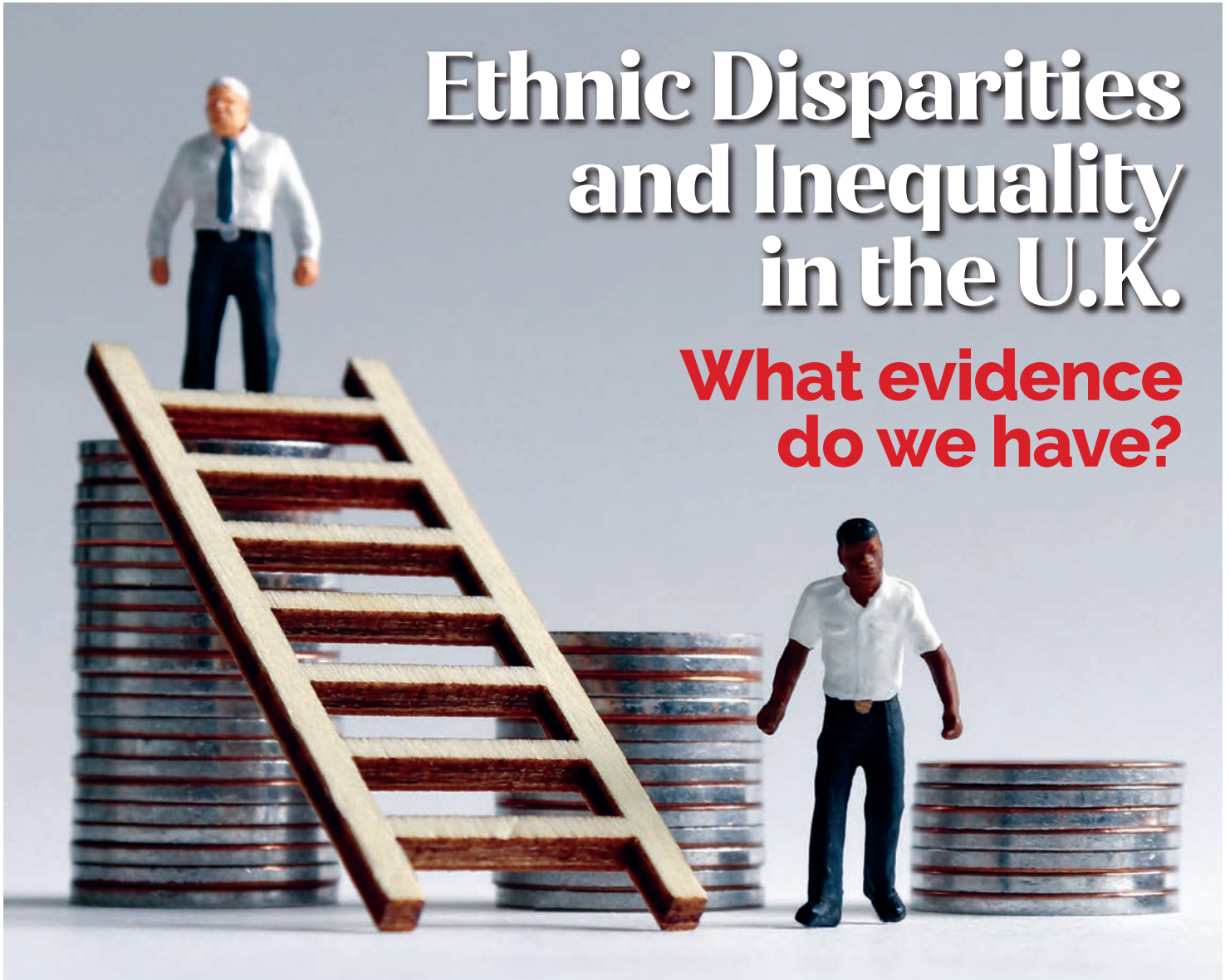


# Ethnic Disparities and Inequality in the U.K.

**What evidence  
do we have?**



## Inside:

A brief history of the Overseas Doctors' Association and British International Doctors' Association.  
COVID-19 and the heart.

The impact of COVID-19 on the management of Osteoporosis.

Anaesthetic Awareness during a Caesarian Section: A Case Report and Discussion.

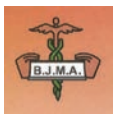
'Tackling Childhood Obesity in Greater Manchester': Full report on the Webinar.

Thinking of Cornea Donation? 'Dans Le Noir' will open your eyes!

# BIDA National Conference 2021

## “Living with COVID-19 and life beyond”

09:30 - 09:40	<i>Welcome</i>	Prof. Sanjay Arya	Organising Secretary, Medical Director & Consultant Cardiologist Wrightington, Wigan & Leigh Teaching Hospitals
09:40 - 09:50	<i>Chairman's Address</i>	Dr Chandra Kanneganti	National BIDA Chairman. General Practitioner, Stoke on Trent
09:50 - 10:00	<i>President's Address</i>	Dr B K Sinha	National BIDA President. General Practitioner, Liverpool.
10:00 - 10:15	<i>Keynote Speaker</i>	Rt Hon Matt Hancock MP	Secretary of State for Health, UK
10:15 - 10:30	<i>Keynote Speaker</i>	Dr Chaand Nagpaul CBE	General Practitioner & Chair of the Council of BMA
10:30 - 10:45	<i>Keynote Speaker</i>	Dr Ramesh Mehta OBE	Consultant Paediatrician & President BAPIO (UK)
10:45 - 11:00	<i>Keynote Speaker</i>	Dr Chris Brooks	Chief Medical Officer / Deputy Chief Executive Northern Care Alliance, Manchester
11:00 - 11:15	<i>Keynote Speaker</i>	Mrs Prerana Issar	Chief People Officer, NHS
11:15 - 11:25	<i>Coffee Break</i>		
11:25 - 12:25	<b>Session 1</b> <i>Introduction</i> <i>Chairpersons</i>	Dr Ravi Sharma Dr Vinod Gadiyar Dr Irfan Akhtar Prof. Colin Melville Prof. Iqbal Singh OBE Lord Victor Adebowale Dr J S Bamrah CBE Panel Discussion	Consultant Gastroenterologist, Northern Care Alliance, Manchester Chair, BIDA Hospital Doctors' Forum. Consultant in Anaesthesia & Pain Medicine, Northern Care Alliance, Manchester Gen Secretary APPNE. Consultant Surgeon, Nottingham University Hospital NHS Trust Medical Director and Director of Education and Standards, General Medical Council (UK) Consultant Geriatrician & Chair CESOP Chair, NHS Confederation Consultant Psychiatrist & Chairman, BAPIO (UK)
12:25 - 13:10	<b>Session 2</b> <i>Introduction</i> <i>Chairpersons</i>	Dr Rakesh Sharma Dr Preeti Shukla Dr Ghulam Abbas Dr Sakthi Karunanithi Prof Azeem Majeed Dr Raj Patel MBE Panel Discussion	General Practitioner, Blackburn & Member, GP Committee, BMA Chair, BIDA GP Forum. General Practitioner, Colne Health Centre, Pendle, Lancashire President, APPS (UK). Consultant Orthopaedic Spinal Surgeon, Bedfordshire Hospitals NHS Foundation Trust Director, Public Health, Lancashire Head of Department of Primary Care & Public Health, Imperial College London Deputy National Medical Director, Primary Care NHS England
13:10 - 13:30	<i>Lunch Break</i>		
13:30 - 14:15	<b>Session 3</b> <i>Introduction</i> <i>Chairpersons</i>	Mr Ibrahim Ismail Bolaji Dr Leena Saxena Dr Shamim Rose Dr Taj Hussein Ms Lucy Warner Prof Maggie Rae Panel Discussion	President MANSAG. Consultant O&G, Northern Lincolnshire & Goole NHS FT Chair, BIDA Women's Doctor Forum. General Practitioner, Wigan & Chair, Wigan Division, BIDA General Practitioner, Liverpool and Governing Body Member, CCG Consultant in Emergency Medicine, Leeds & Associate Medical Director, NHS Improvement, DoH. Chief Executive of the NHS Practitioner Health Service President, Faculty of Public Health, UK
14:15 - 15:00	<b>Session 4</b> <i>Introduction</i> <i>Chairpersons</i>	Dr Sanjoy Bhattacharya Mr Sai Pillariseti Miss Saloni Singh Mr Tinaye Mapako Dr Jeeves Wijesuriya Dr Marina Soltan Panel Discussion	Consultant in Emergency Medicine, East Lancashire Hospitals NHS Trust Chair, BIDA Students' Forum National Secretary, Medical Students Committee Chair of The British Medical Association's Medical Students Committee GP Registrar & Care Quality Commission Specialist Advisor NIHR Academic Clinical Fellow ST3 - Respiratory / #CPRinSchools Founder / GMC RLS Associate / RCP & AoMRC Trainee Rep
15:00 - 15:15	<b>Award Ceremony</b>	Mr Inzamam Rashid Dr Chaand Nagpaul CBE Winner	News Correspondent, Sky News Chair of the Council of The British Medical Association Medical Student Essay Competition
15:15 - 15:25	<i>Summary</i>	Mr Amit Sinha Mr Pranab Sarkar	Editor, BIDA Journal. Consultant Orthopaedic Surgeon National Treasurer, BIDA. Consultant Gynaecologist, East Lancashire
15:25 - 15:30	<i>Vote of thanks</i>	Dr Ashish Dhawan	National General Secretary, BIDA. Consultant Cardiologist Wrightington, Wigan & Leigh Teaching Hospitals



Centre of Excellence in Safety for Older People



# Editorial

**Mr Amit Sinha** FRCS (Tr&Orth) Consultant Orthopaedic Surgeon Media & Communication Lead, BIDA Editor, BIDA Journal.



BIDA pays homage to the late Dr Krishna Korlipara, who was celebrated as one of the “migrant architects” of the NHS. He was the Father of GP co-operative out-of-hours service in the UK. He played an active role in the GP practice community in Lancashire for over 40 years. We will always remember him.

The global COVID-19 death toll stands at more than 1.9 million. Among the lives lost have been those of health-care workers, who have had crucial roles throughout the response and continue to serve at the front lines. We continue to honour all of the health workers who have died from COVID-19.

The rollout of the first COVID-19 vaccine here in the UK is cause for great optimism for us all. There are further challenges along the way, beyond the practical implementation of the vaccination campaign, we have a wider role to play in ensuring that the public and our patients are reassured that vaccines are safe and important to the public health. It is important that we use our skills and experience to reassure others about the efficacy and safety of these products. We must also give others and ourselves constant reminders that the Coronavirus will not disappear, and that we must continue to follow all of the government guidance to keep transmission of virus as low as possible over the winter months.

Through the next few months, the health service across the country must agree a strategy for managing the different pressures of treating patients with COVID-19, and those without COVID-19 who need urgent care or elective work. We must strike a balance between the needs of these three groups of patients if we are to keep the NHS afloat throughout the impending winter storm. These are trying times but we must have faith in the strength of our doctors, nurses and all health care workers.

The Editorial Board wishes to remind our members that BIDA has completed 45 years of existence. This is a proud milestone. In honour

of our organisation, Dr S Kumar and I present the time-line of the ODA and its progress to become BIDA by remembering and honouring our Founder members and a number of stalwarts who have steered BIDA through the years. We salute them all.

The Department of Commission on Race and Ethnic Disparities asked for evidence on “Ethnic disparities and inequality in the UK”. On behalf of BIDA, I had prepared a response, which I would urge our members to read. The Editorial Board would welcome any additional comments or suggestions from you.

Covid-19 has changed not just how we practice medicine but also educated the medical world with different manifestations affecting our body. Drs P Gladston and S Arya have written about the effect of Covid-19 on the heart. Dr V Patel and her colleagues have shown how it has affected the healthcare delivery of Osteoporosis services.

Anaesthetic awareness during general anaesthesia is not a rare event. It is distressing to the surgeon, and the anaesthetist and it can impact on patients significantly leading to adverse physical and psychological sequelae. Dr M Popat and Dr P Sarkar discuss this interesting issue.

We would like to congratulate Prof S Senapati and Jack Carney and his team for hosting a highly successful “Tackling Childhood Obesity” conference. We wish their team to accomplish their mission.

Congratulations to Dr R Katira and his team for setting up the Southport & Ormskirk Division. This is a wonderful reason for celebration. We look forward to the BIDA National Conference on 6th Feb 2021. Please reserve this date in your diary.

We wish the New Year brings a smile on everyone’s faces with hope, joy and a fresh spirit. Let us embrace it with an open heart and go forward with faith and courage.

**A. Sinha**  
Editor, BIDA Journal.



## Instructions for Authors

BIDA Journal is a peer-reviewed journal. We welcome original articles from physicians, surgeons and medical students from any part of the world. These include review articles, scientific articles, case reports, audits and letters to the Editor. Please visit BIDA’s website for instructions.

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# bida National President's report



**Dr Birendra Sinha** National President, BIDA

Dear Colleagues,

I would like to begin by wishing and hoping that you and your families are all safe and well and are continuing to be careful during these unprecedented times.

First of all, I would like to honour our colleagues who have had to continue to work on the front line, a big thank you from all of us here at BIDA.

As mentioned previously we are hoping to start our normal activities including National election proceedings in January, and you will all be informed by mail as to how we carry out this democratic process.

Many BIDA Educational meetings are still taking place despite the logistical problems, by a virtual platform. Many have been arranged by the Divisional leads, but Alison Sherratt our Central Office Manager, has been instrumental in all of them. For this, on behalf of all BIDA members, I want to say a big thank you to Alison. Our grass roots BIDA members seem to have adopted to the virtual way of life in a very short span of time. The other advantage with these virtual meetings is that they are available to all BIDA members across the country. Thank you to all divisions for keeping the momentum going for BIDA members.

As we all know the COVID-19 vaccine scheme has started to be rolled out so we can all hope that we can get back at some point of normality next year, with face-to-face meetings such as ARM/AGM and sporting activities etc.

We had a very successful study day 'Tackling Childhood Obesity' which was organised by Professor Siba Senapati, Dr Vinod Gadiyar & Mr Amit Sinha. This was attended by 153 participants which is amazing - well done to the organising team.

# bida National Secretary's report

**Dr Ashish Dhawan** National General Secretary, BIDA

Dear Friends,

I would like to start by wishing you and your loved ones a happy and prosperous 2021. As the country enters into the New Year, the NHS keeps on struggling with winter pressures and the ongoing Covid-19 Pandemic. 2020 was a very difficult year for UK health care professionals and especially for BAME doctors. Whilst most of BIDA's usual activities like the Sports Tournaments, ARM/AGM and International Congress had to be cancelled due to the Pandemic, we have ensured that we remain in touch with our members via webinars, newsletters and e-mail communications.

