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Global Health

How does a strong system benefit us?

Inside:

Post Covid-19 Cancer Care, Education and Leadership

4th National BIDA Oncology Conference (Biennial)

(Virtual) Saturday 19 June 2021 The Christie NHS Foundation Trust

09:15 to 09:30: **Delegates in the lobby**

09:30 to 09:40: **Welcome and Introduction:** Mr C R Selvasekar
Organising Secretary.
Consultant Colorectal Surgeon, The Christie NHS Foundation Trust

Chairman's Address: Dr Chandra Kanneganti
National Chairman, BIDA. General Practitioner, Liverpool

Session 1: Key Messages in Common Cancers & Case-Based Discussion

Chairpersons: Prof. Sanjay Arya
MD & Consultant Cardiologist, Wrightington, Wigan & Leigh Teaching Hospitals

Dr Nisha Thambuchetty
International Clinical Fellow, The Christie NHS Foundation Trust

09:45 to 10:00: **Greater Manchester Cancer – The Benefits of an Integrated Cancer System**
Mr Thomas Thornber
Director of Strategy, The Christie NHS Foundation Trust

10:00 to 10:15: **Advances in the Management of Skin Cancer & Immunotherapy**
Dr K Gajanan Plastic Surgeon, The Christie NHS Foundation Trust
Dr Avinash Gupta Medical Oncologist, The Christie NHS Foundation Trust

10:15 to 10:30: **Ovarian & Cervical Cancer – Advances in Screening & Prevention**
Mr Sachin Maiti
Consultant Gynaecologist, Manchester University NHS Foundation Trust

10:30 to 10:45: **Early diagnosis in Colorectal Cancer**
Mr. C R Selvasekar
Consultant Colorectal Surgeon, The Christie NHS Foundation Trust

10:45 to 11:00: **Panel Discussion**

Session 2: Cancer Management during COVID

Chairpersons: Dr Vinod Gadiyar
Chair BIDA Hospital Doctors' Forum
Consultant in Anaesthesia and Pain Medicine,
Northern Care Alliance, Manchester

Mr Amit Sinha
Editor BIDA Journal
Consultant Orthopaedic Surgeon

11:05 to 11:20: **COVID Era – Digital innovation during Covid and beyond – GP perspective**
Dr Shikha Pitalia
Director SSP Health. UK Advisory Council British Asian Trust.

11:20 to 11:35: **Impact of Covid-19 on Cancer Care in GM - Regional Perspective**
Prof. Chris Harrison
Executive Medical Director, The Christie NHS Foundation Trust

11:35 to 11:50: **Impact of Covid-19 on Cancer Care - National Perspective**
Mr Hassan Z Malik
President BASO-ACS. Consultant Hepatobiliary and Sarcoma Surgeon, Liverpool University Hospitals NHS Foundation Trust

11:50 to 12:05: **Panel Discussion**

12:05 to 12:20: **Sponsors' Presentations**
12:05 to 12:10: Mr Manish Vaid Head of ICICI Bank UK Plc, London
12:10 to 12:15: Pall Mall Medical UK Plc
12:15 to 12:25: Quilter Finance Advicers
12:25 to 12:30: T.B.C.

Session 3 (A): Cancer Diagnosis & Education - International perspective

Chairpersons: Dr Leena Saxena
Chair, BIDA Women's Doctors Forum;
General Practitioner, Wigan
& Chair, Wigan BIDA Division.

Dr Preeti Shukla
Chair, BIDA GP Forum;
General Practitioner,
Colne Health Centre, Pendle, Lancs.

12:35 to 12:50: **Conduct of Exit Examinations by the National Board of Examinations in the times of COVID**
Prof Pawindra Lal Director, National Board of Examinations – India

12:50 to 13:05: **International Education during COVID and the Future**
Mr Pala Rajesh Vice President, The Royal College of Surgeons, Edinburgh

13:05 to 13:20: **Disrupting Breast Healthcare in India over the Past Decade – Replicating Best of British Practices**
Prof Raghu Ram Pillarisetti
Founder CEO & Director, Ushalakshmi Breast Cancer Foundation, Hyderabad, India

Session 4: Trainees & Medical Students Presentations

Chairpersons: Mr Amit Sinha Editor BIDA Journal. Consultant Orthopaedic Surgeon
Dr K Gajanan Plastic Surgeon, The Christie NHS Foundation Trust

Judges: Dr P K Sarkar Consultant Obstetrics & Gynaecology, National Treasurer BIDA
Dr Sanjoy Bhattacharyya Consultant, Emergency Medicine, Royal Blackburn Hospital
Dr Ashish Dhawan Consultant Cardiologist, Wrightington, Wigan & Leigh Teaching Hospitals
National General Secretary, BIDA

13:25 to 13:40: Oral Presentations, Trainees.
13:40 to 13:55: Oral Presentations, Mediacl Students.
13:55 to 14:10: Poster Presentations.

Session 5: Cancer Diagnostics and Support Organisations

Chairpersons: Mr Ibrahim Ismail Bolaji
President MANSAG
Consultant Obstetrics & Gynaecology,
Northern Lincolnshire & Goole NHS Foundation Trust

Mr Sai Pillarisetti
Chair BIDA Students Forum.

14:15 to 14:30: **Women in Leadership & Breast Cancer Changes during Covid-19**
Dr Sadaf Jafferbhoy
Consultant Oncoplastic Breast Surgeon, Univ Hospitals of North Midlands

14:30 to 14:45: **ColoAlert - A Next Generation Colon Cancer Prevention Test: Clinical Cases**
Prof Dr Maria-Paz Weisshaar
University of Applied Sciences Bonn-Rhein Sieg, Germany
Director, Research and Development, Biox Medical Ltd UK.

14:45 to 15:00: **Cancer and Diagnostics workforce**
Prof Geeta Menon
Consultant Ophthalmic Surgeon, Frimley Health NHS Foundation Trust
Postgraduate Dean South London, Health Education England.

15:00 to 15:15: **Panel Discussion**
15:15 to 15:30: Announcement of Winners of Presentations.
Vote of Thanks Dr Ashish Dhawan
National General Secretary, BIDA
Consultant Cardiologist, Wrightington, Wigan & Leigh Teaching Hospitals.

Hosted by

Editorial

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

Time to heal

The vaccination programme raises an optimistic anticipation of some form of stability in our lives in the UK, but we remain extremely disturbed about Europe and other countries in particular India, where the ferocity of the spread of the pandemic has caught everyone unawares. BIDA and a number of charity organisations have come forward to support and buy the necessary equipment, oxygen concentrators and medicines to transport to New Delhi. Our hearts go out to every individual and family who have been affected by Covid-19 and pray that this pandemic is brought under control.

The recent report in King's Fund mentions, "Recovery and then renewal". Considering what we have all gone through, these are words of hope for everybody. It would also suggest that the health and care workforce who have been working under immense and intense pressure for many, many months would be able to renew their energy. They need their own well-deserved time to heal. The whole healthcare system needs to bounce back. This may not be easy, knowing fully well that the NHS has been at the limit of it's own reserves for several years.

The word "renewal" perhaps refers to the whole NHS needing a fresh outlook for the future with regards to the workforce of both doctors and nurses. The staff shortages cannot be ignored, if we wish to be better prepared to recover the healthcare system and manage the backlog of non-COVID related morbidity that has built up. This will require systematic transformation of the way health and social care are delivered. There will be much we can learn from the innovations in service delivery we have seen in the last year, but it will take months, indeed years to fully recover. The general population's well being affected by lockdown and families, who have suffered loss of loved ones will have been scarred forever.

BIDA's response to The Commission on Race & Ethnic Disparities

The consortium of BAME healthcare professional community are dismayed that CRED have downplayed the significant impact of racism in British society. BIDA joined 36 other sister organisations and have represented to the government and have written in the strongest of terms and called this "a partisan report that has drawn up spurious conclusions which fly against established facts, derided by global experts, and defies the lived experiences of many".

Michael Marmot set out the challenge after a decade of stagnation in this area. He said in the British Medical Journal: "There is now an urgent need to do things differently. We must build a society based on the principles of social justice; reduce inequalities of income and wealth; and build a well-being economy that puts achievement of health and wellbeing, rather than narrow economic goals, at the heart of government strategy. We must build a society that responds to the climate crisis at the same time as achieving greater health equity. "Build Back Better" has become the mantra for what we should aim for post COVID. Important, no doubt, but we also need to Build Back Fairer."

We had joined hands with DAUK with their initiative of celebrating the "Overseas NHS Workers day on Friday 5th March 2021, to celebrate the extraordinary contributions made by international NHS staff during the pandemic.

Articles

Our health relies on the health of our neighbours and that is true locally and globally. This is the foundation of global health. Sai Pillarisetti gives a message with his article on "Global Health" that achieving equity in the healthcare systems around the world is paramount to the welfare of the global society.

Ajit Sinha shares his experience in learning how to be a skillful mentor. "It is about involvement and knowing each other better. It is about finding answers to questions you do not know. Mentoring is a relationship; a bond like a doctor has with his patient", he writes. Who would understand better than us?

David Grimes has written a very thought provoking article on Vit D. Its strength in bone health is well established. However, it has been a missed opportunity indeed by our scientists in understanding and studying the long-term effects of Vit D in improving immunity in the prevention of serious affection of Covid-19. The new virus has not made a guest appearance but plans to stay with us forever.

The article by Soloman Arorose and Ravish Katira lays out a logical holistic programme for reduction of hypertension. Another very useful clinical article by Manisha Saxena and John Kellet is recognition of different patterns of skin manifestations of IBD. We are pleased to include the winning essay by Parivrudh Sharma, a 4th year medical student at Aberdeen University following the BSW essay competition.

BIDA has had a successful National Conference in February. We look forward to another educational and a well-organised National Oncology Conference on 19th June.

Whilst change is inevitable, we all have the power to direct that change. Buddha's principle.

A. Sinha Editor, BIDA Journal.

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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 Chairman's report

Dr Chandra Kanneganti National Chairman, BIDA

Dear Colleagues,

With the successful UK COVID vaccine program and the cases falling, we hope to fully recover from the difficult times we have endured with the pandemic. BIDA Officers and the Executive Committee have continued to work hard in highlighting and championing many issues during the COVID pandemic. Unfortunately, currently India is badly affected with the new COVID Variant. BIDA officers have acted on this and started a fund to support The British Asian Trust. We have collected over £50k so far with generous donations from our members and supporters. My special thanks to Dr. Shikha Pitalia in supporting this initiative and donation.

We continue to campaign on important issues that affect our members. We have responded to the Race Equality Commission's report and, along with other organisations, have sent our views about the report. We have received a response from the Home Office about our letter and our campaign for permanent visas for elderly parents of international doctors in the UK.

We continue to offer a number of solutions to many problems faced by key workers, and have worked collaboratively with the BMA as well as with other doctors' associations. BIDA has been proactive, and has been quoted in a number of both national and local press outlets championing doctors issues, particularly in relation to COVID-19.

We have a National Oncology Conference organised for next month and I hope to see most of you there. We are still planning to hold our Annual AGM/ARM in October 2021 and, once we know the government's advice regarding the meetings, we will announce details soon.

Our delayed national elections are planned to be held soon and you will receive information regarding this from our independent election commissioners.

BIDA's Student Wing is growing stronger under the leadership of its Chairman Sai Pillarisetti. The Student Wing is currently providing a number of educational webinars regularly supporting medical students.

Let's continue our hard work in our place 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 National Secretary's report

Dr Ashish Dhawan National General Secretary, BIDA

Dear Friends,

It is now evident that the Covid-19 fight internationally is far from over. Whilst the NHS keeps on struggling with waiting list pressures and vaccinating the country, India is currently reeling under an acute surge of the pandemic. Due to sheer number of patients, Indian health resources are severely stretched.

