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Similarly, as we stated, neither 'long' nor 'risky' came out as themes in their study.[2] We do acknowledge that the length of the process is important, however, and randomised trials do show that induction increases time in the delivery suite by around 6 hours.[4] Our desire to improve the induction process is a response to this perceived need. In the discussion about risk, the Coates paper states that women had concerns about the 'likelihood of further intervention', but also states that 'concern for the baby always overruled desire for minimal intervention'.[2] This resonates with findings from the 34 randomised trials in the Cochrane review, and also the ARRIVE study, that although induction for women at low risk does lengthen the time spent in labour, it reduces the caesarean section rate and improves neonatal outcomes.[4,5]

The arguments about induction improving a woman's sense of control are not from Coates' qualitative review,[2] but are taken from randomised trial evidence that found that women who were induced reported a significantly increased sense of control.[4]

It is imperative that we are open to new knowledge generated through high-quality research, even when it challenges our prior beliefs. We advocate for improved communication and choice, personalised induction protocols and informed decision making, with system change to make this feasible in practice. ■

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K Lightly, & AD Weeks
Sanyu Research Unit, Institute of Translational Medicine, University of Liverpool, Liverpool, UK

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Re: Maternity services in the UK during the coronavirus disease 2019 pandemic: a national survey of modifications to standard care

Dear Editor,

We read with interest the article by Jardine et al.[1] on the reconfiguration of maternity services in the UK during the coronavirus pandemic.

As much as 53% of O&G trainees were redeployed through this period according to a Royal College of Obstetricians and Gynaecologists' survey[2] but the full impact of this redeployment on training, completion on competencies, deferment of annual review and Certification of Completion of Training (CCT) date, as well as on trainees' mental wellbeing, are still forthcoming. In addition, relaxation of junior doctors' contract (by increasing shift frequency) to accommodate emergency cover was also reported and anxieties about reduced training opportunities were expressed by 82% of Obstetrics and Gynaecology trainees.[2] There is also evidence now to suggest that stress and burnout-related symptoms may be surprisingly more prevalent in trainees in low COVID exposure specialties such O&G and orthopaedics, compared with front line staff in emergency or respiratory medicine.[3]

As we prepare for the second pandemic wave, we would like to share some preliminary data of an online survey assessing the challenges faced by O&G trainees in the London region.

Of 513 ST1-7 London trainees, 177 completed the survey between 20 July and 11 September 2020: 42% of the respondents were senior trainees (ST6-7) and 39% were ST3-5. Over 80% felt that they had not been provided with sufficient resources to manage patients during the pandemic and these deficiencies included conflicting and 'out of date' clinical advice, discrepancies in Personal Protective Equipment (PPE) guidance, shortages of PPE, lack of pastoral care, sudden redeployment without senior support, issues with getting correct renumeration while on emergency rota and rota changes being made without the correct process being followed. Nearly half of our respondents expressed that education and training opportunities had been inadequate, with the following topics being highlighted:

- Need for deanery support with electronic portfolio
- Clear guidance on training progression, achieving operative competencies and starting Advanced Training Skills Modules (ATSMs)
- Lack of debriefing for deployed trainees, especially those to Intensive Care Units
- Need for a support group for trainees having delayed CCT

We hope that this survey can be extended to capture more responses at a national level so that issues faced by trainees can be collated and addressed. Already, medical schools, in conjunction with accrediting bodies and licensing boards, have modified the training structure of students in order to navigate the educational challenges caused by the pandemic.[4] Thus, medical students have not only continued to learn but, in some cases, accelerated their attainment of the types of competencies.

There is a growing recognition that organisational and social support, clear communication and developing an awareness of the importance of mental health, together with a well-defined plan

to attain and achieve training and educational goals and competencies are crucial.

Decades from now, obstetrics and gynaecology consultants of the future may well be quizzed by their curious trainees, 'What did you do during the COVID pandemic of 2020? And how did you learn?' Hopefully, they would be able to say that they continued to contribute to patient care as part of modified maternity and gynaecology services, that they were able to maintain training and achieve competencies through alternative means and, in the process, learnt many formative lessons on how to provide new levels of caring. ■

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W Yoong, S Patra-Das, & A Gunasekera

Department of Obstetrics and Gynaecology, North Middlesex University Hospital, London, UK

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Authors' reply re: Maternity services in the UK during the coronavirus disease 2019 pandemic: a national survey of modifications to standard care

Sir,

We wish to thank Yoong et al. for their interest in our report on modifications to standard maternity care in the UK surveyed during the COVID-19 pandemic,[1] and for their subsequent letter.[2] We had reported the extent to which maternity services had been modified in the UK, in response to a need to protect staff and service users from the risk of infection with SARS-CoV-2, but also in response to staff shortages caused by redeployment and periods of staff self-isolation. An international survey of maternity and newborn health workers identified that similar service modifications were also implemented worldwide, and staff perceived that women feared attending for maternity care because of the presumed risk of being infected with SARS-CoV-2.[3] At the time of our manuscript submission, the impact of service reconfiguration in the UK had not yet been established. Although the widespread impact remains unknown, we welcome the recent Office for National Statistics report showing that rates of stillbirth and preterm birth in England and Wales during the first three-quarters of 2020 have not risen, and in fact have fallen in line with trends over recent years.[4]

Yoong et al. report on the impact of the COVID-19 pandemic on obstetrics and gynaecology training-grade doctors in London.[2] Although some training issues have been caused by the uncertainty of working within a health service during a rapidly evolving pandemic, other concerns have been caused by staff redeployment away from maternity care, without any decrease in demand for this urgent and emergency service. The international survey described above also identified that 90% of staff from low- and high-income countries experienced higher stress levels than usual, and maternity services were impacted by acute staff shortages.[3] In October 2020, the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) published a statement intended to reduce the impact of the COVID-19 pandemic on maternity services during the winter of 2020/21;[5] this statement included a recommendation that maternity service staff should not be redeployed elsewhere within the hospital, and a request that health service leaders recognise the current challenges and pressures on maternity staff and provide appropriate continuing support for wellbeing. We hope that this, along with the continually updated RCOG/RCM guidance and support resources available on the RCOG COVID web pages (www.rcog.org.uk) for trainees and all other maternity service staff, will continue to be accessed by our colleagues over the winter period, and that they find these useful in alleviating their concerns and fulfilling their needs. ■

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