It is now evident that the Covid fight is far from over and we at BIDA will keep on contributing against this fight at a National level, while simultaneously looking after the well-being and interests of BAME doctors. Amongst all this doom and gloom, the recently launched

We are having a BIDA National Conference, of course this will be virtual again and has been arranged for Saturday 6th February 2021. The theme of the day will be "Living with Covid-19 and Life beyond", this is being organised by none other than Prof. Sanjay Arya and he has got a fantastic organising committee of BIDA members to help him out. Anybody who knows Prof Sanjay Arya will realise that this will be one of the best National Conferences BIDA has ever had. There will be a lot of excellent speakers and I urge all members to please join in on the day.

I am glad that we are leaving 2020 behind and we all look forward to 2021 in which things will get better and brighter for BIDA. At the moment the only light at the end of the tunnel is the successful launch of the Covid-19 Vaccine. With the help of the vaccine, I hope all the normal activities of BIDA can resume in the new year. To start with I will be writing to all Divisional Chairman and Secretaries about resuming the fellowship awards in 2021.

As you have already noticed the BIDA Journal is improving upon every edition, we are all thankful to the hard work of Mr Amit Sinha and his team. Mr Sinha has also taken on the role of BIDA Media and Communications Lead officer and has worked tirelessly to write most of our correspondence to the Government and other relevant regulatory bodies. On behalf of each and every BIDA member I would like to thank Mr Amit Sinha from my heart.

I would like to wish all our members a happy, healthy, and prosperous 2021.

**Dr Birendra Sinha**

National President, BIDA



vaccination programme is a ray of hope. BIDA office members would like to reassure all its members that we will keep ongoing pressure on the Government to vaccinate each and everyone in the country as soon as possible.

The backbone of any organisation lies in its members and the same holds true for BIDA. Along with myself, all members of BIDA's Executive Committee are striving to strengthen our organisation by ensuring that our divisions are thriving and our membership keeps going upwards.

Finally, I would like to thank Alison Sherratt from BIDA Central Office for her hard work in keeping the office running smoothly.

Best wishes and stay safe.

**Dr Ashish Dhawan**

National General Secretary, BIDA

# bida National Chairman's report



**Dr Chandra Kanneganti** National Chairman, BIDA

Dear Colleagues,

Happy New Year to all of you and I hope 2021 will bring us happiness and good health to all.

2020 has been a difficult year for all of us with the COVID pandemic. BIDA's Officers and Executive Committee have worked hard in highlighting and championing many issues, including the disproportionate affection of COVID to BAME, Visa issues for international doctors, and successfully getting the immigration health surcharge scrapped during pandemic. We continued to write to the PM and Secretaries of State for both Health and Home, and have received their responses on number of key policy areas. We also offered a number of solutions to many problems faced by key workers and worked collaboratively with the BMA and other doctors' associations. BIDA has been pro-active and has been quoted in a number of national and local press organisations championing doctors' issues.

I would like to pay tribute to Dr. Krishna Korlipara, who sadly passed away on 26th November. Dr. Korlipara was an active member of BIDA since our organisation's early days and has contributed a lot to both the medical profession and to BIDA for years. He was kind, generous and had numerous roles in supporting the medical profession. He will be missed by BIDA and is a great loss to all of us.

We have arranged an important BIDA National Conference on February 6th 2021 with key speakers and interesting current topics. Please register for this and participate. I am thankful to Prof. Sanjay Arya who is facilitating this event, along with the organisation committee members who are supporting this event with tremendous enthusiasm.

BIDA's Student Wing is growing stronger under the leadership of its Chair, Sai Pillarisetti. The Student Wing has already attracted members from 15 medical schools representing different nationalities. Current plans include mentoring support and providing educational resources for international students studying in UK medical schools.

BIDA officers have met regularly in the past few weeks and have worked hard to raise issues, offer solutions, and have also attended stakeholders' meetings representing our member's views.

There is hope in 2021 with the COVID vaccines. Please let us know if you have any difficulty to access to vaccines. Let's continue our hard work in our places of work and at home to support others, and I hope we can come out of this pandemic much stronger soon.

**Dr Chandra Kanneganti**

*National Chairman, BIDA*

# bida G.P. Forum Chairperson's report



**Dr Preeti Shukla** Chairperson, G.P. Forum, BIDA

Dear Members,

First of all I would like to thank you for your hard work, dedication and unfaltering commitment to the NHS and patients in this pandemic, even when on occasions it meant that your well-being was at risk. 2020 was probably the most challenging year in our professional lives and the challenges remain in 2021.

General practice has already risen to confront the issues with its biggest vaccination campaign ever, and has begun to participate with careful planning and enthusiasm. BIDA stressed the importance of vaccinating front-line healthcare professionals first so that we are able to protect the workforce, especially considering BAME doctors are high risk. Organising a large-scale vaccination program in such a short time is no small feat especially when we have had last minute changes to vaccines' delivery schedules and guidelines, but with a lot of good will, and desire to do the best for our patients and for the NHS, we are doing it. In addition, we

are not only providing care to patients with acute needs but also to people with complex long term conditions and people who are awaiting their secondary care appointments and operations. I believe the NHS will overcome this virus and, if I may say so, in large part due to the wonderful work of our colleagues in general practice.

I would like to encourage you all to have your vaccine when offered. I am lucky - I have had my first dose of the Pfizer vaccine with no side effects. I made a video of me getting vaccinated to allay the concerns of the public and to encourage them to have it.

I hope 2021 is a good year for all of us and that you all stay safe and healthy. Once again, thank you for all your hard work for the NHS

**Dr Preeti Shukla**

*Chairperson, G.P. Forum, BIDA*

# A brief history of the Overseas Doctors' Association and the British International Doctors' Association – struggles & objectives



**Dr Surendra Kumar** FRCGP Fellow of The British Medical Association Fellow of The Royal College of General Practitioners Fellow of ODA/BIDA BIDA Special Services Award.  
**Mr Amit Sinha** FRCS (Trauma & Ortho) Consultant Orthopaedic Surgeon. Editor, BIDA Journal.

It is 45 years now since the establishment of the Overseas Doctors Association (ODA), now the British International Doctors Association (BIDA). The idea initiated by our 5 founding members now embodies the aspirations and ideals of all International Doctors. BIDA stands for the interests of International Doctors and highlights their problems. It is their voice, and its strong image provides a platform which represents the welfare of all International Doctors.

When we are looking at the history of BIDA, we will have to cast a brief glimpse into the history of overseas doctors in the United Kingdom.

## History of Overseas Doctors

The greatest immigration of International Doctors started happening after the creation of NHS in 1948<sup>1</sup>. It is worth highlighting that according to one historian, by 1945 there were no less than 1000 Asian doctors in Britain.

The NHS during the 1960's had come to be dependent on the practitioners recruited from overseas. In the training grades there were 8000 young, qualified doctors from overseas, 42% of that total, most of whom were expected to return home later. Early in 1974 the health Department said that, allowing of the many doctors who returned home each year, the maintenance and development of the NHS was dependent on the annual admission of between 2500 and 3000 doctors born overseas. UK medical schools produced 2289 medical practitioners in 1973. The number of overseas doctors practicing in the United Kingdom mostly in the NHS was gradually increasing.

Indeed, the dependence of NHS on overseas doctors became so great that in a debate in the House of Lords in 1961 Lord Cohen of Birkenhead commented on the fact that: "The Health Service would have collapsed if it had not been for the enormous influx of junior doctors from such countries as India and Pakistan"<sup>2</sup>. This statement is more accurate now, as the doctors from the South Asian sub-con-

continent are the architects of the present-day NHS and make up approximately 1/3rd of doctors practicing in the NHS.

While all this was taking place, the overseas Doctors were not organised. They came, after all, from a wide variety of places and by no means all shared the same cultural and religious backgrounds or medical education.

At the same time, when the NHS was recruiting more and more overseas Doctors, the personal and public complaints led to the GMC's concerns about whether the registration arrangements were adequate to ensure the competence of all those it registered. Taking all these things into account Sir Keith Joseph set a committee in 1972 on 'Regulation of the medical profession' under the chairmanship of Professor AW Merrison. Professor Merrison was a professor in Experimental Physics at Liverpool University and then later VC of Bristol University. The Merrison report was published on the 16th of April 1975 and was incorporated into the 1978 Medical Act. The Merrison report was very critical of Overseas Doctors, and only after that did TRAB and later the PLAB TEST came into existence.

In 1974, EEC medical directives were accepted by the Government of the UK. These directives were restrictive and discriminatory to all overseas-qualified doctors. But despite this the BMA raised no objection to them at all. This was indeed overt racial discrimination for the vast number of doctors who were supporting the NHS in the UK. Many overseas doctors had already acquired UK higher qualifications and many of them were British citizens. Doctors Chatterjee and Venugopal took this issue to the BMA, who were not really concerned and remained indifferent. Indeed, Dr. Satya Saran Chatterjee mentions in his memoirs that he received a letter from Dr Akram Sayeed to draw attention to the plights of young overseas doctors working in Britain<sup>3,4</sup>. This acted as a wake-up call for Overseas Doctors!

Shortly after the publication of Merrisons' report the Overseas Doctors realised that they would need to organise to gain proper recognition, and decided to form the Overseas Doctors Association (ODA).





*The founding doctors of the ODA. Clockwise, from top left: Dr S. Venugopal, Dr Akram Sayeed, Dr K Admani, Dr S S Chatterjee and Dr Farrukh Hashmi, who became the first President of the Overseas Doctors' Association, 1975 - 1977.*



### **Box 1: Time line of the initial history of ODA / BIDA**

- 1975: 11th May - Official launch of the Overseas Doctor's Association (ODA).
- 1975: 19th September - First conference of ODA was held in London.
- 1976: The first monthly ODA News Review was published from Leicester. The first editor of ODA News Review was Dr Sunil Bhattacharya.
- 1978: The first ODA President's Cricket Trophy Tournament was coordinated by Dr Bharath Bhasin.
- 1979: GMC elections were held under the new Medical Act. Four out of the ODA's seven candidates were elected, including Dr Karim Admani, Dr Satya Chatterjee and Dr Venugopal.
- 1984: Dr. Krishna Korlipara was elected to the GMC as a member. He continued to serve the council as a member for 25 years and, by the time of his retirement, he had become the longest serving member of the GMC.
- 1985: The 10th Anniversary of the ODA. A plaque was placed at Dr Venugopal's home in Birmingham, which is the birthplace of ODA.
- 1987: ODA (BIDA) Fellowship Awards commenced.
- 1989: The first office was set up in 28-32 Princes Street, Manchester.
- 1991: The first International Congress by ODA was organised by the then newly elected General Secretary, Dr Surendra Kumar. It took place in Delhi, India, was attended by 95 ODA members, and the concept was designed to promote transcultural healthcare.
- 1994: Dr Shiv Pande was elected to the GMC Council. Later on he became GMC Treasurer, the first overseas doctor to have been elected to that post.
- 1996: Dr Surendra Kumar was elected as ODA Chairman and initiated the project of acquiring ODA House.
- 1998: The ODA's constitution was changed.
- 1999: ODA House was acquired. The name of the ODA was changed to British International Doctors' Association (BIDA).
- 2000: Inauguration of ODA House on 25th May under the Chairmanship of Dr Surendra Kumar.  
The name of BIDA formally adopted after the Silver Jubilee in 2000.
- 2012: Dr Raghu Hedge appointed BIDA Sports Coordinator.
- 2015: BIDA Badminton and Table Tennis Tournaments started.
- 2016: Setting up of plaques in BIDA's Central Office with the names of Presidents, Chairmen and Secretaries of ODA / BIDA.
- 2018: The first ever "Special Services to ODA / BIDA Award" was given by BIDA to Dr Surendra Kumar.

## The history of ODA (BIDA)

In practice the ODA was composed predominantly by Doctors from the Indian Subcontinent, although the Association represented the interests of Doctors from all overseas countries.

On the 11th May 1975, a meeting was held in Birmingham at the house of the late Dr S. Venugopal which was attended by a handful of Overseas Doctors. The meeting's aim was to organise and launch the Overseas Doctors Association (ODA) in the UK as a representative body of all overseas doctors working in the United Kingdom. The five doctors present – the late Dr S Venugopal, the late Dr S S Chatterjee, the late Dr A K Admani, the late Dr A A Sayeed and the late Dr F S Hashmi – became founder members of the ODA. A working Committee was formed with Dr Akram Sayeed as Chairman and Dr. Satya Saran Chatterjee as its Vice President. This was the day when the ODA was officially launched. The ODA's aim was to put forward the point of view of overseas qualified Doctors and generally to look after their interests. The ODA had the effect of raising the consciousness of overseas qualified Doctors and gave them a platform to fight the discrimination in the NHS and GMC.



Above: Dr Shiv Pande, Dr Surendra Kumar, the late Dr R Prasad, Mrs O'Driscoll, Dr S Venugopal and Mrs Karczewksa pictured at the first Conference of the ODA, London, 19th September 1975.

On 19th September 1975, the first conference of the ODA was held in London which was attended by 120 Doctors. This conference was a precursor to what would become an annual event called Annual Representatives Meeting (ARM). The purpose of the ARM was to discuss the motions sent from different parts of the country, and the resolutions that were to be passed were to become the policy of the Association. Dr Satya Saran Chatterjee was elected as its Chairman, Dr Farrukh Hashmi as President and Dr Akram Sayeed as Secretary.

The ODA was immediately recognised by the UK Government, The Department of Health, The Royal Medical Colleges, the GMC and the CRE (Commission for Racial Equality). The ODA started dialogues with all of these organisations, and in turn the organisations began to understand the discrimination faced by overseas doctors on issues of training, promotions and job opportunities.

Over the years, the ODA established the rights of the overseas doctors. A few ODA leaders got elected to the council of the GMC. They convinced the GMC to hold the first part of the PLAB examination in the overseas doctors' own countries. This helped many doctors to come to the UK, after successfully completing Part 1 of the PLAB examination. Mr. Finlay Scott went to India to



Dr S Venugopal (top) and Dr K Admani (above) pictured at the first ODA International Congress in New Delhi, India in 1991, being presented with commemorative awards and at a gathering of dignitaries (right).





negotiate and set up PLAB part one examination to be held in India in February 1996.

