some locations. In ST3 this is core content and should not utilise study leave or education development time.

Ring fenced time in a paediatric emergency department or a children's area of a district general hospitals emergency department, supervised by a PEM trained consultant, remains the best training for emergency medicine trainees.

Simulation in an option for improving exposure to previously common presentations such as croup or bronchiolitis.

Facilitating placement in paediatric clinics, anesthetic lists or fracture clinics may be useful for trainees with specific gaps and may be an appropriate use of education development time.

PEM has traditionally provided good exposure to minor injuries, it may be possible to develop some of this experience in an adult or general minor injuries setting at ST4+ but this would be dependent on appropriate supervision.

PEM Subspecialty Training
Many trainees will have had large parts of their PEM subspecialty training disrupted with limited opportunities to extend or repeat placements. An individualised pragmatic approach, which allows individual trainees to develop and meet the competences required to fulfil the role of a subspecialty trained EM and PEM consultant is paramount.

HST
Higher trainees who work in trusts that see children should have time in the paediatric area in their work schedule, preferably supervised by a PEM trained consultant.

Education development time should provide an opportunity for HSTs to address specific gaps as discussed for ST3 trainees above.

References

1) Dann L, Fitzsimons J, Gorman KM, et al. Disappearing act: COVID-19 and paediatric emergency department attendances. Archives of Disease in Childhood 2020;105:810-811.