The hardships and pain this pandemic is bringing to people in India, in various ways is unprecedented. BIDA has launched a fund-raising campaign to help the people of India in their fight against this Pandemic. BIDA has joined hands with British Asian Trust in this campaign.

BIDA OXYGEN FOR INDIA EMERGENCY APPEAL will raise funds that will be transferred to British Asian Trust (BAT). It's advisors and programme partners in India have outlined a package of support that will complement what industry, government and other charities are doing to help. BIDA will ensure that the money raised from this appeal is used entirely for the present Covid crisis.

At the time of writing this report, I am glad to inform our members that we have raised more than £55,000. I am grateful to BIDA members, colleagues and friends, and all supporting organisations who have contributed generously.

Amongst all this doom and gloom, the vaccination programme is a ray of hope. BIDA office bearers 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 organization lies in its members and the same holds true for BIDA. Myself and all members of BIDA EC strive to strengthen our organization by ensuring that our divisions are thriving and our membership keeps going upwards.

Finally, I would like to thank Alison from 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 G.P. Forum Chairperson's report

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

Dear Members,

First of all I would like to applaud all my colleagues for delivering a very successful vaccination programme and that too in very difficult circumstances.

More than 34 million people in the UK have received at least one dose of a coronavirus vaccine which is not an easy feat . As a result of this success so many lives are saved and people have slowly started to return to their normal activities.

In addition, General practice has been working incredibly hard to provide safe care to patients. The latest GP appointment figures in England show that practices delivered almost 5 million more appointments in March than they did the month before, and nearly 3 million more than they did in the same month two years ago, long before the onset of the pandemic.

These figures underline the immense efforts that practices are making in providing care to their communities and the intense workload pressures that staff are under as we continue to respond to the pandemic alongside patients' wider health needs.

Just as we were dealing with these challenges we heard the news of devastating effects of Covid wave in India . As ever, the Indian Diaspora and BIDA members rose to the challenge and not only raised more than £50,000 but are also providing educational and logistical support to colleagues in India . It has been covered in various media outlets including Asian voice .

As your representative I will continue to raise my voice and do whatever is needed for the cause. I would also like take this opportunity to thank everyone for their contributions and am sending my thoughts and prayers to those who have lost loved ones during Covid. We are in it together.

Best wishes,

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

bida National Conference Convenor's report

Prof Sanjay Arya Consultant Cardiologist. Medical Director, WWL NHS Foundation Trust. BIDA National Conference 2021 Convenor.

Dear Colleagues,

"Living with Covid-19 and Life beyond"

Our NHS has been (and is still) under unprecedented crisis. Covid-19 has had an impact on every aspect of healthcare, from direct care to patients to population health and importantly the wellbeing of our hard-working staff. Health professionals have delivered the best possible care under the circumstances and must be acknowledged for their commitment and professionalism. Never have we been forced to change our working patters so radically in such a short time with excellent examples of teamwork, innovation, and leadership.

Sadly British International Doctors, who constitute a significant proportion of the NHS work force, were disproportionately affected by the Coronavirus during the pandemic and many have sacrificed their lives for the NHS. In order to highlight such issues facing our NHS and the BAME workforce, BIDA held its Annual National Conference on Saturday 6th February 2021. The conference was addressed by representatives from various medico-political organisations, along with dignitaries from the NHS Trusts and Department of Health.

Due to the unprecedented circumstances of the Covid-19 pandemic, the conference was held through a virtual Zoom meeting. Approximately 450 delegates registered for the conference with over 300 of the target audience attending at any given time. The meeting was hosted by Quilter Financial Advisers and supported by various BAME organisations in the UK including BAPIO, APPS (UK), MANSAG, APPNE, BJMA and also CESOP. A big thank you to every member of the organising committee and to every BIDA member for making the conference a huge success.

My special thanks to Mr Amit Sinha and Mr Pranab Sarkar for summarising each of the talks delivered by our distinguished speakers.

Prof Sanjay Arya
National Conference Convenor, BIDA

Global Health

Sai Ram Pillarisetti 4th Year medical student & President, BIDA Student Wing

Throughout history, disease has been a natural and inevitable part of human life. But over the last few generations we have witnessed an incredible improvement in the health and wellbeing of populations worldwide. For instance, over the past three decades, the number of children who die before their fifth birthday has fallen by half even as the world population has increased by more than half[1].

This can be credited to a global effort to improve and develop health care around the world – an effort in which the UK has played an indispensable part. However, there remains an enormous amount of work to be done to make the world a more equitable place.

Eradicating the world of diseases has proven to be an arduous task and the world has only done it once before, with smallpox. Smallpox was eradicated in 1980 after decades of tireless immunization campaigns and consigning other illnesses to history books will require efforts of similar scale and dedication.

What is Global Health?

COVID-19 has taught us that we're all connected. Our health relies on the health of our neighbours and this is true locally and globally. This is the foundation of global health. Global health is about understanding and developing healthcare systems around the world and achieving equity in health for all people, regardless of geographical location and economic status.

The UK government describes global health as being focused on people across the whole planet rather than the concerns of individual nations. Global health recognises that health is determined by problems, issues and concerns that transcend national boundaries[2].

My contribution to global health

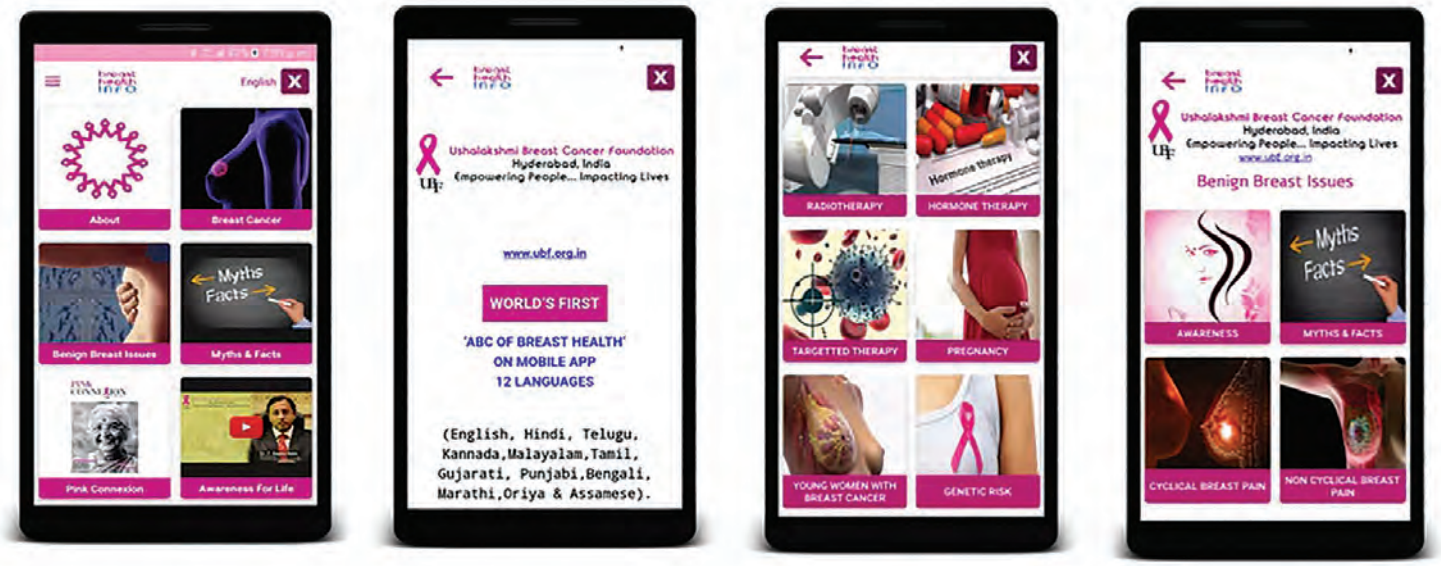
One of the best pieces of advice I have ever received was; "***At the end of the day, it's not about what you have gained but what you have given back.***"

I feel humbled to have contributed to promoting global health by spreading awareness of breast health in India. In association with the Ushalakshmi Breast Cancer Foundation, a Breast Cancer Charity based out of Hyderabad in India, I helped create the World's first Mobile app on breast healthcare available in English and 11 regional Indian Languages. This App – 'ABC's of Breast Health', is freely downloadable on both the Apple and Google play stores.

Some of the issues global health addresses is awareness and stigma, both of which have been addressed in the development of this app. Breast cancer is the most common cancer affecting women in the world. In many parts of India it is still a 'taboo' – a topic that is not talked about openly. This has become a major impediment to early detection of the disease and subsequent treatment to women.

Education and awareness programmes play a vital role in the early detection of breast cancer, which leads to better outcomes. In order to make meaningful progress, it requires committed effort from multiple disciplines, organisations and government bodies, working hand in glove with each other. The NHS Breast Screening Programme is an excellent example of this where GPs, nurses, breast specialists all work together.

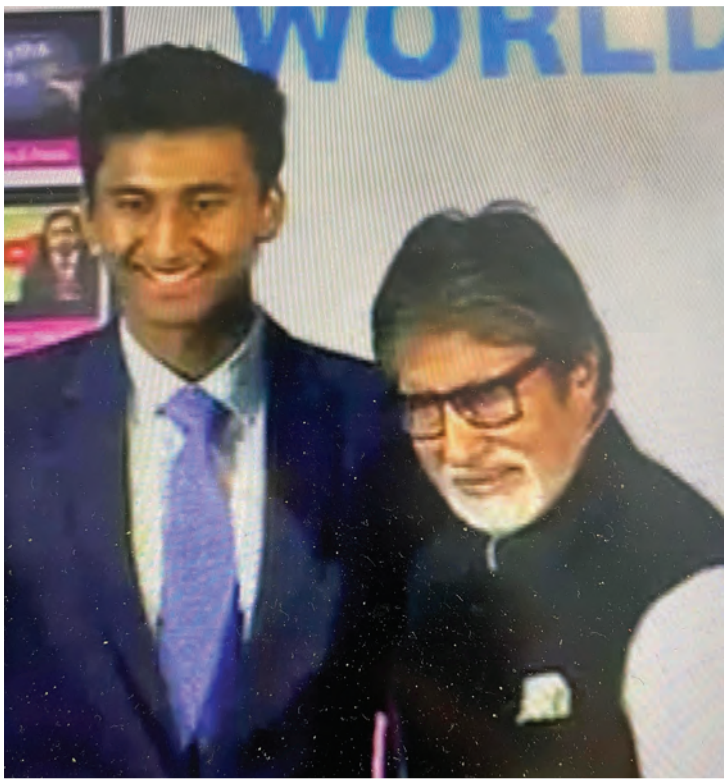
Both my grandmothers were diagnosed with breast cancer. A few years ago, when my maternal grandmother was diagnosed, I became very involved in her care. Her struggle with a life-threatening disease inspired me as I realised that the health of the matriarch of the family has a much wider impact as she is regarded as nerve centre of the family, especially so in the subcontinent of



Above: Mobile phone screenshots of Sai Ram Pillarisetti's 'ABC of Breast Health' App.

India. I realised that breast cancer is the commonest cancer affecting women in India and due to lack of awareness and absence of an organised population based screening programme, more than 60% of breast cancers present in the advanced stages, with most succumbing to the illness within a year of being diagnosed. The opposite is true in western countries such as the United Kingdom.

The mobile app I helped create, 'ABCs of Breast Health' was launched in 2017 by Shri Amitabh Bachchan and provides the much-needed awareness about every aspect of breast health (including breast cancer) in a simple, easy to understand format, which also aims to reassure the 'worried well'. Most people in India have a mobile phone & therefore the content of the mobile app in 11 commonly spoken regional languages has ensured that the information relating to breast health is accessed by women in rural India, where 70% of the population resides. The App also has an interactive 'Myths & Facts' section which is aimed at debunking many of the common myths surrounding breast cancer and ensuring that users are well informed with accurate information.