BIDA has had stalwarts like Dr S N Verma and the late Dr Deepak Trivedi, initially as ARM Chairman and later as the President, who introduced vibrant discussions in the ARM meetings. These discussions generated numerous BIDA policies for the future. The contributions of Dr Ruben Prasad, Dr Raheem Khan, Dr Ramesh Gandhi, Dr Alam Ara Khan, Dr Ashok Kakkar, Dr MM Gupta, Dr Mrs Raj and Satish Ahuja, Dr Aftab Ahmed, Dr Anand Ahuja, Dr Shiv Pande, Dr Prasad Rao, Dr Sabyasachi Sarker and several others were instrumental in building the foundation of the ODA.

Dr Surendra Kumar, who was elected as Chairman in 1996 and then President in 2002, led the organisation to new heights. He wanted to make the organisation more modern, forward looking and fit for the 21st Century. As the General Secretary of the ODA in 1991, he introduced the concept of International Scientific Conferences in different parts of the world to promote Transcultural health care. He also felt that overseas doctors needed a place for themselves and therefore raised funds to buy ODA House in Stockport which had its inauguration in May 2000. By this time many children of overseas doctors had started to graduate as doctors in the UK. It was considered that the ODA name would not be appropriate to reflect their status, and therefore the name of the organisation was changed to the British International Doctors' Association (BIDA).

With the help of Dr S Sarker and Dr RC Gupta the constitution was changed to modernise the organisation. BIDA News Review, which until then had been a free-standing organisation, was brought within the umbrella of BIDA. Its title was changed to BIDA Journal and it was made one of the standing committees of BIDA.



*Top: Dr Surendra Kumar alongside the Mayor of Stockport at the inaugural function of ODA House in May 2000.*

*Above: ODA House, BIDA's Central Office.*

*Left: 11th May 1985 - On the tenth anniversary of the founding of the ODA, a plaque was unveiled at Dr Venugopal's home in Birmingham, the venue where the initial meeting had been held at which the ODA had been established.*

The objectives for which the Association is established are: -

- (a) To promote the medical, dental and allied sciences and to promote and maintain the honour, interests and well-being of the medical and dental profession and in particular, but without prejudice, to the generality of the foregoing of those members of the medical and dental profession who received their medical and dental training.
- i) Outside the United Kingdom or who came to the United Kingdom for the purpose of receiving their medical and dental training, who were prior thereto resident outside the United Kingdom.
- ii) Within the European Union and resident in the United Kingdom and whose parents and/or grandparents were resident outside the United Kingdom and European Union.
- (b) To hold or arrange for the holding of, periodical meetings of the Members or the Association and of the medical and dental profession generally.
- (c) To provide a comprehensive counseling and career advice service to members of the Association or to any other members of the medical and dental profession or to any person desirous of practicing medicine and dentistry.
- (d) To circulate such information as may be thought desirable by means of periodical journal, which shall be the journal of the Association, or, by any other form of publication.
- (e) To promote a better understanding between members of the Association and local and central government, institutions and other bodies, whether professional or otherwise and the general public.
- (f) To co-operate with any company, association, public authority, or other body or person for the purpose of promoting the objects of the Association.

Dr Surendra Kumar was elected to GMC council in 1999 and became one of the Chairs of "Fitness to practice" panels. He continued in this role until 2016 and, during this period, he chaired one of the very highest profile and longest hearings of the GMC, lasting 3 years, concerning the MMR vaccine.

Our current Chairman, Dr Chandra Kanneganti and President, Dr Birendra K Sinha have been dynamic in raising their voices against injustices towards IMGs, and vehemently opposed the decision taken by the GMC with respect to Dr Bawa-Garba's case. This has made BIDA's relationship with the BMA, the GMC and the RCGP much stronger.

### PROTECTION

- Promotes the interests of Ethnic Minority doctors working in the UK
- To highlight and raise any difficult issues of the members to the government
- Support members in difficulty

### COMMUNICATION

- BIDA Website
- Regular updates from BIDA Central Office

### NETWORKING

- With the government, GMC, BMA and all other related organisations to influence change in policy and improve IMGs working environment.
- BIDA Divisional & Forum meetings, Annual ARM/AGM meetings

### EDUCATION

- Regular BIDA Courses
- BIDA International Congress
- Forum Educational meetings
- BIDA Journal

### ADVISORY SERVICE

- Mentoring to protect and promote IMGs career prospects
- Encourages equality of opportunities in education, training and careers.
- Endorses patient care of the highest standard.

## The objectives of BIDA

BIDA encourages second generation International Medical Graduates qualified in the UK to join as members. BIDA, as an organisation, remains the voice of IMGs (International Medical Graduates) (Boxes 2&3). The central committee has been influential in having regular interactions with representative bodies like the BMA, the GMC, the Royal Colleges and with government ministers to influence policy making for recognition of the issues facing the IMGs. They encourage its members to gain representation in bodies such as the British Medical Association and the General Medical Council.

Doctors from the International community have been contributing to the NHS.<sup>5</sup> The story of International Doctors in Britain has not always been one of celebration. There have been numerous cases of discrimination and worse, and many of them were unable to enter or progress in high-profile medical streams.

BIDA remains committed to be the voice of IMG's.

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# Ethnic disparities and inequality in the UK: What evidence do we have?



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## Introduction

There is deep-rooted inequality faced by ethnic minorities due to a combination of structural and cultural racism and individual-level discrimination in the UK. A recent study by the University of Oxford shows stark reality of major inequalities in housing, employment and the justice system<sup>1</sup>. The alarming deaths in the ethnic minority section of the society during the COVID-19 pandemic reflect these imbalances. One only needs to pause and think why the numbers in the UK are greater than any other European countries. This is a document, which I had prepared on behalf of BIDA in response to the Department of Commission on Race & Ethnic Disparities asking for evidence on this subject in question.

## Main causes of racial and ethnic disparities

Poorer housing and nutrition, lower educational and economic opportunity, and greater environmental risks have led to a lower socioeconomic position in the ethnic minorities section of the society. Racial residential segregation may well be another factor causing racial health disparities. This leads to communities of concentrated poverty with high levels of disadvantages and low quality housing stock. Poor physical conditions of living most definitely lead to deprived social environments. These in turn are associated with poorer health, increased prevalence of chronic and acute psychosocial stresses and shortened survival.

BIDA is concerned with the report of the Marmot review that the health gap between wealthy and deprived area is growing<sup>2</sup>. This would drive the racial and ethnic disparities further. Research commissioned by the Royal College of Physicians indicated that there are many causes of health inequalities but deprivation is a key factor<sup>3</sup>.

## Representation, retention and progression in the Healthcare sector workforce.

Representation by ethnic minorities in the management sector of the healthcare is hugely lacking both in the primary and the secondary care.

### PRIMARY CARE

There is good evidence of neglect of the commission service managers in paying attention to the needs of the population where ethnic minorities are more densely populated.

Study done by Sarah Salway and colleagues found very limited attention to ethnic inequity within English healthcare commissioning discovered that while some high level strategic documents made general reference to the importance of meeting the needs of ethnically diverse local populations, these statements were rarely translated into concrete action plans or performance indicators<sup>4</sup>. They found that culturally embedded organisational processes filtered out, or watered down, attention to ethnic inequity.

Many managers and teams did not consider tackling ethnic healthcare inequities to be part-and-parcel of their job, lacked confidence and skills to do so, and questioned the legitimacy of such work. Further exploration of micro-level healthcare commissioning work by individuals and teams showed that most did not consider understanding and tackling ethnic healthcare inequalities.

BIDA suggests greater involvement, understanding, engagement and communication with the ethnic minority population in the commissioning and other related management groups. This would empower communities. This can be brought about by

- Increased representation of ethnic minority leaders and
- Appointment of doctors from ethnic background in policy decisions
- Appointment of managers from the ethnic background in their group.
- Link with community and faith leaders

### SECONDARY CARE

According to the NHS Workforce Statistics on the Gov.UK ethnicity facts and figures website, as at March 2019, over 1.2 million people were employed by the NHS and of the NHS staff whose ethnicity was known, 4 out of 5 (79.2%) were White (including White ethnic minorities), and 1 in 5 (20.7%) were from all other ethnic groups. The statistics in percentages in Box 1 shows the latest figures. This data does not include GPs and dentists. The non-medical staff includes nurses, management, technical and ambulance staff.

Box 1: NHS Workforce statistics March 2019

Ethnicity	Medical	Non-Medical	Senior Management
White	55.6	81.6	92.9
Asian	29.7	8	4.6
Black	4.6	6.3	1.2
Chinese	2.5	0.4	0.2
Mixed	3.2	1.6	0.8
Others	4.3	2.1	0.2

The representation in the management sector in the secondary care is woefully lacking in both the medical and the nursing hierarchy.

BIDA suggests the following measures to bridge this gap

- Encouraging senior doctors to take up management roles. (This can only be brought about by flexibility in the system of the units, as the workload is constrained by the limited workforce in each unit)
- Ensuring the Hospital boards have adequate representation from senior ethnic minority leaders in the community or retired experienced doctors who are willing and capable to contribute.

### Healthcare retention and workforce

The King's fund publications indicate that across NHS trusts there is a shortage of more than 100,000 staff. Based on current trends, they project that the gap between staff needed and the number available could reach almost 250,000 by 2030. Many of the same issues are affecting the social care workforce as well. The NHS has been dealing this with import of doctors, nurses and non-medical staff from other countries. Unfortunately, a good number of local graduates and trained doctors immigrate out of UK to countries, which offers them better conditions of work, pay and a better quality of life.

On the other hand, the ethnic minorities among staff, quite a large proportion of who have come from other countries are often penalised for their contribution to the NHS.



The following factors are responsible for this:

- Restrictive immigration policies, at present exacerbated by Brexit
- Cuts in funding for training places.
- No concern for the health and wellbeing of staff. The increased death of BAME healthcare staff during this pandemic is ample proof for this.
- Evidence of discrimination and inequalities in pay and career progression, which lead to some leaving their jobs early or choosing to locum work.
- Fragmentation of responsibility for workforce issues at a national level and poor workforce planning.

There is a huge disconnect between strategic goals and the workforce in all sectors of the healthcare, nursing and medical. Once these factors are addressed retention of staff would become a lesser of an evil.

### **Root causes of inequalities in health outcomes**

The Marmot review states that "Health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources – the social determinants of health"<sup>2</sup>.

Health inequities are worsening across Britain. Data from the Office for National Statistics (ONS) show that men in England's most deprived areas die almost a decade earlier than those living in affluent neighborhoods<sup>5</sup>. For women, life expectancy is falling in deprived areas. During the coronavirus pandemic, the strong emerging relation between covid-19 death rates and area deprivation reported by ONS<sup>6</sup> and Public Health England<sup>7</sup> has shown the exacerbation of existing inequities and highlighted the need for more comprehensive datasets in order to understand and reduce them.

The UK in its 1965 White Paper Immigration from the Commonwealth included explicit mention of migrant health. A lot of attention has been given to this. Since then, a steady stream of activity has aimed to enhance equality, commitment to equal services for equal need, inequitable access, experiences, and outcomes continue to be documented for minority ethnic groups across a range of English NHS settings. Why haven't these measures translated into improving the health of the ethnic minority population? Some contexts perform particularly badly, notably mental health<sup>8</sup> and maternity care<sup>9</sup> but evidence of ethnic healthcare inequity is widespread<sup>10</sup>.

The root causes are:

- Socioeconomic and racial/ethnic disparities in the process and delivery of health care contribute to these disparities in health outcomes<sup>11</sup>
- Poorer housing
- Poorer nutrition
- Lower educational achievement
- Lower economic opportunity
- Greater environmental risks (occupation)
- Poor mental health
- Long term health conditions
- Greater cancer mortality among patients from deprived areas attributed to "healthcare system factors," including later diagnosis and impaired access to optimal treatment<sup>12</sup>
- Shortened survival
- Language barriers (leading to poor communication)

How do we address inequalities in health outcomes in people of different ethnic groups?

The UK's National Health Service has no system for routine recording of patients' socioeconomic circumstances. The system relies on patient's postcodes to identify, address and monitor socioeconomic inequalities.

Social determinants are not routinely asked about, documented, or coded in clinical settings. The health service is, in effect, blind to those social determinants of health and healthcare.

Lack of robust individual level socioeconomic assessment in healthcare settings means that doctors are unable to identify people whose socioeconomic circumstances increase their risk of adverse health outcomes or treatment failures. Accordingly, it is not possible to identify those who may benefit from care plans acknowledging their social context, or to reliably monitor socioeconomic inequities in healthcare<sup>13</sup>.

The World Health Organization has emphasised the importance of monitoring equitable service coverage across wealth and education gradients as part of achieving universal health coverage<sup>14</sup>. Michael Marmot, one of the UK's leading public health researchers, has also advocated using markers of health equity such as socioeconomic position and education to monitor health and healthcare as a first step in confronting inequities<sup>15</sup>.

The British Medical Association suggests that doctors should consider patients in the context of social factors, noting the adverse health effects of poor housing, unemployment, poverty, and low educational achievement<sup>16</sup>. But these recommendations have not been incorporated into UK policy, or led to any appreciable shift in practice, and the subject has been largely neglected in the UK research agenda.

General practitioners spend large amounts of consultation time on non-medical issues relating to welfare benefits, sick notes, or unemployment<sup>17</sup>. But the socioeconomic circumstances and difficulties discussed are rarely or only inconsistently recorded. By not asking patients about their social circumstances or recording socioeconomic data, doctors help to conceal these problems from public view and from the political agenda.

In Toronto, Canada, routine collection of patients' social data, including housing and household income, has been introduced in four large health organisations. Doctors have used these data alongside an online tool to identify social benefits for which patients may be eligible<sup>18</sup>, tackling income and related issues directly in the clinic. Healthcare teams in Toronto have adopted the single screening question: "Do you (ever) have difficulty making ends meet at the end of the month?" Affirmative answers have proved to be a good predictor of poverty<sup>19</sup>. Once identified, patients whose socioeconomic circumstances put them at risk of poor health and care outcomes can be flagged for enhanced care plans and targeted for specific interventions

In the US, during the Obama healthcare reforms, it was recognised that identifying and meeting patients' social needs could restrain healthcare spending and improve health outcomes. The US National Academy of Medicine delivered specific recommendations for practitioners on the assessment and recording of patients' education level and their experience of financial hardship<sup>20</sup>.

