The Impact of COVID-19 on Pulmonary Fellowship Training in an Irish Setting

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To the Editor:

We read with interest the recent Perspectives piece by Çoruh entitled “Flattening the Curve: Minimizing the Impact of COVID-19 on a Pulmonary and Critical Care Medicine Fellowship Training Program” (1). The authors explored multiple potential disruptions to fellowship training programs caused by the coronavirus disease (COVID-19) pandemic and highlighted the actions undertaken to mitigate the effects in their center, a hospital that “experienced moderate strain.” We report how fellowship training has been affected in an Irish hospital. Multiple different fellowship training programs exist internationally, which have varying formats and expectations for both attending physicians and fellows and all have experienced change owing to the effects of the COVID-19 pandemic.

St. Vincent’s University Hospital is an 836-bed academic health center in Dublin, Ireland, which was significantly affected during the peak of the crisis in Ireland, operating at surge capacity for 8 weeks, with 150% occupancy of the intensive care unit during this time. Fellows were redeployed from pulmonary and other specialist training posts to a ward-based internal medicine service that faced increases in patient caseload, on-call frequency, and working hours. Consequently, pulmonary fellows saw a decreased number of specialty pulmonary patients, resulting in decreased opportunities for detailed assessments and investigations. Before the pandemic, 389 patients were reviewed per month through 11 weekly outpatient clinics in this hospital, the national referral center for adult cystic fibrosis and the largest tertiary referral center for interstitial lung disease and sleep medicine. These clinics were changed to telemedicine “virtual clinics,” which further reduced the capacity for engagement with subspecialty-specific cases and the training opportunities that these consultations afford.

Because of the recognition of bronchoscopy as an aerosol-generating procedure (2, 3), the decision was made at the outset of this crisis for these to be performed by attending physicians to minimize exposure to multiple clinicians, preserve personal protective equipment, and observe social distancing guidelines. Pleural procedures, including thoracentesis and pleural catheter placement, were preferentially undertaken by interventional radiologists for the same reasons. Routine pulmonary function and cardiopulmonary exercise testing was...
postponed, with only urgent cases being
performed, further impacting pulmonary
fellows’ training in their performance,
interpretation, and reporting. Lack
of access to these procedures and
investigations raises the possibility that
fellows may not be able to achieve
procedural competence. Although the
pandemic has allowed for this to be
acceptable to central training bodies, this
could impact trainee confidence and
competence in these skills (4).

Formal delivery of education, which
previously included specialty-specific case-
based conferences, journal clubs, teaching
conferences, and research meetings, has
decreased as the demands on service
provision have increased. The impact of this
on trainees has been offset somewhat by the
conversion of institute-wide teaching sessions
to virtual lecture series accessible to all users
(5). However, exposure to teaching by
attending pulmonologists is a core
component of fellowship training and was
largely unavailable because of the increased
demand on attending physicians.

Physician burnout is common in medical
trainees and can be influenced by several
factors (6, 7). The multiple increased
demands on fellows combined with the
reduction of access to core components
of pulmonary training programs have
the potential to increase burnout rates. This
is compounded by the societal impact of
COVID-19 restrictions, with many fellows
unable to access the usual support networks
they may rely on to ameliorate burnout.

Fellowship training has been significantly
affected by the COVID-19 pandemic as
outlined above and in the Perspectives piece
by Çoruh (1). Although steps may be taken
to mitigate many of these factors, these actions
are dependent on the individual institutional
setup and clinical demands. It is critical to
prioritize strategies to optimize training in
times of increased service demand, such as
during the COVID pandemic, and
planning for this is especially important, as we
face the possibility of a second wave and other
novel viral infections in the future.

Author disclosures are available with the
text of this letter at www.atjsournals.org.

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