Above: Sai Ram Pillarisetti alongside legendary Bollywood star Amitabh Bachchan at the launch of the 'ABCs of Breast Health' App.

More recently, I have been working with the Bill & Melinda Gates foundation as a 'Health Legend' as part of their 'Health Legends Campaign' to promote the importance of Global Health here in the UK. The Health Legends campaign aims to champion global health by telling the stories of health workers here and around the world. Just 5 'Health Legends' across the UK were chosen from a range of health-related disciplines - a medical student, physician, student pharmacist, student paramedic, and an advanced nurse practitioner (www.healthlegends.org).

During the course of the campaign, I have been invited to speak to children at several schools across Lancashire on the importance of global health as well as encourage them to pursue a career in medicine. I have also written blogs on the importance of global health, created awareness of global health issues on social media and I feel very privileged to have been chosen to be a part of this initiative, and I hope to make an even greater impact as a qualified doctor in the fullness of time.

Above: A tweet that Health Legends sent out about Sai Ram Pillarisetti.

Finally, I believe it is vital that we recognise the importance of global health in improving the quality of life of human beings worldwide and address the inequalities through education, advocacy and implementation of innovative initiatives.

How does a strong global health system benefit us?

There are many benefits of a robust global health system but one in particular, which has been highlighted in recent times, is the spread of viruses like COVID-19. The spread of infectious diseases has come to the forefront of global health and with better strategic partnerships between various organisations, diseases like COVID-19 could have proved to be much less damaging to the world than what it is today, which is supported by a concept called 'the global solution'. It states that global health issues often can only be effectively solved at the macro level through cross-cultural, international, and global collaboration and co-operation among different entities and stake-holders[3].

We live in a global environment with millions of people travelling across borders every year. Along with these people, influenza, tuberculosis, and other exotic illnesses have 'passportfree travel' into the country. Establishing a robust and inter- connected global health system will better help us contain outbreaks from spreading across borders.

Equally, a strong global health system will enable research to be conducted on these uncommon infections, so doctors are better able to treat individuals in the future, whether in the UK or anywhere else.

Finally, the most important reason why global health should be of significance is empathy. Global Health initiatives give us the opportunity to help and treat individuals from poorer countries that would otherwise not be able to receive this life saving treatment. I strongly believe that the world will be a much more equitable place with more global health initiatives. The eradication of Polio in India, malaria treatment in Africa, and treatment for the AIDS epidemic in developing countries are all excellent examples of the outcomes of global health initiatives and are testament to why we need even more awareness, interest and action generated towards this vital movement.

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1. World Population Prospects - Population Division - United Nations [Internet]. Population.un.org. 2020 Available from: https://population.un.org/wpp/Download/Standard/Interpolated/
2. What is global health?. Global Health Action. 2010;3(1):5142.
3. Chen X, Li H, Lucero-Prisno D, Abdullah A, Huang J, Laurence C et al. What is global health? Key concepts and clarification of misperceptions. Global Health Research and Policy. 2020;5(1).

Mentors and Doctors

Ajit Sinha MBA MSc CPHR SHRM-SCP RCIC Principal Consultant, Checkpoint Strategies, Canada

"Ajit and I first met when he became my Chartered Professional Human Resources Mentor in late 2017. At the time, I was a second-year university student with no idea of what I wanted to do after graduation. In one of our many meetings, he stressed the importance of writing down your goals and strategies to achieve them. That simple idea really hit home for me...Since the end of our mentorship, I have worked for the Canada Border Services Agency, the Ministry of Forests, Lands, Natural Resource Operations and Rural Development, and did some international recruiting for my university. Ajit's mentorship has encouraged me to take big risks with my professional development and I am very grateful for it. Even though we don't talk as much as we did back then, I know I can always rely on him for career advice from wherever I am in the world."

...Ryan Chandler, LinkedIn, December 02, 2019 [1]

These kind words inspire me every day to do more selflessly for those who look up to me for advice. No text book or case studies explain why Ryan Chandler continues to remember me. He still writes picking my brain, seeking advice and I cherish each moment spent with him. He is not alone. They are many like him who will seek mentorship from other leaders / managers because they know and understand the value of mentoring. Ryan will certainly develop and be responsible to create several more leaders like him. This young man of twenty two years acknowledged my learning of years. I firmly believe that more mentoring will always be less. I will be honest to admit that I have not been perfect. I have committed and still commit mistakes but do not give up. Was I always like the person Ryan has spoken about? No, I was not.

I started working at a young age of twenty responsible for a team of eight. In India, this was an achievement. Sadly, with no experience under my belt and not so well informed superiors, peers and colleagues, I soon developed into a person who believed in passing "orders". I had little realization of the amount of pain, hurt and damage that I was causing due to my autocratic style. In the absence of guidance and mentorship, I had assumed that orders and compliance were the mantra for success. Intermittently people would leave my team and new ones would join but the realization was not setting in. I continued this unfortunate trend of ignoring happiness and the opportunity to build team bonding for around two years. My understanding was that more a person was in awe of me, the better I was. If you wished to define an ineffective supervisor, I would have fit perfectly as an example. Decades later I wonder how I had been getting away with such insensitive behaviour.

At the end of my second year in the job, I committed an unpardonable error which could have led to approximately $50,000 loss to the company. It was my overconfidence and lack of collaborative spirit which stopped me from consulting others or seeking advice of my well informed team. I was "high" in awe of my powers. The incident was of a power breakdown and connected repair. I gave an order to connect the raw power from the city directly to the building power switch board instead of connecting to the stabilizer which used to arrest surges in power and protect the costly servers. Unfortunately our stabilizers were burnt out as a result of this. In my belief that power to the business should be restored at any cost to plug the financial loss to clients, I gave the instruction to connect the power directly. My whole team unanimously reacted advising me not to take this action, but I did not heed their advice and forced powering the building.

Fortunately for me no damage was done but fluctuation in the voltage led to an automatic shutdown of machines, servers as well as workstations. There was uproar from employees and the management. The question every senior manager was asking – "what did you do?" The power unit was shut down immediately. I was sure that our CEO would certainly terminate me and I will possibly not find a job for an unforeseeable length of time. Nothing of that sort happened. We continued work on the repair of the stabiliser. After continuous 30 hours of repair, stabilized power to the building was restored.

My CEO did speak to me. He uttered just two words with a smile; *"well done"*. I saw him walk away and suddenly he turned and said, *"Look after your team and they will look after you"*. Those words had a profound effect on me and I changed that day. That evening I remembered and thought of all my actions in the events of the last two of years of my life and realised that I had ruined my relationships with my team, and friends. During this time, I did not support or help one single colleague or subordinate and never gave a reason for anyone to look forward to working with me or as a team. I needed a shoulder to cry and seek forgiveness. That evening itself I did decide to approach a supervisor for help. He was someone who was more qualified, richer in values and certainly more experienced. I had seen him behave and serve like a solid support to everyone who went to him. Fortunately he agreed to help me improve and be a better leader. My learning started that day from my guide and mentor.

Mentoring is about sharing and knowing each other better. It is about finding answers to questions you do not know. It is about defining what your success means to you. It is about making you proficient in finding solutions on your own, sharpening those skills which are subdued due to inhibitions and pushing the comfort zone to increase your potential and capacity. Impact of good mentoring lasts for years. Humility, patience and service come naturally to mentors. Mentoring is a relationship; a bond like a doctor has with his patient. A patient wishes to meet with "her/his" doctor and not just any doctor because there is faith and trust. Similarly, a mentee when faced with a dilemma consults or seeks advice or bounces solutions off her/his mentor because there is trust between them.

It has been proven time and again that mentoring supports employee growth, employee engagement, and accelerates knowledge gain in the areas of interest to the employee as well as the organisation to make way for tomorrow's leaders. The ideal mentoring bond *"extends beyond the career to include discussions about behavior, values, relationships, parenting, finances, and even spiritual life*[2]*."* I have personally remained connected with my school principal right until he passed away. He guided me through both personal and professional circumstances, made me feel supported and confident when I doubted myself and taught me to build and nurture relationships for life. His mentorship has been invaluable in my growth and success, and I strive to provide similar guidance and support to my mentees.

Few people affect an individual's professional and career development like a mentor. There is no doubt that mentors occupy a special place. *"The good ones possess high-level knowledge of a mentee's industry and work, they have an invaluable store of personal experience, and their interest is selfless and singular: they want to help their mentee grow and succeed."* [3] In everyone's life, there is always the need to speak to a knowledgeable person who can give sound advice in a particular field or to learn a new skill, or someone who is a safe sounding board to test your logic, or even someone who is younger but has a skill that you wish she/he will teach you. This can happen anywhere in the world, in any profession and is not governed by the level of experience. In one of the studies[3], it has been propositioned that the number of mentors are far less than the number of people who need them. *75% of professional men and women want to have a mentor, only 37% have one*[3]. The pressure of becoming successful in life and earning more to achieve luxuries aspired for, clouds the decision to share and support others around us who are in urgent need for help.

There are several ways to drive mentoring in organisations. Successful organisations have mentoring programs that works for them. Sixteen such programs of Fortune 500 companies are listed in an article in the "Together" journal[4]. People from any profession will benefit if they do an in depth study of the different programs mentioned. One or a combination of the programs will succeed for your team. There is no one solution for designing and implementing a successful mentoring program. Each team driven by their culture and needs evolve mentoring programs which succeed for them.

In addition to the traditional mentorship relationship, in many fortune 500 companies, C-suite executives have millennial mentors who guide them to learn how to target the younger consumers. As Estée Lauder's CEO, Fabrizio Freda, noted, the company "had come to a place where the future could not be informed by the past" and therefore decided to implement a reverse mentoring program [5]. Millennial mentors created a unique online portal to exchange new ideas. Any discussion on this platform was circulated among employees and executive leadership team so that they knew what changes the company needed to implement to be relevant in business. There were inputs to change strategy to attract clients and engage employees. Jim Crawley, CEO of BNY Mellon | Pershing, learnt and acquired digital skills to be active on social media and LinkedIn in a reverse mentoring relationship with a much younger mentor[5]. Donna Hager, a career engineer, resigned as the VP Aecom, world's largest construction company to create her own company Macon Deve Engineers. She was encouraged to start a woman-owned company in New York to meet the target percentage of allocating work to only women-owned companies. There was enough work for such companies and not many companies available.

Unfortunately contracts were not offered to her due to lack of people. She ended up hiring part time senior executives to meet the needs of the business. What she discovered was that younger full time employees gravitated to senior experienced people and began a mentor-mentee relationship[3]. This led to a phenomenal growth of the company. There is one more befitting example of a mother living the dream of her daughter who died of cancer. Louisville based consultancy and staffing service, TKT & Associates was the brain child of Tierra Kavanaugh. This staffing company had two staff members when it was formed; Tierra, the founder and Sheila Kavanaugh, the co-founder – her mother. From 2006 to 2020, the company grew to 250 members with a three year growth of 11,106.7%. Tierra mentored her mother every day. Then the pandemic hit them and on April 30, 2020, Tierra died of natural causes. *One of Tierra's real strengths was her ability to look at a company and identify the gaps to create customized servicing and programming for it. She also excelled at documenting her strategic vision and putting the proper people into place to execute it*[6]. This mother's deceased daughter was her role model and mentor. In the present environment of pandemic and the fact that she is one of those few black CEOs, she is determined to succeed. That is the power of mentoring, determination and legacy.