BIDA calls upon the government to:

- Adopt a holistic way of addressing the health equities in the population in particular the BAME population and consider patients in the context of social factors, noting the adverse health effects of poor housing, unemployment, poverty, and low educational achievement.
- Consider a policy in the NHS for primary care doctors to use their patient's data alongside an online tool to identify social issues and record ethnicity.
- Improve data collection and reporting by ethnicity in the NHS at appropriate levels.
- Need to enhance the skills, confidence and competence of individual managers and teams and to improve organisational systems and processes that support attention to ethnic diversity and inequity.
- Commission Public Health England to create a national framework for risk assessing BAME healthcare workers, which could be adopted in all four nations.

- Engage in public health messaging in multiple languages, particularly addressing communities which have been deemed to be high risk
- Work with organisations, charities and regional directors of public health in areas of social deprivation to ensure that all sections of society are considered and protected.
- Produce leaflets and documents for essential information for selected medical conditions for all Ethnic minority groups in their respective languages e.g. BAME with learning difficulties etc.
- Agree to regularly meet with us and other BAME groups to agree an agenda for changes that must take place to protect our patients and healthcare workers.

### **Suggestions of other ways to address racial and ethnic disparities...**

The NHS has a performance-driven, top-down culture. The holistic approach for patient care sometimes gets lost. There is complete absence of clear national direction of care of the vulnerable ethnic population. The apparent disconnect between national commitments and local provision of health services to multi-ethnic patient populations raises questions about how central government policy becomes translated into service design and delivery on the ground.

BIDA would like to draw attention to well-researched papers, which require the need for more fundamental action on the following issues:

- Poor understanding of the nature and causes of ethnic inequities in health and healthcare <sup>21</sup>.
- Reluctance to engage with racism and exclusion <sup>22</sup>.
- Uncertainty regarding the entitlements of minority ethnic people <sup>23</sup>
- Ethnic (and other) equity must be given much greater visibility, legitimacy and resources at macro policy level.
- We must spell out more clearly: how and why ethnicity affects health and healthcare access; what standards of service provision are expected; and what commissioning responses are appropriate.
- Need for more 'systems-based' approaches that recognise the institutionalised and structural nature of problem: (The Stephen Lawrence Inquiry 1999) <sup>24</sup>
- Ethnicity, inequity and racism remain uncomfortable topics within health-policy making circles <sup>22</sup>.
- We need to break these barriers of negative thinking.

Doctors can make these changes happen. So why have they not done so already and why have socioeconomic inquiries been widely neglected? These include concerns about lack of time, pressures on healthcare staff to complete other mundane tasks, and the prioritisation of achieving targets over social determinants. Another common concern is the supposition that patients would object.

There are examples of good practice and innovation.<sup>25</sup> One such example of worthy practice is the attitude of midwives in maternity care in the UK. They routinely ask every expectant mother about financial security, employment status, occupation, education, and housing. It is a collective failing that the children born to some of those mothers will have their lifespan diminished by as much as a decade because of socioeconomic circumstances.

While it is important not to overlook pockets of good practice and innovation like "Intermediate care", "Rapid recovery in General surgery", "Use of Day case surgery", "Introduction of Nurse led services" etc for all groups of the society, we have known for years about poorer health outcomes in deprived areas of the country, with successive governments failing to act. Now we see that mortality rates in patients from the most deprived areas were more than double the least deprived areas. The Covid pandemic has laid bare the fallacies of this super NHS system in the UK. The risk of death of people of Bangladeshi ethnicity was twice that of White British people. In people of Chinese, Indian, Pakistani, Other Asian,

Caribbean and Other Black ethnicity it was between 10-50% higher. These findings are not limited to patients of BAME ethnicity either. BAME Health and Social Care workers have also been disproportionately affected by COVID-19 too. Risks assessments of staff in many cases are meaningless unless steps are taken to safeguard those at risks.

The socio-economic duty is key to ensure that the needs of vulnerable people, who can all too often be forgotten, are considered in every decision. It is vital that the impact of policies made at the highest level of government on the poorest in society is weighed up before final decisions are made.

### **Conclusions**

Racial and ethnic disparities are unfair but evidently avoidable. Putting them right is a matter of social justice. Over the years, there have been several reports, which unfortunately have all been shelved. The Covid-19 pandemic has been yet another "wake-up" call for the political leaders, the Commission for Race and Ethnic disparities and all organisations who strive to uplift the standard of the BAME population. The NHS is blind to the social determinants of health and healthcare of the general population. Will this ever change?

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# COVID-19 and the Heart

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## Abstract

The COVID-19 pandemic has brought many new challenges to the health systems all over the world. As the pandemic has progressed, we have started to learn more about its pathogenesis. The primary effects of COVID-19 are on the respiratory system, however more evidence is coming to light showing that COVID-19 is having substantial effects on the other systems<sup>3,16</sup>. One particular area of interest is the effects of COVID-19 on the cardiovascular system (CVS). This can be broadly classified into its direct effect on the CVS in the form of new or worsening of existing cardiovascular disease (CVD) as well as its indirect effects on the CVD.

## Cardiac manifestation of COVID-19

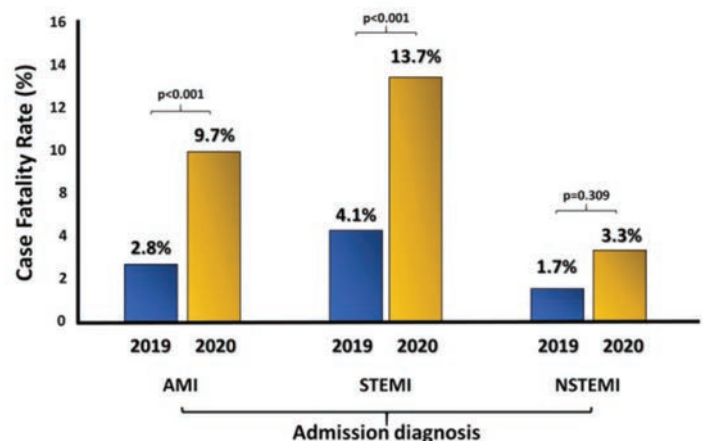
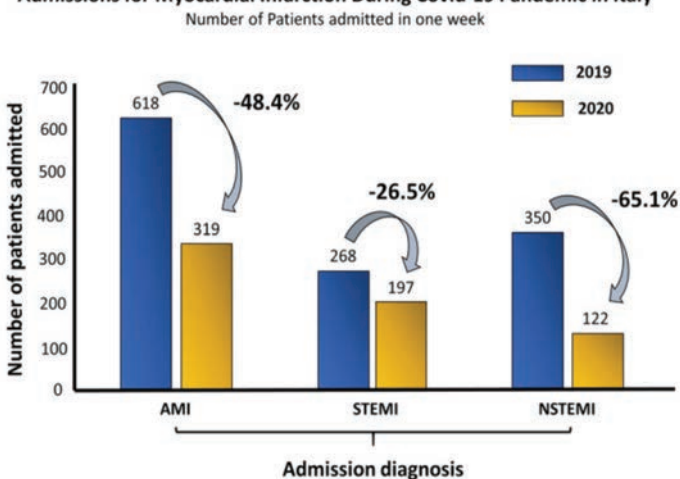
During the time of the first wave of COVID-19 many countries went into a strict lockdown. This had a direct impact on the incidence of cases presenting to the hospitals with cardiac and other conditions. A retrospective cross-sectional study of presentations in 9 emergency departments across the UK<sup>1</sup> compared similar time period for 2019-2020 with 2018-2019. They found that cardiac presentations to the emergency departments fell by around 33-87%. Another retrospective cohort study showed that after the first lockdown in the UK there were excess deaths of around 8% in total, (2085 deaths). Most of these excess mortality figures were due to increased deaths at home, with care homes also recording similar increase. Interestingly, according to the same study there were no excess deaths in relation to CVD in the hospital settings. The biggest increase was seen in acute cerebrovascular accidents (CVA) which showed the greatest excess deaths followed by acute coronary syndrome (ACS)<sup>2</sup>. This is further backed up by a similar study done in Italy, one of the worst hit countries during the first wave of the virus. An observational, nationwide survey was conducted to collect data on admissions for acute myocardial infarction in Italian CCUs throughout a

1-week period during the COVID-19 outbreak, compared with the equivalent week in 2019. They found 48.4% reduction in admissions for an acute MI compared with the equivalent week in 2019. The reduction was significant for both STEMI and non-STEMI. The STEMI case fatality rate during the pandemic was significantly increased compared with 2019, along with a similar increase in complications. They concluded that admissions for acute MI were significantly reduced during the COVID-19 pandemic across Italy, with a parallel increase in fatality and complication rates<sup>31</sup>. This is further demonstrated in Figure 1, below.

The full mechanism of how COVID-19 causes direct cardiac complications is still unclear as of now. There is growing evidence which suggest two possible mechanisms (Fig 2 and Fig 3). The first proposed process revolves around the idea that the cytokine storm and associated elevation in the inflammatory markers leads to myocardial injury<sup>3</sup>. One of the early retrospective cohort studies in Wuhan<sup>4</sup> looked at certain biochemical markers in those who survived and those who sadly died. In this study the main marker used was the high sensitivity cardiac troponin-I (hs-cTnI) level during the course of their COVID-19 disease. First measurement done on day 4 of the illness did not show a significant elevation, however on the 7th day the hs-cTnI levels elevated substantially with higher elevations seen on day 13 (55.7pg/ml, double its level of day 7) and on day 22 (290pg/ml). There was also significant increase in markers suggesting cytokine storm including ferritin, D-dimer, lactate dehydrogenase and IL-6. These suggest the strong possibility that the cytokine storm is responsible for myocardial injury. Another study in Wuhan found elevated troponin levels in patients admitted on the ICU.

Myocarditis is one of the presentations that seems to be increasingly linked to COVID-19, including fulminant myocarditis described by Wang et al<sup>5</sup> which seems to be the first case of fulminant myocarditis. Interestingly, case studies from Kim et al<sup>6</sup>, Trogen et al<sup>7</sup> did not show respiratory involvement, however they showed either an increase in BNP or troponin levels. In particular, the Rabi-en- Ortiz et al<sup>8</sup> case study showed

**Admissions for Myocardial Infarction During Covid-19 Pandemic in Italy**



**Figure 1:** Graphical depiction of the reduction in admissions and increase in mortality in Italian CCUs (31).

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concave ST elevation with no respiratory symptoms but elevated BNP and troponin levels and cardiogenic shock. These studies show that even in the absence of respiratory symptoms, COVID-19 can lead to direct cardiac injury. This is further backed up by a case report from Spain in which a young female was reported to suffer from myocarditis with no respiratory features, though CT features of COVID-19 were noted.<sup>9</sup>

The other suggested mechanism of cardiac injury is the role of the angiotensin-converting enzyme 2 (ACE 2) receptors in the myocardium with down-regulation which alters the cardio-protective effects of angiotensin 1-7, with an increase of TNF- $\alpha$  production associated with the myocardial dysfunction<sup>10</sup>. In the SARS-COV1 (which is a related virus to SARS-COV2 causing COVID-19), pulmonary infection caused cardiac involvement. Zheng et al also supported this theory<sup>11</sup>. Due to this potential mechanism this caused a concern in particular to the drugs ACE inhibitors and ARBs due to its mode of action. However many studies<sup>12-15</sup> have now reported that these have minimal effects.

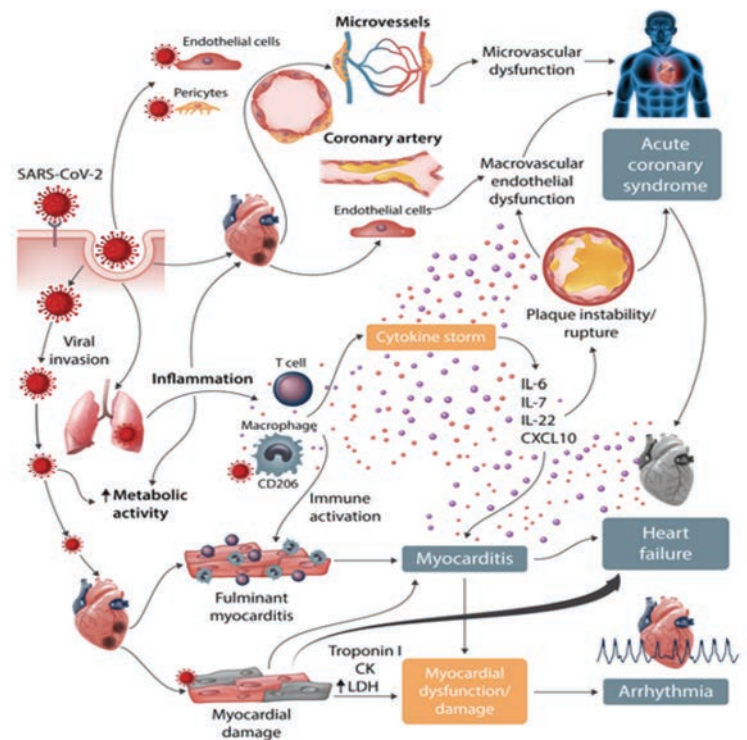
As for COVID-19 causing other specific cardiac manifestations, the evidence is there that it can cause other injury, albeit less than the evidence for myocarditis<sup>18</sup>. One such manifestation is Acute Coronary Syndrome (ACS). It seems that similar to other viruses such as SARS and influenza, COVID-19 can also precipitate ACS<sup>19-20</sup>. Two case series from New York<sup>21</sup> and Italy<sup>22</sup> have highlighted this possible manifestation. In the New York study 18 patients with COVID-19 and ST segment elevation (indicative of potential acute myocardial infarction), five of the six patients with myocardial infarction required percutaneous coronary intervention (PCI)<sup>21</sup>. In the case studies from Italy involving 28 patients with COVID-19 and ST segment elevation myocardial infarction, assessment by coronary angiography showed that 17 patients had evidence of significant lesions that required revascularisation<sup>22</sup>. The theory behind mechanisms underlying COVID-19-induced ACS might include plaque rupture, coronary spasm or micro-thrombi owing to systemic inflammation or cytokine storm<sup>19</sup>.

Another manifestation of COVID-19 on the cardiovascular system is cardiac arrhythmias, though the exact contribution of COVID-19 to cardiac arrhythmias remains uncertain given that arrhythmias, such as atrial and ventricular tachycardia and fibrillation, can be triggered by myocardial injury or other systemic causes such as fever, sepsis, hypoxia and electrolyte abnormalities. One must not also forget to mention the medications used to treat COVID-19 (Azithromycin, Remdesvir etc.) could itself cause these manifestations<sup>18, 30</sup>. Palpitations have been reported to be one of the presenting symptom of COVID-19 in patients without fever or cough<sup>23, 18</sup>.