Similar examples of reverse mentorship can be observed in the medical profession as well. Have you noticed that almost every doctor that you meet is soft spoken, is an active listener, attends to the clients patiently and explains his results taking her/ his time as if she/he had all the time in the world? Being a good doctor is very much like being a good mentor. There are many similarities between doctor's behaviour and soft skills in the medical profession and mentor's behaviour and soft skills in mentoring relationships.

Dr Sanjay and Dr Vineet have listed key principles that doctors follow. This team *"found that practicing mindfulness— being patient, focused on the moment, and accepting of events as they unfold— is important.*[7]*"* Exceptional mentors demonstrate similar traits. They have an ethical duty to teach the new members of their team the skills to become symbols of excellence. When doctors and mentors commit a dereliction of duty in mentoring, the loss is quite high. Both a doctor and a mentor have the higher pedestal of knowledge and expertise. Though they occupy the seat of authority, they operate with the patient's / mentee's interest as the key guiding principle. Depending on the situation and the urgency, there is room to accommodate. The most important one is being available to the patient / mentee. Many of the senior level doctors and mentors have busy schedules and mentoring is difficult to accommodate in their fast paced work life. One does have access to innovative technological tools to choose from. In the current pandemic world, working has shifted to virtual and remote options. We have a plethora of choices. In the pandemic environment, we have all resorted to online meetings. Whether we work with Zoom or Teams or in-house software, mentoring sessions or one on one meeting have also moved online.

71 percent of Fortune 500 companies offer a mentoring program in their workplaces[4]. Our own Chartered Professionals of Human Resources BC & Yukon Association in Canada has a special mentoring program run every year for its members. Ryan participated in one such program. To add to the other resources mentioned earlier, Tele-mentoring is creating global Communities of Practice in Health Care[8]. Simply summarised, leaders attract leaders and form a pool of talent which others can tap and gain knowledge from.

Every mentee must receive quality time. If face to face discussions are not feasible, video conferencing can be leveraged as an option. It is important that for that length of time the mentor is completely available. It must be determined in advance what the mentee needs.

If the mentor does not have the skill, it will be prudent to direct the mentee to the right source to learn. This applies for the mentors themselves as well. Take for example the British Medical Association website has a specific page for mentoring[9] that all doctors can refer to find a mentor, and also understand what benefits mentors can provide. This web page walks through the step by step process of how to become a mentor, how to train for mentorship, how mentees find mentors including preparation for the first meeting. It also has reference resources to find additional information.

Most of the medical organizations aspire to be a role model for all medical services across the world. The National Health Service of the United Kingdom constantly endevours to improve the health of doctors, their well-being and training. The research by Professor Michael West and Dame Denise Coia[10] presents practical proposals and a road map to develop healthy and sustainable workforce. It is an impressive detailed mapping of case studies to support desired changes. The authors have highlighted the urgent need for a culture change. They have mentioned that doctors leave NHS due to stress and lack of opportunity to become mentors. One program, talks of an initiative "FIRST FIVE" to support General Practitioners run by Royal College of General Practitioners. This role model service includes a formal mentoring practice similar to the one corporate employees have access to as a best practice HR tool. Unfortunately, implementation of these initiatives is not always as expected due to limited time availability. A 2014 report[11] indicates that while availability of doctors should be approximately 21.7 hours per day to attend to all her/his patients. In reality, *"The family physicians said they spend 34.1 hours in direct patient care each week, or about 22 minutes per encounter, with 2,367 people under each physician's care*[11]*."* As per the report[11] discussed earlier, NHS is also witnessing the lack on the part of senior doctors and consultants who do not have the time to mentor a staff member . Physician burnout is a universal dilemma that is seen in healthcare professionals, particularly physicians, and is characterized by emotional exhaustion, depersonalization, and a feeling of low personal accomplishment[11].

A 2014 NHS guide by Melanie Lloyd[12] on Mentoring services in NHS is a great resource to support doctors. Two points covered in detail in this document are subjects that we must understand for doctors as well as any mentors. One is that we tend to confuse between mentoring, coaching and counselling. They are three different support actions for staff members. The second point states that there are many benefits of mentoring. John C Crosby is quoted in the same document that *"Mentoring is a brain to pick, an ear to listen and a push in the right direction.*[12]*"* Benefits available for doctors to improve their knowledge, behaviour, skills and setting expectations are no different from any other organisation.

Mentoring is always about improving the culture of the organisation and growing future leaders. If doctors in NHS are stressed and fatigued, it is a blessing if there is a hand to hold, a guide to seek answers, a door to knock and a human being to advice. Many others across the world look up to NHS for best practices. NHS should invest in building formal mentorship programs and provide the support doctors need to be able to benefit from these programs. This may include building frameworks and processes that allow doctors to mentor while performing their day-to-day tasks and being able to set aside dedicated time for development and growth of the next generation of doctors. Mentoring is a two way process; an agreement between mentors and mentees. Both have responsibilities, defined tasks and a commitment to support each other. There are benefits for both of them. Like Jim Crawley, CEO of BNY Mellon and Estee Lauder's CEO, Fabrizio Freda learnt from much younger employees who supported them as their mentors. Exactly the same way, senior professionals in any industry or even doctors learn about the ethnic background, cultural nuances, professional strengths / weaknesses, generation gap issues and many other differences which when supported improves their performance and service.

Mentoring is a perfect method to educate, share and improve as well as a stress remover. An organisation that believes in the power of mentoring, benefits from the results of it. There is a need to reach out to leaders and managers who wish to share their skills and create better leaders for the organisation. Either a manager should come looking for you or you should find the mentor who will help you achieve your goals. Guidance from a superior or even a friend soothes and has a calming effect. Mentoring can help maintain the emotional strength to handle stress as well as high demand situations. The article[13] in Howard Business Review presents the state of mind of a doctor conversing with a colleague in a cafeteria line after the September 9, 2001 terror incident. It brings out the scare which was in the minds of people and the fact that no one was alone. In their combined experience in the medical profession, the post COVID status in their field of work has seen stressed doctors, nurses and health care workers. The complexities, uncertainty remains with the end of pandemic continuously moving forward with no firm end date in sight. The article states: "Thus you as a mentor can play a critical role, providing them with a stabilizing force, someone who can help talk them down when they're triggered, scared, burned out, or confused – all off the record.[13]"

Every professional needs a mentor to fast track their careers and broaden their horizon of vision. Whether you wish to attain a goal, or learn a new skill, expand your professional network, or even when you need help, you must not wait for someone to come to you. You need to search and find the mentor you need. A mentor can help you create a new image for yourself in the organization, assist in setting clear and achievable goals, identify leaders and connect them with you, and in the path get valuable learning for them too. If you are a leader, find a mentee to create another leader. If you are a mentee, find your saviour who can show you the path to success. Every day is just a new beginning.

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Mucocutaneous manifestations of Inflammatory Bowel Disease

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Background

Inflammatory bowel disease (IBD) is a chronic relapsing disorder, whose pathogenesis is multifactorial and results from an interaction between genetic, immunologic, microbial, and environmental factors. IBD often begins during adolescence, but may affect younger children. IBD includes Crohn's disease (CD) and ulcerative colitis (UC). Extraintestinal manifestations (EIMs) affect 25-40% of patients with IBD.[1] Mucocutaneous signs affect 2-34% of patients and are reported in 22-75% of patients with Crohn's disease and 5-11% of patients with ulcerative colitis.[1] EIMs may precede the development of gastrointestinal symptoms or occur concurrently or after the onset of IBD. Colonoscopy and biopsy are the definitive diagnostic tests whereas faecal calprotectin (FCP) is a non-invasive sensitive stool test for the assessment of gastrointestinal inflammation. This review elaborates on the mucocutaneous signs of IBD and the potential risk of drug induced IBD.

Introduction

Common mucocutaneous manifestations associated with IBD (Table 1)[1] can be classified into specific, reactive, associated, malnutrition-related and treatment-related. Specific diseases share the granulomatous features of IBD, whereas reactive share common pathogenic mechanisms.

Specific mucocutaneous signs of IBD (Table 2)

Cutaneous Crohn's disease - CCD (Figs 1, 2): There is no consistent correlation between the appearance of skin lesions and intestinal Crohn's disease activity. CCD is commonly associated with colorectal rather than intestinal disease.[2] In view of the varied clinical appearances the incidence may be underestimated. Therefore skin lesions that develop in patients with Crohn's disease should be biopsied. Three patterns have been recognised: metastatic, orofacial, and perianal.[2]

Cutaneous manifestation	Incidence of cutaneous manifestation in patients with		Incidence of IBD if patient presents with the cutaneous manifestation confirmed histologically
	CD	UD	
Specific [a]			
Orofacial	9 - 10%	1.5 - 4%	50% (CD)
Perianal	36–52% depending on site of CD	Rare	Close to 100% (CD)
Metastatic	Rare	Very rare	100% (CD)
Reactive [b]			
Pyoderma gangrenosum	0.5 - 20%	1 - 12%	1 - 93%
Erythema nodosum	4 - 15%	3 - 10%	4%
Aphthous stomatitis	10 - 17%	4%	18% (closer to 100% in complex multiple aphthous ulceration)
Perianal fissures, fistulas	20–60% (≥ 1 episode)	Rare	< 10%
Sweet's syndrome	< 0.05	< 0.05	28%
Bowel-associated dermatosis–arthritis syndrome	Rare	UC > CD	Rare
Aseptic abscess syndromes	Rare	Rare	15% with familial history of granulomatous disease
Leucocytoclastic vasculitis	Extremely Rare	Extremely Rare	Extremely Rare
Pyodermatitis vegetans, pyostomatitis vegetans	Rare	UC > CD	High, often bowel disease presents after these cutaneous manifestations
Associated			
Psoriasis	11.2%	5.7%	CD risk ratio: 2.53 [c] UC risk ratio: 1.71 [c]
Secondary amyloidosis	0.9%	0.07%	Rare; however, CD is fourth leading cause
Autoimmune bullous disease: linear IgA bullous dermatosis	Rare	Currently unpredictable due to lack of population studies	UC prevalence in LABD: 7.1% CD prevalence < UC
Vitiligo	0.5%	1.1%	0.9%
Hidradenitis suppuritiva	17%	14%	CD risk ratio: 2.12 UC risk ratio: 1.51
Acquired epidermolysis bullosa	Rare	UC > CD	25–30% have CD [c] UC prevalence < CD [c]

- CD = Crohn's disease; IBD = inflammatory bowel disease; LABD = linear IgA bullous dermatosis; UC = ulcerative colitis.
- a Same histology as the related inflammatory bowel disease;
- b An inflammatory disorder with different histology from the related inflammatory bowel disease;
- c Risk ratio compared with the general population.

Table 1. Common cutaneous manifestations associated with inflammatory bowel disease.

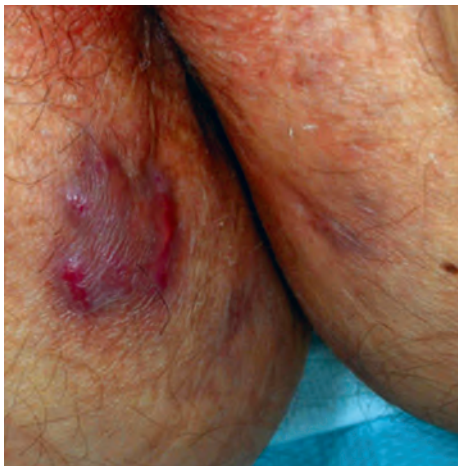

Fig 1.Erythematous plaque on the inner aspect of the right thigh of a patient with cutaneous Crohn's disease [2]

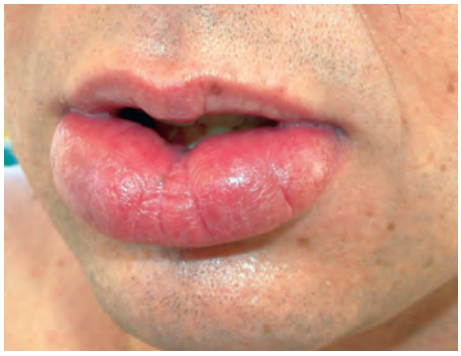

Fig 2. Oral lesion during exacerbation of Crohn's disease [10]

Metastatic Disease	Non-contiguous granulomatous inflammation of the skin; can involve genitals, lower limbs and intertriginous areas of the skin.
	Erythematous papules, pustules, nodules, plaques, abscesses, fissures, fistulae or ulcers; may be tender.
	Swelling or induration of the genitalia; may progress to lymphoedema.
Perianal CD	Contiguous granulomatous inflammation of the perianal skin or abdominal surgical sites.
	Erythema, erosions, fissures, fistulae, sinus tracts, abscesses, ulceration of the perianal skin and anal canal, scarring.
Orofacial CD	Non-contiguous granulomatous inflammation can be histologically detected in such lesions.
	Swelling of the gingiva, lips, cheeks and face; fissures of the lips and tongue; indurated mucosal tags, cobblestoning and mucogingivitis, deep linear ulcerations.(9)

Table 2. Patterns of Cutaneous Crohn's disease

Pyoderma Gangrenosum	Characterised by ulcers with irregular undermined or overhanging violaceous borders, surrounding inflammation; pathergy may initiate cutaneous lesions. Usually affects lower limbs, but may arise anywhere.
Pyostomatitis Vegetans (PV)	Multiple small pustules with snail-track appearance; vegetating erosions. May involve the oral, vaginal, nasal and rarely periocular mucosa.
Sweet's Syndrome	Tender, oedematous, erythematous papules, plaques, vesicles, bullae or pustules within the plaque, and target-like lesions. Areas often involved are face, neck and extremities.
Erythema Nodosum	Tender erythematous warm subcutaneous nodules, which can later develop a bruise-like appearance; usually distributed symmetrically over the shins.
Oral Aphthous Ulcers	Multiple round or oval tender oedematous mucosal ulcers, with an erythematous border; may involve buccal or labial mucosa, aphthous stomatitis and angular cheilitis.

Table 3. Presentations of Reactive Mucocutaneous signs of IBD

Reactive mucocutaneous signs of IBD (Table 3)

Neutrophilic dermatoses include Pyoderma gangrenosum (PG) (Fig 3), Sweet's syndrome (Fig 4), bowel-associated dermatosis–arthritis syndrome, and aseptic abscess syndrome. Pyostomatitis vegetans (PSV) is a rare pustular disorder that is a marker of IBD and usually precedes the onset (Fig 5). Pyodermatitis vegetans a variant of PSV is a mild skin involvement. Peristomal PG may develop in months to years after stoma creation. Sweet's Syndrome is an autoinflammatory mucocutaneous disorder which may appear localised or wide-spread with fever and malaise. The cutaneous eruption usually resolves spontaneously within weeks to months but may recur. Erythema nodosum (Fig 6) is predominantly septal panniculitis. It may be accompanied by fever and arthritis. Erythema nodosum is often reflective of active bowel disease. Oral aphthous ulcers are common in both forms of IBD.[2]

Associated mucocutaneous signs of IBD

Autoimmune blistering disease: The diagnosis of IBD predated the development of the skin condition in most patients. The association of Linear IgA dermatosis is more common with UC. A literature review revealed that in

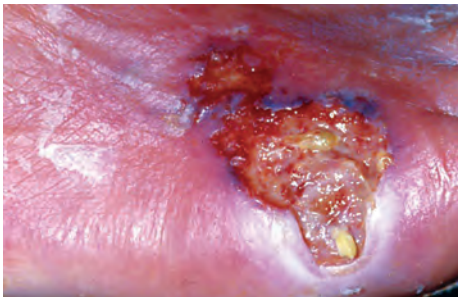

Fig 3. Pyoderma gangrenosum on the dorsal aspect of the foot. Source: archive.

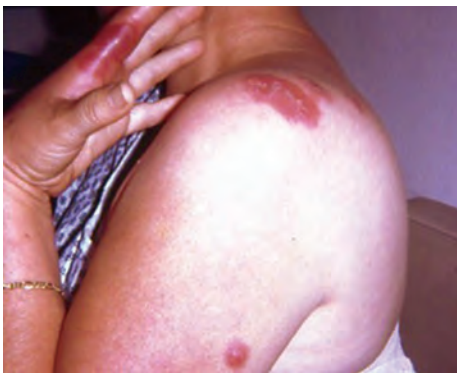

Fig 4. Sweet's syndrome on the left hand, left proximal arm and left shoulder 11

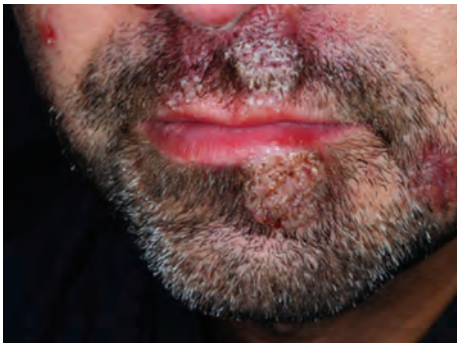

Fig 5. Vegetating plaques localized on the beard region aspect of a patient with ulcerative colitis-associated pyostomatitis vegetans.2

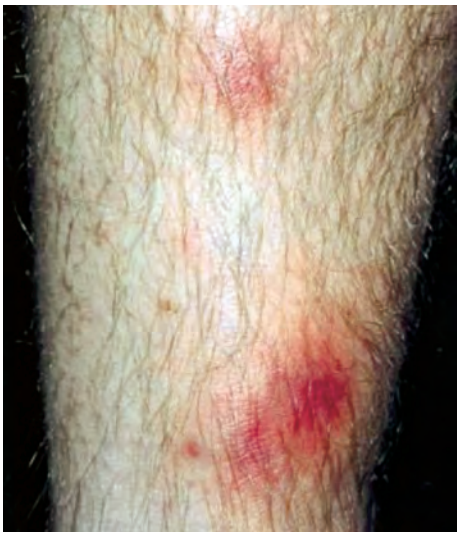

Fig 6. Erythema nodosum on the shin. Source: archive.

reported cases of this association, procto-colectomy has resulted in remission of skin disease in all cases where it has been performed, in contrast to variable results seen in cases where colectomy alone was performed.[3] The association between EBA

and IBD was more common for CD than for UC.[4]

Psoriasis: The 10-year incidence of CD was 2–5 per 1000 patients and of UC 7–11 per 1000 patients, depending on psoriasis severity and the presence of psoriatic arthritis. There is an increased risk of incident psoriasis in patients with IBD.[5]

Hidradenitis suppuritiva (HS) can frequently co-occur with IBD. HS prevalence is 26% in CD and 18% in UC.[6]

Rosacea: The prevalence of IBD (also Coeliac disease, H.pylori infection, Small intestinal bacterial overgrowth and Irritable bowel syndrome) was higher among patients with rosacea when compared with the control subjects.[7]

There are anecdotal reports of SAPHO (synovitis, acneiform eruptions, palmoplantar pustulosis, hyperostosis and osteitis) and PAPA (Pyogenic arthritis, Pyoderma gangrenosum and acne) syndrome associated with IBD. Case reports of cutaneous signs associated with Crohn's disease included secondary amyloidosis, pyoderma facial, subacute lupus, Behcet's disease, Behcet's like presentation of bullous PG and cutaneous polyarteritis nodosa. Case reports associated with ulcerative colitis included dermatitis herpetiformis and cutaneous gangrene secondary to focal thrombosis. Nonspecific cutaneous signs as nail clubbing, palmar erythema, thrombophlebitis and vitiligo can be infrequently associated with IBD.

Other mucocutaneous signs secondary to treatment of IBD include injection site reactions, infusion reactions, paradoxical reactions, eczematous and psoriasis-like reactions, cutaneous infections, and cutaneous malignancies. Manifestations due to nutritional malabsorption such as stomatitis, glossitis, angular cheilitis, pellagra, scurvy, purpura, acrodermatitis enteropathica, phrynoderma, seborrheic-type dermatitis, hair and nail abnormalities have also been reported.[2]

Drug-induced IBD: Drugs that have been reported to cause or worsen IBD-like conditions include isotretinoin, antibiotics, non-steroidal anti-inflammatory drugs (NSAIDs), sodium phosphate, oral contraceptives, mycophenolate mofetil, etanercept, ipilimumab, rituximab, and secukinumab. Physicians should take a cautious approach in patients with pre-existing colitis, and alternative therapies selected first. Patients should also be made aware of this potential risk.[8]

Conclusion

Mucocutaneous manifestations can be an important clinical indicator for the risk of Inflammatory bowel disease or may reflect disease activity in pre-existing IBD. Any patients with new gastrointestinal symptoms or mucocutaneous signs need to be referred for urgent review to the Gastroenterologist or Dermatologist respectively. A negative FCP test (if low pre-test probability) may provide reassurance that no concurrent bowel inflammation is present. Physicians should also be aware of the drugs which can trigger IBD. The mucocutaneous manifestations often respond to the treatment of the bowel disease; however, they may require additional therapy in collaboration with the Dermatologist.

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Vitamin D and the Covid-19 Pandemic

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About 1.5 billion years ago plankton became able to produce the oil that we now call 7-dehydrocholesterol (7-DHC). This molecule was able to absorb UV from the sun and it acted as a sunscreen to reduce radiation damage to the plankton, the resultant molecule was cholecalciferol, now also known as vitamin D. For a billion years it had no function but evolution at the time of the Cambrian explosion of more complex life forms, a complex protein (VDR) evolved and it required a double hydroxylated form of cholecalciferol (1,25(OH) D) to activate it. This was a vital step in evolution in that it initiated defensive immunity against pre-existing bacteria and viruses. Without this complex life could not have developed.[1]

Plankton today continue to produce 7-DHC, which the Sun converts into vitamin D. Plankton are the natural food of fish and so vitamin D enters our food chain. The action of UV on 7-DHC is the only way in which vitamin D can be produced. Nutrition is just a small part of the vitamin D supply for the vast majority of humankind. We also produce 7-DHC in the skin, and UV converts it into vitamin D. Whether vitamin D is produced in the skin (it is just 7-DHC that is synthesised) or taken in the diet it enters the blood and it is transported to the liver. It then undergoes a slow process of hydroxylation to 25(OH)D, also known as calcifediol, now a hormone. In this form it re-enters the blood, being transported by vitamin D binding protein (DBP). 25(OH)D in the blood is the reservoir form in which vitamin D is ready for instant use should it be needed.

Deficiencies of vitamins and hormones

The importance of vitamins and hormones came to light when deficiencies developed specific clinical syndromes. So it was with vitamin C deficiency appearing on long sea journeys, the recognition of diabetes resulting from pancreatectomy in laboratory animals, the reversal of myxoedema by thyroid extract. The industrial revolution and the development of atmospheric pollution led to the appearance of rickets in large numbers of children in the new industrial cities. Deficiency of vitamin D was then recognised, and its importance in bone metabolism was determined. This was quite simple as rickets and its adult equivalent osteomalacia could be identified at the time on clinical criteria, and also on histology and on x-ray. Serum levels of calcium, phosphate, and alkaline phosphatase could be measured easily, and then parathyroid hormone (PTH).