COVID-19 has also been notoriously known to have an association with abnormal coagulation which could increase thrombotic events and possibly indicating a hypercoagulable state<sup>24, 25</sup>. In particular, venous thromboembolism, including deep vein thrombosis (DVT) and pulmonary embolism (PE) has been found to be a common complication in critically ill patients with COVID-19<sup>18</sup>. An autopsy study showed deep vein thrombosis was present in 7 of 12 patients who died with COVID-19 in whom venous thromboembolism was not suspected before death, and pulmonary embolism was identified in 4 of the 12 patients<sup>26</sup>, strongly supporting the concept of the hypercoagulable state. This is however not limited to only venous thromboembolic events but arterial thrombosis has also been reported. A case study of 2 patients reported that a 60-year-old male showed an acute aortic-iliac thrombosis and a mesenteric thrombosis. He had complained of loss of sensation in his lower limbs two weeks prior to suffering from dry cough and malaise. It was only after a CT scan that thrombotic occlusion of the infra-renal aorta extending into the common iliac arteries was identified. His chest radiology showed ground glass appearance consistent with COVID-19 and his D-dimer was significantly raised. The second case is of a 75-year old with 2 weeks symptoms of dry cough and malaise presenting with severe abdominal pain. On CT angiography, intraluminal thrombus was present in the

descending thoracic aorta with embolic occlusion of the superior mesenteric artery. Interestingly there was no evidence of coexisting atherosclerosis. Chest radiography was again suggestive of COVID-19. This case series suggests that the prothrombotic sequela of COVID-19 are not only confined to the venous circulation but macrovascular thrombi in the arterial circulation can occur in susceptible individuals during COVID-19 infections, even in the absence of disseminated intravascular coagulation (DIC) or severe respiratory manifestations<sup>27</sup>.

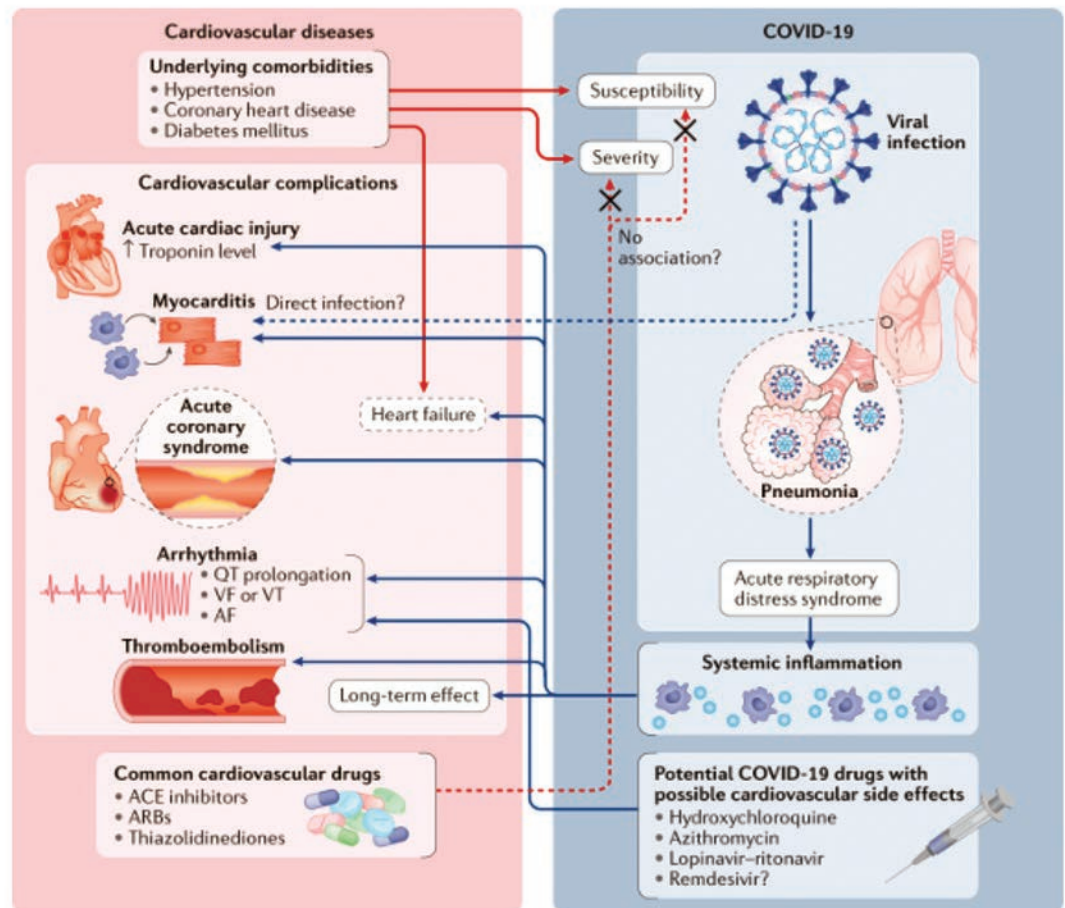
To further support this theory, a case series in New York showed five patients aged  $\leq 50$  years who presented to the same hospital with large-vessel ischaemic stroke. In particular, the first case out of the five, developed cough, headache, and chills lasting one week and then had progressive dysarthria with numbness and weakness in the left arm and left leg over a period of 28 hours. A CT head and CT angiography showed a infarction of the right middle cerebral artery territory with a partially occlusive thrombus in the right carotid artery at the cervical bifurcation. She was COVID-19 positive and also had CT features of COVID-19. Over a 2-week period from March 23 to April 7, 2020 5 patients presented with new-onset symptoms of large-vessel ischemic stroke, all of whom were noted to be COVID-19 positive<sup>28</sup>. Like with most things regarding COVID-19, the exact mechanism as to why it causes a hypercoagulable state is not known. A theory is that the severe inflammatory response and endothelial damage induced by COVID-19, in combination with underlying comorbidities might predispose patients to a hypercoagulable state<sup>29</sup>. However just as with cardiac arrhythmias certain pharmacological agents used to treat COVID-19 could also compound and affect the coagulation profile<sup>30</sup>.



**Figure 2: Cardiovascular involvement in COVID-19: Key manifestations and hypothetical mechanisms.** This diagram not only shows the suspected pathogenesis of how COVID-19 could cause new cardiac lesions but also how it can aggravate and worsen pre-existing CVD. SARS-CoV-2 anchors on transmembrane ACE-2 to enter the host cells including type 2 pneumocytes, macrophages, endothelial cells, pericytes and cardiac myocytes, leading to inflammation and multi-organ failure. In particular, the infection of endothelial cells or pericytes could lead to severe microvascular and macrovascular dysfunction. Furthermore, in conjunction with the immune over-reactivity, it can potentially destabilise atherosclerotic plaques and explain the development of the acute coronary syndromes. Infection of the respiratory tract, particularly of type 2 pneumocytes, by SARS-CoV-2 is manifested by the progression of systemic inflammation and immune cell over-activation, leading to a cytokine storm, which results in an elevated level of cytokines such as IL-6, IL-7, IL-22, and CXCL10. Subsequently, it is possible that activated T cells and macrophages may infiltrate infected myocardium, resulting in the development of fulminant myocarditis and severe cardiac damage. This process could be further intensified by the cytokine storm. Similarly, the viral invasion could cause cardiac myocyte damage directly leading to myocardial dysfunction and contribute to the development of arrhythmia.<sup>17</sup>

**Figure 3:** Another concise diagram showing the relationship of proposed mechanisms of the pathogenesis of COVID-19 and its effect on CVD, both existing and new lesions (18).

(Image kindly reproduced from Nishiga, M., Wang, D.W., Han, Y. et al. COVID-19 and Cardiovascular disease: from basic mechanisms to clinical perspectives. *Nat Rev Cardiol* 17, 543–558 (2020). <https://doi.org/10.1038/s41569-020-0413-9> under PMC Open Access Subset for unrestricted research re-use and secondary analysis in any form or by any means with acknowledgement of the original source. These permissions are granted for the duration of the World Health Organization (WHO) declaration of COVID-19 as a global pandemic).



## Summary

There were significant delays in patients presenting with CVD during the first wave and lockdown with resultant increase in cardiovascular events and mortality, thereby leading to an indirect negative impact of COVID-19 on CVD. This in particular was demonstrated in the higher mortality seen in particular to care home residents. One could hypothesise that the reduction of presentations in the hospital is linked to this increase in mortality.

There is increasing evidence that COVID-19 can cause acute cardiac injury such as myocarditis, even in the absence of respiratory involvement, though in smaller numbers in comparison to respiratory effects. There is also evidence suggesting a correlation to other cardiac manifestations such as ACS and arrhythmias but owing to the various risk factors, drugs used in the treatment of COVID and the group of patients presenting with these serious effects more study will be needed to determine if there is a definitive link or if it is merely just a correlation.

The mechanism of how exactly COVID-19 causes myocardial injury still needs further investigation but the cytokine storm and ACE-2 involvement seem the most likely reason. However, as most of the evidence is from retrospective studies and case studies, further data is required to make any definitive causal links between COVID-19 and CVD.

## Acknowledgements

Figure 1: Graphs kindly reproduced from (31) De Rosa, S. et al. Reduction of hospitalizations for myocardial infarction in Italy in the COVID-19 era. *Eur. Heart J.* 41, 2083–2088 (2020). This allowed under PMC Open Access Subset for unrestricted research re-use and secondary analysis in any form or by any means with acknowledgement of the original source. These permissions are granted for the duration of the World Health Organization (WHO) declaration of COVID-19 as a global pandemic.

Figure 2: COVID-19 and the cardiovascular system: implications for risk assessment, diagnosis, and treatment options: Tomasz J Guzik, Saidi A Mohiddin, Anthony Dimarco, Vimal Patel, Kostas Savvatis, Federica M Marelli-Berg, Meena S Madhur, Maciej Tomaszewski, Pasquale Maffia, Fulvio D'Acquisto Cardiovascular Research, Volume 116, Issue 10, 1 August 2020, Pages 1666–1687, <https://doi.org/10.1093/eurheartj/ehaa106> under PMC Open Access Subset for unrestricted research re-use and secondary analysis in any form or by any means with acknowledgement of the original source. These permissions are granted for the duration of the World Health Organization (WHO) declaration of COVID-19 as a global pandemic.

Figure 3: Nishiga, M., Wang, D.W., Han, Y. et al. COVID-19 and cardiovascular disease: from basic mechanisms to clinical perspectives. *Nat Rev Cardiol* 17, 543–558 (2020). <https://doi.org/10.1038/s41569-020-0413-9> under PMC Open Access Subset for unrestricted research re-use and secondary analysis in any form or by any means with acknowledgement of the original source. These permissions are granted for the duration of the World Health Organization (WHO) declaration of COVID-19 as a global pandemic.

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# The impact of COVID-19 on the management of Osteoporosis patients



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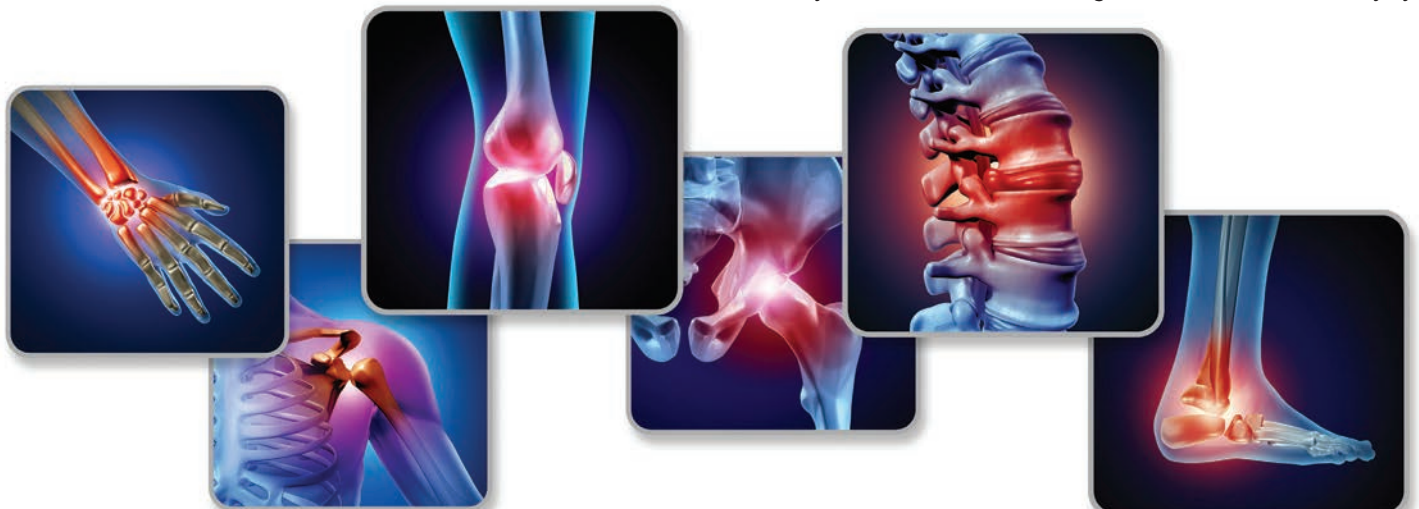
It is well known that the COVID-19 pandemic has had a significant adverse impact on health care delivery, particularly so for the management of chronic conditions. Osteoporosis and metabolic bone disease service is one such service which has been hugely affected by the pandemic. We share our experience under various headings below:

**Outpatient Services:** Osteoporosis predominately affects fragile, older populations, who often have multiple co-morbidities and live alone. Mortality from COVID-19 disease is also higher in these groups of patients and thus these high-risk patients are either shielding or self-isolating to prevent infection. Many of the outpatient clinics for both new and follow up visits were cancelled at the start of the pandemic in order to reduce the risk of spread of infections, and to increase capacity for COVID related activities in the hospital by redeploying many of the Health Care Workers (HCW) to acute care. Stringent measures to reduce the infection spread like social distancing had to be practised compromising outpatient clinic space and planned activities in the hospitals. This combined with limited services in primary care caused huge inconveniences to our patients who are already very vulnerable.

Virtual consultations (mainly telephonic and few video) were commenced in Metabolic Bone and Rheumatology Bone clinics about six weeks into the pandemic. Overall, there has been positive feedback supporting remote consultations based on hospital survey conducted in the department locally. Prescriptions generated during these virtual consultations were sent to pharmacy and appropriate measures were taken to access these medications timely with the support of voluntary services.