Careful observation

Clinical medical science, like all sciences and understanding, is based on observation, a scientific philosophy that has been forgotten and even discredited by many during the Covid-19 pandemic. A critical observation in the late 19th and the early 20th centuries was the close association between rickets and tuberculosis. In Glasgow the two were particularly common in the poor. An investigation by the Scottish physician, Dr HS Hutchison in Bombay confirmed the association between rickets and tuberculosis, but in India the two were "rampant" among the wealthy whereas they were very rare among the poor, who appeared to be very healthy. He put this down to the poor people spending all day outside in the fields, while the wealthy spent their time indoors, especially the mothers who had the luxury of practising purdah. The Sun was the key to health.[2]

The start of immunology

In the mid-19th century it had been demonstrated at the London Tuberculosis Hospital (now the Brompton Hospital) that cod liver oil was of benefit in the treatment of tuberculosis. This had become a domestic treatment in the fishing villages of Scotland, but vitamin D was not identified until the 20th century.[3]

At the beginning of the 20th century it had been noted by Niels Ryberg Finsen (Nobel Prize) that UV could heal cutaneous and probably internal tuberculosis. This led to the sanatorium movement, but it is was in the days before formal epidemiology, immunology, and the randomised controlled trial (RCT). However careful observations were as important then as they are now, and they must not be ignored.

These observations set the scene for the functions of vitamin D extending beyond calcium and bone metabolism to immunological protection. Further investigation had to wait until the developments of new technologies in about 1980. The accurate measurement of vitamin D was crucial. Earlier vitamin D had to be measured by bioassay, one international unit being defined as the daily requirement of a 10-gram immature mouse. It became possible to equate one unit as being equivalent to a mass of 0.025 micrograms, which is 25 billionths of a gram.

Intracellular actions of vitamin D

It was noted that 25(OH)D was converted by renal cells into 1,25(OH)D, which would circulate in the blood in tiny quantities measured in picograms (billionths of gram), and control levels of ionised calcium. The critical step was to identify that 25(OH)D is taken up by immune cells and further hydroxylated to intracellular 1,25(OH)D. It then activates intracellular vitamin D receptors (VDR), which with retinol forms a hetero-dimer that controls the activity of several genes, altogether more than 10% of our genes. These include the genes that up-regulate the defensive cascade of immunity and those that down-regulate TNF-α and the components of the severe initial non-specific inflammatory reaction, the so-called cytokine storm.

A serious problem is that "immunity" and the influence of vitamin D cannot be measured in an individual. It is not like measuring serum calcium or PTH. The white cell count in the peripheral blood can be measured very simply, but not the function of T- and B-lymphocytes, or macrophages. The only component of immunity that can be measured in large numbers of individuals is the blood level of vitamin D. Its utility can be measured over a long time but extensive clinical research has been lacking.

Covid-19

The pandemic of Covid-19 took us by surprise. Clearly we had no way to "attack" the new respiratory virus and so it was essential to mobilise all defensive measures. Personal isolation is usual with a viral respiratory illness, but this was taken to a new extreme in the form of "Lockdown", with closure of schools, universities, places of worship, family gatherings, transport, much of the economy, and a large proportion of elective surgery within our hospitals. Despite this the UK experienced more than 4 million cases and more than 126,000 Covid-19 deaths.

What else could have been done at the onset of the pandemic? The obvious answer is that we should have maximised defensive immunity. Vaccines have been developed with remarkable speed, but it would inevitably have taken about a year, during which time many deaths would have occurred. We had the knowledge of the role of vitamin D in enabling defensive immunity. We knew that vitamin D deficiency was very common, a study in Germany five years earlier having identified deficiency in more than 80%.[4] We knew that South Asian and Black African immigrants in the UK had a high frequency of vitamin D deficiency, as a melanin-rich skin produces far less vitamin D than white skin. We knew that the elderly were inevitably deficient of vitamin D as their dry skin synthesised very little 7-DHC, and therefore the sun could produce very little vitamin D.[5] We knew of the low blood levels of vitamin D in the obese, thought to be the result of sequestration of vitamin D in the excess of fat cells.[6] We knew that in temperate zones such as the UK (about 54 degrees north of the equator) vitamin D production by the sun took place only in the summer months, and that blood levels of vitamin D are significantly lower during the winter. We knew that respiratory illness are more common when blood levels of vitamin D were at their lowest. We also knew that vitamin D supplements would reduce the incidence of acute respiratory illnesses.[7]

As deaths increased during late March and April, it might have been expected that medical science would come to the rescue by putting into action the knowledge of the correction of widespread vitamin D deficiency, and the optimising of defensive immunity. But medicine remained silent. The fact that 96% of UK doctors dying from Covid-19 were of Black African or Asian ethnicity was not acted on by medical organisations. The reason was obviously severe vitamin D deficiency rather than socio-economic deprivation. The medical groups of all ethnicities in the UK failed to take action or undertake research, while the ethnic minority citizens of the UK continued to die from Covid-19 in excessive numbers.

The realisation of vitamin D deficiency

Many reports have indicated that the outcome from Covid-19 is closely related to blood levels of vitamin D, no symptoms or only mild illness with high levels, death with low levels. Without a reserve of 25(OH)D in the blood, the essential escalation of the immune response will fail and the cytokine storm will not be suppressed. It had been demonstrated in prospective studies that a low blood level of vitamin D predicts a fatal outcome. Most of the observational studies were "snapshots" [8] but other were predictive, the blood levels of vitamin D being established in advance of the Covid-19 illness.[9,10]

Clinical research in Spain

We also received the results of an open randomised trail of calcifediol, 25(OH)D, from Córdoba, Spain, involving 75 patients admitted to hospital on account of critical illness with Covid-19 pneumonia. 50 patients were randomly given calcifediol, 25(OH)D, on admission to hospital with an additional 25 acting as controls and receiving just high quality standard treatment. 12 (50%) of the control group required transfer to the ICU and 2 died. Only one of the 25(OH)D treated group required ICU transfer (2%) and he survived. This a 96% efficacy in reducing the need for ICU transfer (50-2=48=96%). This was a remarkable effect.[11]

A detailed analysis from the Massachusetts Institute of Technology found no significant defect in methodology and calculated the probability of the result being chance was less than 1 in 1 million.[12] NICE stated that the result of this trial should not influence the way in which Covid-19 patients should be treated in the UK.[13] 86,000 UK citizens have died since the result of the Córdoba trial became available on September 3rd. Many of these deaths could have been avoided.

The second study from Spain was from Barcelona. It was also a clinical trial of calcifediol, 25(OH)D. It was an open randomised trial, and the design was constrained by its performance at a time of extreme pressure on the eight Covid-19 wards of the hospital. 379 patients received standard care. 551 patients received in addition 25(OH)D. 21.1% of the control patients required transfer to the ICU, compared to 5.1% of the 25(OH)D treated group. This represents a 74% efficacy of avoiding the need for ICU transfer.

Rather than continuing the trial to point of deaths, the trial could have been stopped at that point, in the way that subsequent vaccine trials were stopped when reduction of cases was demonstrated. However in the Barcelona trial there was a conflict between clinical duty and scientific rigour. The decision was made to break the protocol and allow the attending physicians to decide whether the control patients should be given 25(OH)D when admitted to the ICU. 50 of the 80 control patients admitted to the ICU were started on 25(OH)D. On the basis of intention to treat, 25(OH)D gave a 56% efficacy of survival. The gain was 39% efficacy when the controls given 25(OH)D were added to the initial treatment group. For reasons either spurious or unclear the pre-print has been removed from the web site, but not before many investigators were able to download a PDF.

Denial from NICE

NICE had made no official comment on the Barcelona study but a very critical statement was made by one of its members on social media. The first criticism was the method of randomisation, but it was clear from the data displayed that randomisation was successful and the two groups were comparable. This is usually not perfect in human studies, especially when dealing with the critically ill.

The weight of evidence in favour of the use of vitamin D and its activated form 25(OH)D in the prevention and treatment of Covid-19 is overwhelming. Yet the authority of NICE has denied the use of vitamin D and 25(OH)D to clinical doctors who have been treating the sick and dying. NICE claims that there is "insufficient" evidence, but late in the day, NICE has issued a disclaimer indicating that it merely advises and that ultimate responsibility lies with the attending physician to determine the treatment appropriate.[14]

The responsibilities of clinical doctors

Clinical doctors in all specialties must make decisions that might lead to the survival rather than to the deaths of their patients. Sometimes the luxury of a perfectly structured, performed, and analysed controlled trial might not be available, and this has certainly been the case during the Covid-19 pandemic.

More than 4 million Covid-19 cases in the UK and more than 126,000 deaths indicate that, despite the hard and dedicated work of our health professionals, additional forms of treatment have been required. The denial of vitamin D by government and NHS agencies must be regarded at the best as incomprehensible. The decision has obviously been made by bureaucrats in offices, away from the cut and thrust of clinical medicine.

Clinical decision-making can be summarised by Pascal's Wager. Blaise Pascal (1663–1662) established his 2x2 contingency table whilst deciding whether or not to believe in God. He decided that the best utility would be to do so. We can apply the same logic in deciding whether or not to prescribe vitamin D as 25(OH)D, calcifediol as in the Córdoba and Barcelona protocols to a patient with severe Covid-19 in whom transfer to ICU or death would be likely (Fig 1). Based on existing evidence, the best that we have at present, to do so would probably prevent ICU transfer and death. There would be no risk of side effect and minimal cost (about £10). The utility of this decision would be very high. On the other hand NICE and through it the government and the NHS, decided to withhold vitamin D / 25(OH)D. There would be no benefit resulting from this decision with the treatment being so safe and so cheap. The disadvantage of this decision would be a major risk to the survival of the patient. This is the decision with the lowest utility, a decision that should never have been taken.

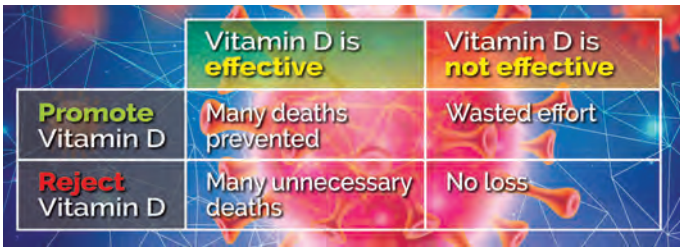

Figure 1. Pascal's Wager, applied to the promotion or rejection of Vitamin D

Why should Vitamin D not be given?

We have been dealing with not just one patient but with 126,000 deaths in the UK. Why has the NHS taken the decision with the lower utility, to withhold vitamin D? The clinical challenge is simply the correction of a vitamin / hormone deficiency. For doctors to have prescribed vitamin D, especially in its rapidly acting activated form 25(OH)D, to patients very ill with Covid-19 pneumonia cannot be criticised and must be applauded. With a treatment that is very cheap, very safe, and that would have potential benefit, the greater utility would be to accept Pascal's wager and use vitamin D. I would hope that doctors would do their best to prevent their critically ill patients from dying by using all treatments with potential benefit, as long as they do not put these patients at risk.

And what about patient participation? At the time of the initial pandemic, there was paucity of knowledge of the behaviour of the Covid-19 virus. There was no established line of treatment. NICE had agreed that there is need for research into the utility of Vitamin D supplementation in assessing its value in preventing Covid-19. This was a reasonable position during the first wave, preferably coupled with the incorporation of a Vitamin D arm in the "Recovery trial". This opportunity was not taken. NICE chose to ignore considering the Vitamin D as a potent immune modifying micronutrient.

But NICE has now published its cynical disclaimer concerning Vitamin D:

"The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian." [14]

Disclaimer: DSG, the author declares that he has no competing interests.