**Dual Energy X-ray Absorptiometry (DEXA) services:** DEXA scans along with other non-urgent diagnostic services such as ultrasound scans, computerised tomography (CT)/Magnetic Resonance Imaging (MRI) were also paused to protect patients and prioritise the care of hospitalised patients. In the absence of DEXA scans, we relied on Fracture Risk Assessment Tool (FRAX) calculations for risk stratification and deciding the appropriate treatment as recommended by the Royal Osteoporosis Society (ROS) and National Osteoporosis Guideline Group (NOGG)<sup>1</sup>. FRAX assessment is helpful in initiating treatment and also planning for a pause (popularly referred to as 'drug holiday') in osteoporotic treatments<sup>2</sup>. Despite these recommendations, Google Analytics shows a significant ~58% reduction in the use of FRAX assessment coinciding with the start of the pandemic<sup>3</sup>. The use of FRAX has improved in recent months however this is far from normal level of usage. This may signify potential negative impact on osteoporosis care leading to under treatment, which may result in rise in fracture risk in future years.

**Osteoporosis treatments:** Many day-case services were also paused resulting in a significant disruption in our ability to provide parenteral treatments such as Denosumab injections and Zoledronate infusions. However, with the help of the already established shared cared agreement (SCA) process, we were able to maintain the administration of denosumab injections safely in primary care. Patients and also Health Care Professionals (HCPs) were understandably concerned about the use of Denosumab (a monoclonal antibody), which could potentially increase susceptibility to infection during the pandemic. This was promptly addressed by our specialist teams based on advice and support from NHS England, National Institute of Health and Care Excellence (NICE) and ROS who released statements on its safety and the need for continuing the treatment without delay by



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more than 4 weeks<sup>4</sup>. In some regions, self-administration of denosumab injections was supported and well accepted by patients. Among certain very vulnerable patients with high risk of fragility fractures, oral therapies i.e. alendronate, including effervescent tablets (Binosto) and risedronate were commenced cautiously in preference to parenteral therapies. Patients who were followed up virtually were also reassured to continue their oral therapy. Considerable number of patients on parenteral therapy, especially intravenous Zoledronate, had inevitable delays in their previously scheduled treatment plans, due also to other reasons like non-availability of dental checks and transport as well as patients' increased anxiety levels in attending the day case unit.

Parathyroid hormone (PTH)-analogue (teriparatide) treatment is recommended by NICE for the secondary prevention of osteoporotic fragility fractures in people with severe osteoporosis who are not able to take first line treatments or have failed other treatments<sup>5</sup>. However, 'T score' from DEXA scan results is a pre-requisite to initiate treatment. Thus, there were reduced numbers of patients who could commence teriparatide or its biosimilars (Movymia and Terrosa) due to delays in DEXA assessments.

**Vitamin D and other risk factors:** Vitamin D plays an important role in not only osteoporosis and bone health but also supports immune function and reduces the risk of respiratory tract infection. We came across instances of certain patients inappropriately taking mega doses of over the counter Vitamin D supplements. NICE arranged a rapid review of this topic in the context of the pandemic and advised to keep following the Scientific Advisory Committee on Nutrition (SACN) recommendation of daily intake of 10ug or 400 IU through diet or supplements for everyone over 4 years in high risk group to be taken all year round<sup>6,7</sup>. Tolerable upper intake level for vitamin D in adults according to Institute of medicine is 4000 IU a day<sup>8</sup>. Higher doses should not be taken unless recommended by a health professional. This information on supplementation without the need for testing vitamin D levels was discussed in our Leicester Osteoporosis Group (LOG) meeting and information was disseminated to primary care through virtual meetings and newsletters.

Elderly patients with multiple co-morbidities who were advised to self-isolate and shield to reduce the spread of COVID-19 infection have had a huge negative impact on the physical, cognitive and emotional aspects of their lives, resulting in reduced physical stamina due to deconditioning, increasing the risk of falls, early dementia and also increasing anxiety and risk levels due to loneliness<sup>9</sup>. Virtual and nurse-led clinics have been helpful to keep in touch with vulnerable patients and also encourage them to remain physically active, thereby allaying their anxiety levels. We need to review the ill effects of deconditioning and work towards reducing frailty and falls risk, which in turn will reduce fracture rates.

Overall, the disruption caused by COVID-19 on osteoporosis care has been significant. Telemedicine supporting timely assessments, the immense contribution from osteoporosis nurse and administrative colleagues, risk stratification using FRAX, pragmatic treatment approaches and good team working between specialists and primary care significantly helped in managing high-risk patients with osteoporosis. We need to be vigilant and continue to monitor the incidence of fractures, during and after the pandemic, as there is data suggesting the underuse of DEXA and FRAX for risk stratification.

It is paramount to continue to restore and build on osteoporosis care during such emergencies as the COVID-19 pandemic, thereby ensuring patients remain well, independent and out of hospital.

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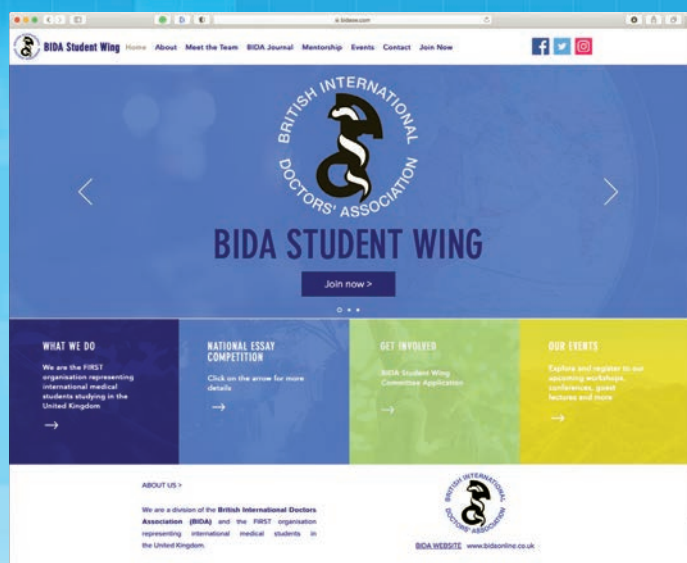
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and laxatives. **Pregnancy and lactation:** Use only under medical supervision. Studies have shown safe use up to 4,000 IU daily but reproductive toxicity has been seen in animal studies. The 20,000 IU dose should not be used during pregnancy. Vitamin D is excreted in breast milk, when prescribing additional vitamin D to a breast-fed child consider the dose of any additional vitamin D given to the mother. **Undesirable effects:** Allergic reactions are possible. Uncommon adverse reactions include hypercalcaemia and hypercalcauria. Rare adverse reactions include: pruritus rash and urticaria. **Overdose:** Refer to SmPC. **Legal Category:** POM. **Pack size:** Fultium-D<sub>3</sub> 800 IU capsules x30 – NHS Price £3.60. Fultium-D<sub>3</sub> 800 IU capsules x90 – NHS Price £8.85. Fultium-D<sub>3</sub> 3,200 IU capsules x30 – NHS Price £13.32. Fultium-D<sub>3</sub> 3,200 IU capsules x90 – NHS Price £39.96. Fultium-D<sub>3</sub> 20,000 capsules x15 – NHS Price £17.04. Fultium-D<sub>3</sub> 20,000 capsules x30 – NHS Price £29.00. **MA Number:** 40861/0002 [Fultium-D<sub>3</sub> 800 IU capsules], 40861/0003 [Fultium-D<sub>3</sub> 3,200 IU capsules], 40861/0004 [Fultium-D<sub>3</sub> 20,000 IU capsules]. **MA Holder:** Internis Pharmaceuticals Ltd, Linthwaite Laboratories, Linthwaite, Huddersfield, West Yorkshire HD7 5QH, UK. **Full Prescribing Information is available from Internis Pharmaceuticals Ltd. Date of preparation:** August 2020. **unique ID no.** FUL-543.

**Fultium-D<sub>3</sub> Drops** **Abbreviated Prescribing Information.** Please refer to the Summary of Product Characteristics (SmPC) before prescribing Fultium-D<sub>3</sub> Drops. Use care when prescribing in pregnancy, as high doses of colecalciferol may affect the fetus. **Fultium-D<sub>3</sub> Drops:** 1ml of oral solution contains 2740 IU (68.5mcg per ml) colecalciferol; 3 drops contains 200 IU colecalciferol. **Indications:** Prevention and treatment of vitamin D deficiency in adults and children, and as an adjunct to specific therapy for osteoporosis in patients with vitamin D deficiency or at risk of vitamin D insufficiency. **Dosage and administration:** For oral use. Can be taken directly or mixed with a small amount of food. **Adults:** Treatment of deficiency: 12-60 drops (800-4000 IU) daily; During pregnancy and breast-feeding: 6-60 drops (400-4000 IU) daily; Osteoporosis adjunctive therapy: 12 drops (800 IU) daily. Maintenance or prevention of deficiency: 12-24 drops (800-1600 IU) daily; During pregnancy and breast-feeding: 6-30 drops (400-2000 IU) daily. **Children:** Treatment of deficiency: 0-2 years: 6-15 drops (400-1000 IU) daily; 2-11 years: 6-30 drops (400-2000 IU) daily; 12-18 years: 6-60 drops (400-4000 IU) daily. Maintenance or prevention of deficiency: 0-2 years: 3-15 drops (200-1000 IU) daily; 2-11 years: 6-15 drops (400-1000 IU) daily; 12-18 years: 6-24 drops (400-1600 IU) daily. **Contraindications:** Hypersensitivity to vitamin D or any of the excipients; hypervitaminosis D; nephrolithiasis; diseases or conditions resulting in hypercalcaemia and/or hypercalcauria; severe renal impairment. **Warnings and Precautions:** Use caution in patients with impaired renal

function or sarcoidosis. Monitor effect on calcium and phosphate levels in these patients. Consider risk of soft tissue calcification. Use other forms of vitamin D in cases of severe renal insufficiency. Consider the need for calcium supplementation in individual patients. Where calcium supplementation is necessary, close medical supervision is required. Use caution in patients receiving treatment for cardiovascular disease. Make allowances for vitamin D supplementation from other sources. Monitor to prevent hypercalcaemia. **Interactions:** Concomitant phenytoin, barbiturates and glucocorticoids can decrease the effect of vitamin D. Ion exchange resins, laxatives, actinomycin and imidazole may also reduce the effect of vitamin D. Oral calcium and vitamin D potentiates the effect of digitalis and other cardiac glycosides. **Pregnancy and lactation:** Limited clinical data in pregnancy. Animal studies have shown reproductive toxicity. RDI in pregnancy is 400 IU. Pregnant women who are vitamin D deficient may need a higher dose. Pregnant women should follow the advice of their GP, as their requirements may vary depending on disease severity and response to treatment. Vitamin D and metabolites are excreted in breast milk. Overdose in nursing infants has not been observed, however, when prescribing additional vitamin D to a breast-fed child, consider the maternal dose of any additional vitamin D. **Undesirable effects:** Hypercalcaemia and hypercalcauria. Refer to the SmPC for the full list of side effects. **Legal Category:** POM. **Pack size:** Fultium-D<sub>3</sub> Drops, 1 x 25ml – NHS Price £10.70. **MA Number:** 40861/0005. **MA Holder:** Internis Pharmaceuticals Ltd, Linthwaite Laboratories, Linthwaite, Huddersfield, West Yorkshire HD7 5QH, UK. **Full Prescribing Information available. Date of preparation:** July 2020. **unique ID no.** FUL-542.

Adverse events should be reported. Reporting forms and information can be found at: [www.mhra.gov.uk/yellowcard](http://www.mhra.gov.uk/yellowcard) or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to 01484 848164.

**References:** 1. Hyppönen E, Power C. *Am J Clin Nutr* 2007; 85: 860-868. <https://nutrition.bmj.com/content/bmjnp/early/2020/05/13/bmjnp-2020-00089.full.pdf>. 2. Lanham-New SA, et al. Vitamin D and SARS-CoV-2 virus/COVID-19 disease. *BMJ Nutrition, Prevention & Health* 2020;0. doi:10.1136/bmjnp-2020-00089. 3. NICE. Vitamin D: increasing supplement use among at-risk groups. Public health guidance 56. NICE, 2014. Updated August 2017. Available at: [www.nice.org.uk/guidance/PH56](http://www.nice.org.uk/guidance/PH56). 4. IQVIA Data (52 weeks RxA and HPA) November 2019.

FUL-555a Date of preparation: October 2020



# Anaesthetic Awareness during Caesarean Section:

## A Case Report and Discussion



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### Introduction

Accidental awareness during general anaesthesia (AAGA), also called 'unintentional' anaesthetic Awareness, is defined as a clinical condition that occurs when a patient under the general anaesthesia become aware of some or all events during surgical procedure and has direct recall of those events. Because of routine use of neuromuscular blocking agents (also called paralytic) during GA the patient is often unable to communicate with the surgical team if this occurs. It is now widely recognised AAGA, which is not a rare event, can impact on patients significantly leading to adverse physical and psychological sequelae. Although with majority experiencing no long-lasting distress and only a fraction would resort to complaints and medicolegal actions.

We present a case of accidental awareness during general anaesthesia which was distressing for the patient had had the potential for complaints and medicolegal consequences for the clinicians.

### Case Report

**History of presentation:** A 34 years old obese (BMI 40) primigravida, who had no significant past medical history, with singleton gestation and uneventful antenatal period presented with spontaneous labour at 39 weeks' gestation. An emergency section was performed under general anaesthesia administered by a specialist registrar for severe fetal distress (category 1 LSCS). A live baby girl weighing 3,800 g was delivered in good condition. Her intra-operative and immediate post-operative recovery period was uneventful. She had an uneventful anaesthetic recovery and she was stable.

**Post-operative events:** Six hours later in the post-operative period she complained to the midwives that she was aware of what was happening during the operative procedure. She recalled a sensation of a cut, some dragging pain accompanied by a sensation of not being able to breathe properly and not being able to communicate. She also could hear theatre staff and doctors talking during the surgery.

The consultant anaesthetist, who was involved with her surgery, was immediately informed of the circumstances. He reviewed the patient straightway and concluded that her account was consistent with a case of AAGA, Class 5<sup>1,2</sup>. He apologised to the patient and gave her an explanation of what had happened. The preoperative, intraoperative and post-operative anaesthetic procedures that was followed was explained including Rapid sequence Induction.

The anaesthetist was accompanied by a senior midwife who was present during the review. Her husband was present during this consultation. The patient did not seem to be unduly concerned by the experience, understanding the need to deliver her baby as rapidly as possible.

**Follow up intervention:** Following her discharge from the hospital, her community healthcare professionals including her general practitioner were advised to keep an eye on her. Six weeks later when she was followed

up in the clinic as planned, she was reviewed by the Consultant Obstetrician and the consultant Anaesthetist who were involved with her care. She appeared to be satisfied with the explanations given about her care. She was offered further follow ups which she declined. The patient reported here, a category 1 caesarean section with ASA grade III<sup>3,4</sup>, was at significant risk for AAGA with the potentials for complaints, claims and medicolegal consequences. It seems likely that early and prompt professional interventions lead to a satisfactory outcome in this case.

### Discussion

The patient reported here highlighted a typical case of 'Accidental Awareness under general anaesthesia' (AAGA) during which she experienced some short-term unpleasant sequelae of general anaesthesia. According to the Michigan Awareness Classification the symptoms the patient suffered were consistent with AAGA class 5 awareness<sup>2</sup>. However, the problems were resolved satisfactorily with prompt and appropriate professional interventions. The patient was counselled by the consultant anaesthetist involved with her care, explaining that it was an emergency situation, and the urgent need for delivering the baby. The patient was satisfied with the explanations. Her general practitioner was kept informed of the situation. She was offered further follow ups for a longer period to ensure that she did not develop Post traumatic Stress Disorder or any other serious potential psychological problems. But she did feel this not was necessary.

The incidence of AAGA (with explicit recall) in the general population has been reported as 1-2 per 1000 cases undergoing general anaesthesia. NAP5 survey<sup>5</sup> reported an incidence of new cases of AAGA as notified to the anaesthetist prospectively of approximately 1:19,000 which is much lower than the incidence previously published and ascertained through direct patient questioning of 1-2:1000. NAP5 estimated that while 1 case is reported to the anaesthetist 30 other cases may experience AAGA but not reported it. In obstetric patients NAP5 reported a very high incidence of 1:670.

It has been recognised that even during seemingly an adequate general anaesthesia, patient can retain explicit or implicit memory along with the ability to subconsciously process auditory stimuli. Explicit awareness refers to conscious recollection of events, either spontaneously or as a result of direct questioning. Whereas implicit awareness (memories) exists without conscious recall but they can alter patient's behaviours after the event<sup>1</sup>.

A wide range of experience from the trivial to something akin to a feeling of torture and a wide range of psychological consequences (from none to life-threatening) has been reported. While some do not feel anything physically, others can experience excruciating pain and fear. NAP5 Survey<sup>5</sup> revealed that recall was present in 50% of cases experiencing a few isolated events. In about 50% cases there were distress with sensation of paralysis or pain, but could also occur only when isolated sound or tactile sensation were experienced

A patient experiencing AAGA reports 48% auditory recall, 48 % sensation of not being able to breathe and 28% pain. In over 50% of these patients who experienced psychological distress, the symptoms may range from anxiety, fear of surgery and anaesthetics and sleep disturbances to flashbacks, nightmares and post-traumatic stress disorders. It has been suggested that distress during AAGA is strongly associated with immediate and longer-term psychological sequelae.

Obstetric patients undergoing emergency caesarean section are considered at 14.8-fold increased risk for AAGA compared with the general population. NAP5 Survey<sup>5</sup> report has suggested that obstetric anaesthetic practice should be regarded as a high-risk sub-speciality for AAGA, because the use of rapid sequence induction with thiopental and neuro-muscular blockade during maintenance in a population with a relatively high incidence of obesity and difficult airway management regarded as major risk factors for AAGA. NAP5 survey report provides an useful insights into the possible causes of AAGA including poor anaesthetic techniques and equipment failure (Table 1) and the risk factors including obesity and emergency caesarean section that are commonly associated AAGA (Table 2). In order to prevent AAGA during obstetric anaesthesia, NAP5 report has made the following recommendations;

1. The anaesthetist should regard obstetric patients, particularly those undergoing caesarean section, as at being at increased risk of AAGA. This risk should be communicated appropriately to the patients as part of the consent process and preoperative counselling if at all possible.
2. Consideration should be given to reduce the risk of AAGA by giving appropriate reassurance.
3. The anaesthetist should regard failed regional anaesthesia technique leading to the need for GA for obstetric surgery to be an additional risk for AAGA
4. Documentation - a successful defence against litigation requires that the anaesthetist has made thorough records of procedures undertaken. A handwritten record, not backed up with a printout, is of minimal medicolegal value since the anaesthetist may have recorded what s/he thinks was being given rather than what was actually being given.

**Table 1: Causes of Accidental Awareness during GA**

1. Reduced Practitioner's vigilance
2. Poor Techniques - errors during the dynamic phases (induction and emergence) (70% of cases) such as syringe swaps, mixing of drugs, NMBA administered before hypnotics, drug administration discontinued during emergence despite residual paralysis
3. Technical errors during the maintenance phase (30% of cases) such as omission or late commencement of a volatile agent, failure to turn on the vaporiser or adequately monitor the end-tidal levels of volatile anaesthetics, stopping inhalational agent delivery too early before the end of surgery and the intentional use of low doses in favour of haemodynamic
4. Medication errors and drug error can be prevented by clear and uniform labelling of syringes, use of standard syringe sizes and concentrations, and double check of syringe before use.
5. Selection of inadequate anaesthetic agent dose
6. Malfunction of the anaesthesia delivery system
7. Resistance to anaesthetic agents
8. Masking the signs of awareness by some disease states and concurrent medications.

AAGA is largely a preventable<sup>6</sup> and the incidence can be reduced through audit and education<sup>7</sup>. In small minority of cases may not be possible to prevent AAGA completely, because of significant inter-individual

differences in pharmacokinetics and dynamics possibly genetically determined.

It is vitally important that professionals are aware of the recognised causes and associated risk factors that make the occurrence of AAGA more likely, so that the clinical practice can be improved and the risk of intraoperative awareness is minimised.

While anaesthesia professionals involved in the care of women should try to balance the psychological risk of AAGA against the physical risk of excess anaesthesia, the raised awareness of the problems and issues and improved anaesthetic understanding would prove to be an important preventable measure. Early identification of high-risk cases, improved communication with patients, improved preparation, modifying the anaesthetic procedures during surgery and close monitoring would facilitate risk reduction.

**Table 2: Risk factors for AAGA in obstetric anaesthetic practice (NAP5, 2014)**

1. Age - more common in younger adults (25-45 years)
2. Obesity
3. ASA 3-5 patients are twice more likely than ASA 1-2
4. Out of hours category 1 and 2 caesarean section.
5. Seniority of the anaesthetist – the more Junior the anaesthetist, the greater the risk
6. Difficult airway Management
7. Rapid sequence Induction
8. Use of thiopental
9. Use of Neuro muscular Blockade
10. A short period between anaesthetic induction and start of surgery
11. Patient with limited haemodynamic reserve
12. Previous history of intraoperative awareness

In the event of patient reporting AAGA, the clinicians should respond promptly and act professionally. Meeting with patients, ideally should include the anaesthetist who provided the anaesthetic care and where this is a trainee, a suitable senior colleague. Structured interview questionnaires should can be used in order to establish patient's recall when interviewing the patient after the event<sup>1</sup>. If psychological distress is suspected, Awareness Support Pathway, which has been created emphasising the value of empathetic communication, as recommended by NAP5 study, should be followed and immediate referral to a psychiatrist should be considered. Active and early support may offer the best prospect of mitigating the impact of AAGA.

Prompt identification of the condition and response would facilitate appropriate management in a timely manner, prevent long term consequence and would help to avert medicolegal consequences leading to good outcome.

It is therefore important that clinicians should implement and maintain intervention strategies to prevent it from happening and in the process reduce the risk of complaints, claims for negligence and Avoiding medicolegal consequences and the costs.

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# Proceedings: Webinar on Tackling Childhood Obesity in Greater Manchester

27th November 2020

## Background

Obesity is a complex problem with many different drivers including behaviour, environment, culture and genetics. The margins for good health are widening in the UK and at its root the problem falls hardest on those people, particularly children, from low-income backgrounds. The National Childhood Obesity Plan outlines actions the Government will take towards halving childhood obesity by 2030 such as sugar reduction, calorie control, food labeling, advertising and promotion. However achieving this target requires sustained collaboration between many different partners who all have a role to play: young people, families, schools, medical practitioners, public bodies, private sector, voluntary and community organisations. Indeed this kind of collective ownership will be crucial in the coming years if we are to successfully drive down levels of obesity

## OASIS-GB

Back in 2015, colleagues from Salford Royal NHS Foundation Trust (Consultant Bariatric Surgeon Professor Siba Senapati and Consultant Physician Dr Akheel Syed) and Salford Metropolitan Athletic Club (Senior Coach Jack Carney) formed a group which aimed to bring together a wide partnership of key individuals and organisations from the worlds of both medical intervention and prevention. The Obesity Awareness

Support and Information Service (OASIS-GB) vision was to meet regularly and plan a series of initiatives, seminars and conferences aimed at improving the levels of ownership, leadership and partnership in relation to the national challenge of obesity.

One such conference was delivered as a webinar, due to the restrictions experienced through Covid, in November 2020 and was entitled 'Tackling Childhood Obesity in Greater Manchester'. The doubling of obesity levels between first and final years of primary school was seen as a priority focus to try and stem the increase of these issues into adulthood.

## The Webinar

The planning group for the webinar consisted of Prof. Siba Senapati, Organising President and Chairman of OASIS-GB, Mr Jack Carney, Senior Coach Salford Metropolitan Athletic Club, Co-Chair and Organising Secretary, Dr Vinod Gadiyar, Consultant Anaesthetist and Hospital Doctors Chairman of BIDA, Mr Amit Sinha (Consultant Orthopaedic Surgeon and BIDA Journal Editor), Mr Mohamed Alasmar, Senior Clinical Fellow of Surgery at Salford Royal Hospital, Stevie Robinson (ABL Health), and Alison (BIDA Central Office).

The webinar provided a unique opportunity to bring together a broad audience from different sectors and backgrounds across Greater Manchester. The range of presenters and panellists also enabled us to share experiences from a variety of perspectives: politicians, medical practitioners, public health, media, higher education, schools, young people, health improvement, leisure, voluntary and community. The programme started with a message from Andy Burnham (Greater Manchester Mayor), followed by Welcome Address by Prof. Margaret Rowe, Dean of Health and Society from Salford University followed by a host of speakers focusing on childhood obesity in the first session. The session concluded with the speakers of first session along with some Key panelists of Greater Manchester. The second session started with address from John Merry (Salford's Deputy City Mayor) followed by various presentations from key primary school teachers, council and voluntary



sectors and ended with a lively discussion with members of the Greater Manchester Health Care Partnership.

A total of 181 participated in the webinar, which included health professionals, academics, school teachers, council officers, voluntary sector workers and politicians.

Studies across the UK have shown that obesity can be successfully tackled where there is a combination of ownership, leadership and partnership in place. The programme content therefore aimed to deliver a balanced weighting between: speaker inputs to set the policy and medical context, in order to create collective ownership; good practice case studies, showing local examples of good leadership; and group questions and panel discussion to establish a platform for future collaboration and partnership.

Interesting topics included: medical management of obesity; data analysis; serious case review procedures; nutrition, exercise and behaviour; media portrayal of childhood obesity; the role of local councils; good practice case studies from schools, leisure services, health improvement, voluntary and community initiatives.

The audience were asked to consider:

- Are there things we should be giving more consideration to when making local policy and resource decisions?
- Are there things we are missing or not getting right?

They were encouraged to post questions to the presenters and panelists through the on screen Q&A box and to exchange views and points through the chat box as we progressed through the morning.

A separate session was held with the Youth Parliament at their scheduled meeting two days after the webinar in order to receive the perspective of young people in these issues

The main highlights from the webinar are summarised below:

### Issues and Challenges

- We have good medical understanding and analysis of obesity and its consequences, as well as a varied offer in place aimed at lifestyle change and prevention (GM Moving, Red Pepper Programme, Energy Clubs, etc) but there is a constant challenge around client referral and take up
- 'Framing' is an important starting point for delivering change: service design should be based on how people, rather than professionals, define their own community, key challenges and potential solutions
- Environment and individual behaviour are key determinants of lifestyle but eating healthily in some neighbourhoods can be a challenge because the cheapest and most available foods often happen to be calorie rich, processed, high in sugar/ salt/ fat content, lacking in nutrition and heavily marketed
- Affordability and availability of healthy choices (specifically food and exercise) depends on where you live and your personal circumstances
- Caloric values of food are available through many of the supermarket and

restaurant chains but there is variance as to how much attention is paid to this information by customers

- School curriculum around physical activity and nutrition can often slip down the priority list where there is either a lack of leadership backing or budget constraints

- Messages and images about obesity are often negatively portrayed through media and this can be exacerbated by poor choice of language (for example portraying things as moral rather than health issues)

### Ideas and Suggestions

- Services should focus on 'place' rather than 'issue' by establishing a variety of co-designed scenarios in different settings (schools, leisure services, GP practices, patient post-operative care) then recognise and accept the issues identified and commit to the consequences for service design, delivery methodology and resourcing
- Establish a number of cohort analyses and test whether there is any link between prevention opportunities and personal success (eg does regular exercise in schools improve educational performance? do co-designed GP services lead to improved health outcomes?)
- Capture and share success stories across sectors (schools, leisure, health improvement, voluntary and community) by agreeing a common methodology for evidencing 'social value'
- Secure backing from the Council for an holistic and preventative focus on 'whole population health' versus a reactive focus on obesity and related illnesses. The support of political leaders will be needed here to specifically address : availability and affordability of opportunities for regular physical exercise; cleaner air zones; living wage for all residents; environmental and spatial planning; school food procurement; tackling holiday hunger
- Issue a 'call to action' across all sectors to deliver their own positive public messaging about general health and well being and to provide positive news-worthy stories to major local media outlets

- Utilise the strong alignment we have across sectors (evidenced through the spread of organisations and individuals attending the webinar) to agree collective pledges in tackling childhood obesity. This would mean reflecting on how we can adjust our own targets and budgets to support obvious things that work locally, then committing the delivery of these within a partnership pledge

### Next Steps

OASIS-GB (Obesity Awareness and Support) will continue to meet to put in place a plan of action based on the ideas and suggestions identified from the webinar and will report back to those individuals and strategic bodies who were engaged in the presentation of the webinar and who carry responsibility for policy and resources decision making: GM Mayor, Salford Deputy City Mayor, Chief Executive of the Northern Care Alliance Group of hospitals and the GM Health and Care Partnership.