Editor's Comments:

There is a major UK trial currently underway – CORONAVIT NCT04579640. This does not have a rigorous placebo arm. It is comparing "standard of care" – national recommendation of 10 micrograms (400 IU) /day, with higher doses (800 IU/day and 3200 IU/day). However, the trial is primarily powered to assess impact of vitamin D supplementation on risk for acute respiratory infection of any cause, and it remains to be seen whether it will be adequately powered in respect of COVID-19 severity. Moreover, if as the UK Scientific Advisory Committee on Nutrition has concluded, 400 IU/day is adequate to ensure sufficiency, then this trial might be destined to be negative. Finally, NICE may be unlikely to recommend vitamin D supplementation on the basis of a trial that has no clear placebo arm. (Ref: BMJ 2020;371:m4912)

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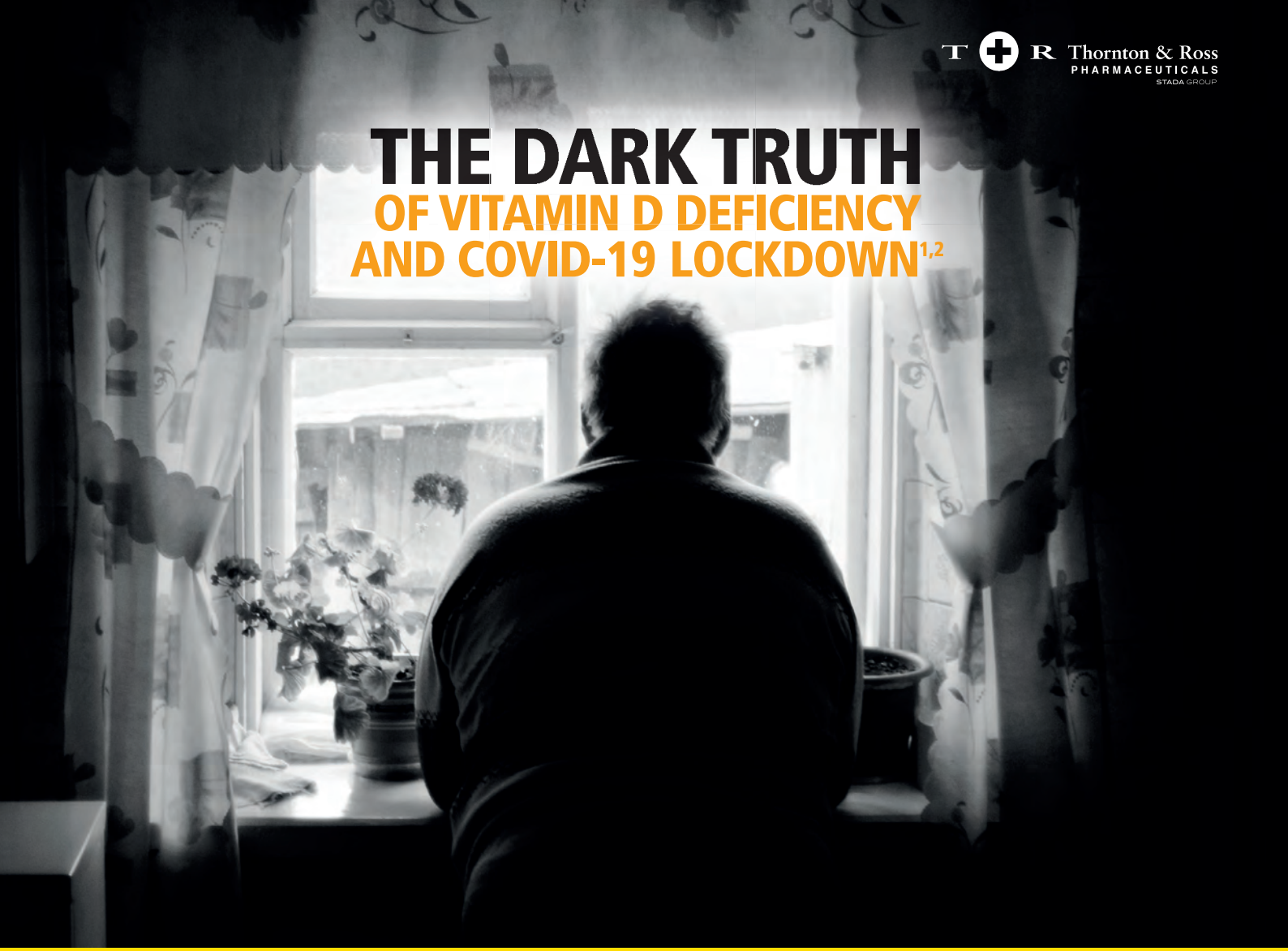

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Adverse events should be reported. Reporting forms and information can be found at: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store. **Adverse events should also be reported to 01484 848164.**

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Questioning your trainees – Time to get it right

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All healthcare professionals develop their questioning skills in reaction to communicating with patients in order to elicit necessary information. Unfortunately, some clinical educators and educational supervisors do not always recognise or use these skills when it comes to working with their trainees.

Questioning is a dialectical process and one which is incorporated into human interactions from a very early stage with questions and statements working together to form the basis of conversation. It can be argued that the quality of learning is very much dependent on the skill of questioning.

Often, in an educational setting there is a lack of skilled questioning on the part of the teacher because we have developed an educational culture, which expects students to know "the right answer".

The over emphasis on the supposition that there is only one correct answer can result in educators focusing on asking only low level questions, which seek factual responses, testing only recall ability rather than knowledge application.

Also, learners can be uncomfortable with the feeling that they do not know the correct answer. In order to avoid this, teacher-centred-approach trainers may find it useful to use Bloom's taxonomy, which divides types of learning into what may be seen as an ascending hierarchy, in order to analyse the types of questions they are asking.

As a trainer, it is helpful to consider during the planning stages, prior to a teaching sessions, the ways in which different types of questions can be used to explore different types of learning. Incorporating Bloom's taxonomy into the learning process also helps encourage learners in the formulation of questions themselves in their own independent learning, since it highlights the importance of exploring the higher order thinking through the application of theory with practice.

There are many approaches to questioning and the following is an example from Brockbank and McGill:-

A. Opening

The supervisor's responses are accepting, clarifying and descriptive.

Examples

1. Could you expand on what you meant by.....?
2. Could you give further explanation of.....?
3. Are there any implications in what you said about.....?
4. Would you agree if I sum up what you are saying as.....?

B. Development

The supervisor probes the trainee's understanding and encourages the learner to move into an exploratory phase.

Examples

1. Have you thought about ?
2. How do you know that ?
3. Does it follow from what you said that ?
4. How does that compare with ?
5. What if we look at it this way ?

C. Conclusion.

The trainee is asked to evaluate critically and to focus on action.

Examples

1. Do you think/feel differently now about.....?
2. What specifically do you need to know about.....?
3. What is the point of looking into.....?
4. Have you identified resources and planned how to.....?

Effective use of questioning can enhance learning and create a positive educational climate, which will enable the trainee to explore different elements of a learning situation and engage fully with the learning process.

The crucial component is to ensure that questions are selected which provide opportunity for the learner to carefully consider issues and explore them at a deeper level, to facilitate reflection and learning.

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An Overseas NHS Workers Day:

The DAUK calls for fast-track citizenship for frontline NHS staff – An interview with Dr KM Fardeen

Dr Ellen Welch Editorial Lead, Doctors' Association U.K.

The Doctors' Association U.K, supported by BIDA, introduced the inaugural 'Overseas NHS Workers Day' on Friday 5th March 2021, to celebrate the extraordinary contributions made by international NHS staff during the pandemic, and to raise awareness of the main issues they are facing. The Royal College of Physicians, British Association of Physicians of Indian Origin, Hospital Consultants and Specialists Association, Royal College of Surgeons and UNISON all backed the event, along with NHS organisations around the Nation, who took to social media to show their support, by wearing blue and green and holding a minutes silence for those who lost their lives to Covid-19.

Following the event, DAUK liaised with 'Days of the Year' to secure this as an annual event to promote to the public each year.

Between March and December last year, 883 health and social care workers in England and Wales died from Covid-19. Despite these figures, and the well documented PPE inadequacies, International NHS workers have continued to show up to work each day, while facing uncertainty about their future in the UK. Fourteen percent of the NHS workforce identify as migrants, with almost 200 different Nationalities represented.

Since the start of the pandemic, Dr Kazi Mashfia Fardeen, a Medical Registrar in London, has been working hours of overtime on Covid wards to ensure her patients receive the best possible care. *"I have not felt protected."* said Dr Fardeen; *"My work has exposed me to the virus, which I caught before Christmas. During the first wave we were not given appropriate PPE, and the on call team were handed one FFP3 mask each to be used only during a cardiac arrest call."*

"The work hours are much longer as most days we have to stay back beyond finishing time and all these hours go unnoticed." She said. In addition to the long hours and emotional toll of the covid wards, for overseas NHS workers like Dr Fardeen, is the added anxiety over her right to remain in the UK. Dr Fardeen trained to be a doctor in her home country of Bangladesh and moved to the UK in 2018 to gain further experience within the NHS.

The process of renewing a UK visa is both expensive and time consuming. Immigrants to the UK are required to pay an 'immigration Health Surcharge' (IHS) also known as the NHS surcharge, which adds a further £624 per year (£3120 for 5 years) to the cost of a UK visa to enable access to the NHS. Tax-paying immigrants are essentially paying for the NHS twice. *"I did not understand why I had to pay the IHS"* said Dr Fardeen, *"As a frontline worker, I do not work any less than the local doctors do. I have an overseas colleague who worked 27 extra locum shifts (350 hours) to pay for his wife and children's visa and IHS."*

In May last year, following pressure from campaign groups, Boris Johnson agreed to exempt all foreign health and care workers from the IHS and granted an automatic one year extension to their visas during the pandemic. The Doctors' Association UK, who canvassed for these changes, described the surcharge as *"an insult to all who are serving this country at its time of greatest need."*

Dr Fardeen's visa was extended last year and the IHS fees was waived, however she faced a 5 month delay receiving her biometric residence permit (BRP). *"I live alone in the UK and have not been able to visit my family."* She said, *"I had to call the home office everyday, because I cannot re-enter the country without a resident permit. If the government granted overseas NHS staff indefinite leave to remain it would mean we do not have to repeat these processes every few years."*

Across the channel in France, hundreds of immigrant frontline staff, including healthcare professionals, cleaners and shop workers, have had their service during the pandemic recognised with fast-track citizenship. There are calls for the UK to follow this example. Following the Overseas NHS Day Celebrations, MPs took notice and tabled a motion in parliament to recognise foreign nationals and grant indefinite leave to remain to those working in the healthcare sector.

For Dr Fardeen, like many frontline staff, the pandemic has taken its toll both physically and mentally. *"I do not feel I had the option to slow down and reflect on what had been happening"* she said, *"To be able to continue living in the UK I need my job and the day I do not have one, I will have to leave."*

It is essential to read the Home Office's guidance regarding ILR decisions for adult dependent relatives (ADR), which was most recently updated in August 2017, taking into account the judgment of Britcits v Secretary of State for the Home Dept [2017] EWCA Civ 368.

The Home office has recently reviewed these documents and decided that no change is required to the regulations. DAUK and all other organisations will continue to challenge the Home Office to consider the severe impact the current ADR regulations are having on the lives of Immigrant doctors, other HCWs and their families and campaign to change the rules in the near future.

Non-pharmacologic management of Hypertension

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Introduction

Hypertension is a serious medical condition that significantly increases the risks of heart, brain, kidney and other diseases. An estimated 1.13 billion people worldwide have hypertension, most (two-thirds) living in low- and middle-income countries.[1]

Fewer than 1 in 5 people with hypertension have the problem under control. Hypertension is a major cause of premature death worldwide. One of the global targets for non-communicable diseases is to reduce the prevalence of hypertension by 25% by 2025 (baseline 2010).[1]

Hypertension is the third largest cause or morbidity in the UK after cigarette smoking and poor diet. Hypertension affects more than one out of every 4 adults in the UK.[2] A lot of cases of hypertension are undiagnosed mainly because most cases are asymptomatic and when there are symptoms, they are mostly non-specific. Lots of studies have revealed that most cases are incidentally diagnosed during routine medical checks or employment screening programs.