# BIDA National Conference 2021

## "Living with COVID-19 and life beyond"

Keynote Speakers:

**Dr Chaand Nagpaul CBE**  
Chair, BMA Council

**Dr Taj Hussein**  
Associate Medical Director,  
HNS Improvement, Dept of Health

**Prof Iqbal Singh OBE**  
Chair of the Centre of Excellence  
for Safety in Older People's Care

**Lord Victor Adebawale**  
Chair, NHS Confederation

**Dr Chris Brookes**  
Chief Medical Officer,  
NHS Northern Care Alliance

**Dr Sakthi Karunanithi**  
Director, Public Health, Lancashire

**Mrs Prerana Issar**  
Chief People Officer, NHS

**Prof Azeem Majeed**  
Head, Primary Care & Public Health,  
Imperial College London

**Ms Lucy Warner**  
Chief Executive,  
NHS Practitioner Health Service

**Dr Ramesh Mehta OBE**  
President, BAPIO (UK)

**Prof Maggie Rae**  
President, Faculty of Public Health, UK

**Dr Raj Patel MBE**  
National Deputy Medical Director  
of Primary Care, NHS England  
and NHS Improvement

**Prof Colin Melville**  
Medical Director & Director  
of Education & Standards, GMC

**Dr J S Bamrah CBE**  
Consultant Psychiatrist,  
Chairman, BAPIO (UK)

Medical Students' Forum:

**Mr Tinaye Mapako**  
Co-Chair, BMA  
Medical Students' Committee

**Dr Jeeves Wijesuriya**  
Immediate Past-Chair, BMA  
Junior Doctors' Committee

**Dr Marina Soltan**  
NIHR Academic Clinical Fellow ST3  
#CPRinSchools Founder  
GMC RLS Associate

**06 Feb 2021 (Virtual) [bidaonline.co.uk](http://bidaonline.co.uk) #bidanationalconference**



# Thinking of Cornea Donation?

## Dans le Noir will open your eyes



**Dr Satya V Sharma** M.B.E. D.L. Deputy Lieutenant, West Midlands.  
Chair, Tribute to Life Board, NHSBT, UK. Ambassador, Organ Donation, NHSBT, UK. President, British Red Cross, West Midlands.  
President, Black Country Division, British Medical Association. Patron, Interfaith, Wolverhampton.

*Some time ago a video received about “Dans le Noir” proved to be an eye opener. This video was about a restaurant in London claiming to be regularly ranked among the ten most original restaurants in the world, a unique location for a romantic dinner, or an evening with friends. It was highly recommended for a visit; the obvious question was why?*

The short video explained Dans le Noir means “in the darkness”. Mystery revealed a restaurant with a pitch-dark room where you are not able to see anything and the meals are served for each table of ten persons. You eat in complete darkness. The fact that the serving waiter was completely blind added to the anxiety. Two glasses for each diner, one with corrugated surface outside for orange juice and another with plain surface for water. Being a vegetarian not eating fish, meat, chicken or even eggs, I decided to phone expecting “we are unable to cater for your needs”. In fact, completely opposite happened when the manager informed, we get requests for all sorts of meals and mine was not at all difficult. At this point the need to avoid garlic and onion was added which was also accepted. I invited a friend, a celebrity radio announcer in London. His dietary needs were similar.

After three courses it was time for coffee and we were brought back to a well-lit coffee lounge upstairs where we were shown the details of the three courses consumed. We looked at each other and none of us could get full marks although we scored pass marks.

It was time for reflection!

What would the world be like for persons born blind and for the persons who could see everything but lost eyesight later due to an accident or incurable illness?

Can we help? Yes.

“The gift of sight” Eye donation is classed technically as “tissue donation”. The eye is never transplanted whole. The cornea is transplanted which is the clear outer layer at the front of the eye that helps the eye to focus light.

Cornea donation does not affect the looks of deceased donor. After donation, specialist team will ensure the donor maintains a natural appearance. Many donors go on to have an open casket funeral. In the UK, the donated eye removed is replaced by a prosthetic eye.

Cornea donation does not delay the funeral arrangements. Specialist nurses always speak to the family to see if there are considerations around someone’s faith, beliefs or culture in respect to funeral plans.



We travelled together and despite traffic, arrived for Saturday dinner well in time. In the well-lit reception room, there was a young couple who looked terrified about the whole visit. Will they survive? The fact that 1.6 million diners had no casualty so far and had contributed hugely to a noble cause through patronage helped convert terror to a soothing “Ah, probably right”.

It is not often that you find yourself partaking in a conga line at the beginning of an evening’s entertainment – normally that curious pleasure is reserved solely for the initiation of drunken once things are well underway – but then this was no ordinary night out. We were instructed to form an orderly queue with eight other diners, each placing our right hand on the right shoulder of the person in front. There was a sudden burst of excitement at the front of the queue, and we were introduced to Peter, our waiter for the evening. In we charged, to the depths of the Dans Le Noir building, down a ramp, through some heavy curtains – and into the darkest space. Your eyes just do not adjust. You become disorientated and the room seems cavernous, with voices and the jangling of fork to plate coming at you from all angles. We were informed the room seats sixty diners, but when you are in there you have no idea of the size, scale or layout. Which is why it makes sense that Peter is blind. Soon the first course arrived and the waiter seemed to remember everyone’s name and the meal ordered. He asked me to raise my right hand and from the voice he could guess, felt the hand to hand over the plate.

We had a good chat with the person sitting next to us and social manners were at best. The second course and the pudding were served similarly. We started guessing what we had eaten? Potato or sweet potato? Cauliflower and peas were unmistakable.



People with poor eyesight can still donate their corneas. Many conditions that affect a person’s eyesight do not affect the corneas directly, meaning it can still be possible to donate.

Cancer doesn’t stop you donating your corneas. People with most types of cancer can still donate their corneas. The corneas do not contain blood vessels, eliminating the risk of transmitting most types of cancer.

Donation does not need to take place immediately. Corneas can be donated up to 24 hours after death. The donation can take place after death in hospital, in hospices, or in funeral homes. There is a lot of misinformation around the subject of cornea donation, but the reality is that it can mean the gift of sight to someone desperately in need of a transplant. For authentic information please visit <https://www.organdonation.nhs.uk/helping-you-to-decide/about-organ-donation/get-the-facts/>

There is a village in India where 90 percent residents have signed to be eye donors after death to provide vision to someone else.

The visit to “Dans le Noir” restaurant in London, one of two in London and one of many around the world to help with the charity of providing eyesight, truly proved to be “AN EYE OPENER”!

# Letter to the Editor

**Bhagya Weerasinghe** International Clinical Fellow in Ophthalmology  
**Jai Shankar** Consultant in Ophthalmology, Wrexham Maelor Hospital.

## Effective Communication: A key to improve AMD clinical attendance during the Covid-19 pandemic.

Dear Editor,

We were very interested to read the article by Popat and Sarkar<sup>1</sup> and fully agree that there needs to be effective communication between clinicians and patients. Whilst the article, rightly so, placed emphasis on communication between doctors and patients, communication between clerical staff and patients is equally important.

Like most specialties, the Ophthalmology Department at Wrexham Maelor Hospital, North Wales, has experienced marked reduction in clinic attendance at our intra-vitreous therapy service for wet age-related macular degeneration (AMD).

All elective NHS activity was cancelled on 17th March 2020.<sup>2</sup> Shortly thereafter, a nationwide lockdown had been imposed by the UK government on 23rd March 2020.<sup>3</sup> We would like to present the preliminary results of our evaluation of AMD clinic attendance during the COVID-19 pandemic.

We considered all scheduled AMD clinic appointments from 9th March to 22nd April 2020 when pre- and complete lockdown measures were implemented across the country. There was a total of 503 scheduled AMD clinic appointments during this 6-week period, of which only 273 appointments were kept. Therefore, the overall non-attendance rate was 45.7% during the period. A higher rate of absence was noticed even before the complete lockdown. There had been a 27% non-attendance rate 2 weeks prior and increasing up to 44% 1 week prior to lock down. This reached the peak of 61% during the 2nd week of complete lockdown. This was compared to the previous year's non-attendance rate for AMD clinics over the same period of time of 13.5% (Figure 1).

We presumed patients' unawareness of the continuity of AMD clinics could have been a reason for the unprecedented non-attendance rate apart from their reluctance to attend an acute hospital site. Patients were subsequently contacted telephonically by our AMD coordinator. They were informed about the non-cancellation of AMD clinics and continuity of Intravitreal Injection care. Furthermore, they also were able to reassure patients about the measures taken by us to prevent virus transmission and improve patient safety. Thereafter, there was a significant improvement in the attendance rate although the non-attendance rate continued to remain higher than the same period the previous year.

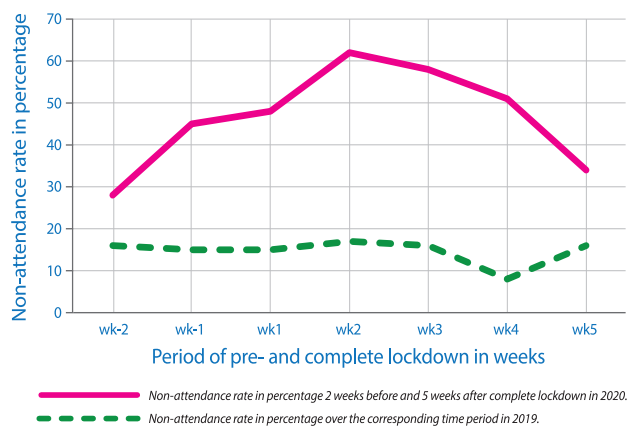
Therefore, we agree fully with the authors that good communication is crucial to effective patient management and is the responsibility of all staff, both medical and non-medical. It is important to continue to adopt this approach over the coming months, especially in light of the pandemic continuing to evolve.

*Bhagya Weerasinghe and Jai Shankar*

### References:

1. Popat M & Sarkar P. Effective Communication. *BIDA Journal* 2020;26(3),20-21.
2. NHS England Letter (2020): Next steps on NHS response to COVID-19. <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/urgent-next-steps-on-nhs-response-to-covid-19-letter-simon-stevens.pdf>. [Accessed on 31st July 2020].
3. Prime Minister's statement (2020): Prime Minister's statement on coronavirus (COVID-19) 23 March 2020 <https://www.gov.uk/government/speeches/pm-address-to-the-nation-on-coronavirus-23-march-2020>. [Accessed on 31st July 2020].

Figure 1: Comparison of AMD clinic non-attendance rate in 2020 and 2019



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# Divisional News

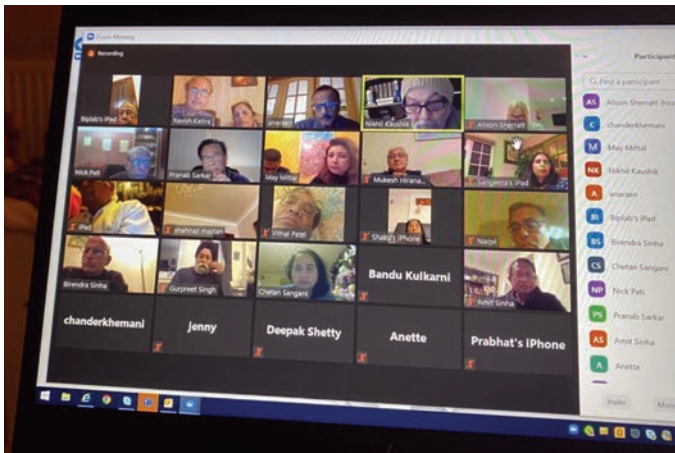
## Launch of a new BIDA Division:

### Southport & Ormskirk Division's first meeting

The Southport & Ormskirk Division of BIDA was launched at a virtual online meeting held on 15th December 2020, and the following office bearers were appointed:

- Chairperson - **Dr. Ravish Katira** (pictured above)
- Vice Chairperson - **Mr. Chetan Sangani**
- Secretary - **Mr. Asheem Naraen**
- Treasurer - **Dr. Vikul Mittal**

The inaugural academic event was both very well attended and well received as it was quite topical. Dr Rashmi Gupta, Consultant Microbiologist at Liverpool University Hospitals NHS Foundation Trust spoke on 'Covidology - trials and tribulations'.



## Congratulations!

### Dr Raghu Pillarisetti FRCS OBE

Our heartiest congratulations to **Dr Raghu Rama Pillarisetti**, founder of KIMS-Ushalakshmi Breast Cancer Foundation, on being the recipient of the Order of the British Empire (O.B.E) in the New Year's Honours list of Queen Elizabeth II. This is in recognition of his services and surgical education towards initiating awareness and improving breast cancer services in India through a series of innovative measures. He has implemented South Asia's largest population-based screening programme, developed the world's first breast health mobile phone app in 12 languages, and launched the world's first life-size augmented integrated reality for breast cancer awareness. The award also gives acknowledgement towards improving Indo/UK relations.

Dr Pillarisetti, during his whole period of stay in the UK, was an active member of BIDA and made several important contributions to the Association. BIDA is proud of his achievement, and wishes him well.



## O B I T U A R Y



## Dr Krishna Korlipara

Dr. Krishna Korlipara came to the UK from South India 56 years ago, and settled in Bolton in 1968. Like most of that generation of doctors he worked in hospitals before moving into General Practice in 1972. He continued to keep up his interest in Cardiology by working as an Associate Specialist in Manchester at Wythenshawe Hospital.

Dr Korlipara was one of the key players in the establishment of the Overseas Doctors Association, which later became BIDA. He served as General Secretary of the ODA and was a key part of gaining well-deserved recognition in the early years of the Association. Whether he belonged to an organisation or not, he always worked hard supporting the cause of overseas-qualified doctors. He was also the founding father of "GP Co-Operatives". He established Bolton Medical Services Limited in the late 1970s, and proceeded to tour across the width and breadth of the whole UK helping other General Practitioners in establishing out of hours GP Co-Ops.

He served as the Chairman of NAGPC (National Association of GP Co-operatives), and also served the GMC for a considerable time as Head of the Professional Conduct Committee.

Dr Korlipara was a very sought-after speaker, and could easily speak for an hour without resorting to any notes. He was extremely well-liked by one and all. He was a committed doctor, and his passing is a huge loss to medical community. He will be missed dearly by all who had the pleasure of knowing him.

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