Several studies have proven that hypertension is a major risk factor for cardiovascular event and related disability including Heart failure, coronary artery disease, stroke, chronic kidney disease, peripheral arterial disease and vascular dementia. [2,3,4]

Treatment

Non-pharmacologic and pharmacologic (drug) treatments.

This write up is a summary of global evidences of the impact of the non-pharmacologic interventions on pre-hypertensive and hypertensive patients. Non-pharmacological interventions help reduce the daily dose of antihypertensive medication and delay the progression from pre-hypertension to hypertension stage.[5] Non-pharmacological interventions include lifestyle modifications like dietary modifications, exercise, avoiding stress, and minimizing alcohol consumption.

Diet

Nutritional requirements of hypertensive individuals can be addressed through adopting either the Dietary Approaches to Stop Hypertension (DASH) diet or through traditional Mediterranean diet. These dietary guidelines promote the consumption of fruits, vegetables, grains, dairy products, and food rich in K+, Mg+2, Ca+2, and phosphorus.

Restriction of Na+ intake has the greatest role in lowering the blood pressure. The DASH diet alone has the effect equal to that of a single drug therapy. After dietary modifications, exercise and weight loss are the second major intervention for hypertension management.[6] Dietary Approach is tabled in Table 1.

Exercise

Regular aerobic exercise results in reductions in blood pressure of 5-7 mmHg among individuals with hypertension and these reductions translate to a reduced risk of CVD of 20-30%. Emerging research suggests that dynamic resistance exercise may also serve as an efficacious strategy to lower blood pressure to levels similar to aerobic exercise.[7]

Frequency: For aerobic exercise, 5-7 d/wk, supplemented by resistance exercise 2-3 d/wk and flexibility exercise ≥ 2-3 d/wk.

Individuals with hypertension are encouraged to engage in greater frequencies of aerobic exercise than those with normal BP because we know that a single bout of aerobic exercise results in immediate reductions in BP of 5-7 mmHg, that persist for up to 24 hr (i.e., post exercise hypotension). For this reason, individuals with hypertension are encouraged to exercise on most days of the week in order to benefit from the acute effects of aerobic exercise on BP.

Intensity: Moderate [i.e., 40-<60% VO2R or 11-14 on a scale of 6 (no exertion) to 20 (maximal exertion) level of physical exertion or an intensity that causes noticeable increases in heart rate and breathing] for aerobic exercise; moderate to vigorous (60-80% 1RM) for resistance; and stretch to the point of feeling tightness or slight discomfort for flexibility.

Time: For aerobic exercise, a minimum of 30 min or up to 60 min/d for continuous or accumulated aerobic exercise. If intermittent, begin with a minimum of 10 min bouts.

Type: For aerobic exercise, emphasis should be placed on prolonged, rhythmic activities using large muscle groups such as walking, cycling, or swimming. Resistance training may supplement aerobic training and should consist of 2-4 sets of 8-12 repetitions for each of the major muscle groups. For flexibility, hold each muscle 10-30 s for 2-4 repetitions per muscle group. Balance training (neuromotor) exercise training is also recommended in individuals at high risk for fall (i.e., older adults) and is likely to benefit younger adults as well.[7] Example of these exercises are described in Table 1.

Stress

There is growing empirical support for the hypothesis that exposure to chronic psychosocial stress contributes to the development of hypertension.

The effects of chronic stress in a number of domains are being investigated, including work-related stress, relationship stress, low socioeconomic status (SES), and more recently, race-related discrimination. Associations between each of these and BP outcomes have been reported, but the level of evidence varies, and many questions remain regarding the mechanisms involved, as well as vulnerability and protective factors that may be important in determining the impact of chronic stress on hypertension

Laboratory studies have provided convincing preliminary evidence that thinking about stressful events, in addition to experiencing them directly, can delay BP recovery.[8]

The impact of stress on the development of hypertension is believed to involve a sympathetic nervous system response, in which release of catecholamine leads to increased heart rate, cardiac output, and BP. Sympathetic responses to acute stress are well documented, but the process by which stress contributes to sustained BP elevation over time is not well understood. It may be repeated activation of this system, failure to return to resting levels following stressful events, failure to habituate to

repeated stressors of the same type, or some combination that is responsible for the development of hypertension.[9] The Interventions to reduce stress are described in Table 1.

Alcohol

Studies have shown that continued alcohol use across several days creates a more sustained rise in blood pressure.[10] Because of this, consistent binge drinking and long-term heavy drinking, can lead to chronic hypertension – which is a risk factor for coronary artery disease.[11]

According to the journal Atherosclerosis, scientists found that binge drinking increased the development of atherosclerosis, or the hardening and narrowing of arteries, which can lead to a heart attack or stroke.[12]

Alcohol is high in calories and sugar. Alcohol-associated increase in body weight and obesity can further elevate the risk of high blood pressure on a long-term basis.[13]

Treating Alcohol-Related Hypertension

In order to keep health risks from alcohol to a low level if you drink most weeks:

- Men and women are advised not to drink more than 14 units a week on a regular basis
- Spread your drinking over 3 or more days if you regularly drink as much as 14 units a week
- If you want to cut down, try to have several drink-free days each week

Fourteen units is equivalent to 6 pints of average-strength beer or 10 small glasses of low-strength wine.[14] Quitting or reducing the amount of alcohol consumed can begin to lower high blood pressure.[15] Alcohol has both acute and chronic effects on blood pressure. High-dose alcohol has a biphasic effect on BP; it decreases BP up to 12 hours after consumption and increases BP > 13 hours after consumption. High-dose alcohol increases HR at all times up to 24 hours.[1]

Smoking

Tobacco smoking can acutely increase blood pressure, which can be substantial. Although the effects of long-term smoking are uncertain, there occurs risk of arterial stiffness, masked hypertension, renovascular hypertension and severe hypertensive retinopathy.

Impact of non-pharmacologic interventions on hypertension

Table 2 summarizes the impact of some non-pharmacologic interventions on the systolic blood pressure of hypertensive and normotensive individuals. It further estimates and describes the dose/amount/type of interventions required to achieve certain degree of reduction in blood pressure.[48]

Summary

The DASH diet promotes consumption of whole grains, vegetables and fruits, lean meat, and fat-free dairy products and the inclusion of micronutrients in the diet.[49] These foods are also naturally low in sodium and contain nutrients, which may help lower BP.[49] This diet can also decrease concentrations of total cholesterol and LDL (low-density lipoprotein), which may predict a reduction of approximately 13% in the 10-year Framingham risk score for cardiovascular disease.[50] Another report demonstrates that eating a DASH diet every day has a significant effect

INTERVENTION - MEDIAN INTENSITY	BRIEF DESCRIPTION
Dietary Approach	
DASH [17, 18] Eating on the DASH pattern every day	Diet rich in fruits, vegetables, whole grains, and low-fat dairy with reduced sodium and saturated and total fat content
Low-sodium (5g/day) and high-potassium salt [19, 20]	Use a salt substitute (25%–30% potassium chloride, 50%–65% sodium chloride, and 5%–10% calcium and magnesium sulphate) to cover all cooking, or test food cooked using salt substitution
Salt restriction[21, 22] Restrict daily sodium intake <100 mmol (5.85 g salt) /day.	Restrict daily sodium intake <100 mmol (5.85 g salt) /day. Professional advice: • How to reduce their salt intake • Avoid foods that contain large amount of salt • Offer metric salt-spoon or placebo to participants.
Physical Exercise	
Aerobic Exercise [23, 24] 3 days/week, 50 minutes/time	Supervised exercise (eg, treadmill or brisk walking, jogging, bicycle training, swimming, ball games), at least 30 min/time; almost all were moderate or high intensity (60%–90% of the maximum heart rate or maximum oxygen consumption)
Isometric Training [25, 26] 3 days/week, bilateral contractions at 30% of Maximum Voluntary Contraction (MVC)	• Involves sustained contraction against an immovable load or resistance with no or minimal change in length of the involved muscle group. • Four 2-min isometric contractions at 30% MVC using alternate hands with a programmed handgrip dynamometer, with a 1-min rest period between each contraction for 3 d per week.
Resistance Training [27, 28] 3 days/week	• Perform active movement progress through muscle to overcome external resistance, such as leg press, leg curl, knee extension, chest press, seated row, overhead press, triceps dip, and biceps curl, 50–60 min/d, 2–3 d/wk
Tai Chi [29] 3 days/week, 50 min with 50% to 60% VO2max	• Chinese systematic callisthenic exercises with slow circular movements - muscles to remain relaxed while making sustained movement -Taught by instructors • Includes warm-up exercises, tai chi practice, and cool-down exercise.
Qigong [30] Qigong classes 2 days/week, home practice 2 days/week	A traditional Chinese health and fitness exercise, includes qi gong baduanjin, shuxin ping xue gong and dao yin shu qigong. Qigong experts help participants to reconstruct this instrument using a warming-up exercise, qigong, and cool-down exercise.
Interventions to reduce stress	
Breathing Control [31, 32] Everyday 15 minutes /time	• Use of a device guides participants toward slow and regular breathing in the evening • Goal is <10 breaths/min with accumulating ≥40 min of therapeutic breathing per week).
Meditation [33] Practice meditation 20 minutes twice a day	Transcendental meditation is considered the principal approach for stress reduction instructed by professionals meditation instructor • Practice 20 min twice a day while sitting comfortably with eyes closed.
MBSR [34, 35] Practice MBSR techniques 45 minutes every day	A multicomponent group intervention that provides systematic training in mindfulness meditation as a self-regulation approach to stress reduction and emotion management. It includes: • Gentle stretching and mindful yoga • A meditative body scan • Mindful breathing • Mindful walking
PMR [36, 37] Practice PMR techniques 15–20 minutes twice a day	Achieve deep relaxation by • Tensing and relaxing various muscle groups throughout the body systematically.
Yoga [38] Practice yoga 3 days/week, 45 minutes Or 30min/day	Instructions by a professional yoga instructor through yoga home training or a yoga class.
Interventions to lose weight	
Low-calorie diet [39] Low-caloric diet every day for weight loss	• Detailed guidelines on the daily number of servings from each food group and on fat intake to achieve weight loss of ≤10% of each participant's baseline body weight. • To enhance compliance with the low-calorie diet, participants are provided with food diaries that assisted them in recording intake.
Exercise [39] Exercise 3 days/week, reach 60%–80% peak heart rate	• Individualized exercise prescription consisting of 30–40 minutes exercise (eg, aerobic exercise or others). • To enhance compliance, details of each exercise session recorded in a training diary and reviewed by the counsellor.
Low-calorie diet plus exercise [39] Low-caloric diet for losing weight, with exercise 3 days/week, reaching 60%–80% peak heart rate.	• Detailed guidelines on a low-calorie diet to achieve weight loss and decrease BMI and • Perform systematic exercise training, 30–45 minutes/day.
Restrict Alcohol	
Alcohol Restriction [40, 41] Reduce alcohol intake by half or abstain	• Reduce alcohol consumption to <14 drinks weekly or 50% cut or total abstinence • Education for alcohol restriction (investigators).
Combined Intervention	
Aerobic exercise plus DASH [42] At least 5 days/week, 30–60 minutes aerobic exercise plus DASH	Follow the DASH eating pattern + aerobic exercise
Aerobic exercise plus resistance training [43] At least 2 days/week at a centre	• Attend an aerobic exercise session • A resistance training session • Endurance training
Salt restriction plus DASH [44] Follow diet every day	Follow the DASH eating pattern with salt restriction (sodium intake <100 mmol/d).
Low-sodium and low-calorie diet every day; 3 days/week, reach 60%–80% peak heart rate	Participants who are overweight or obese follow a low-sodium (80 mmol/d) diet with low-calorie intake to achieve weight loss of 4.5 kg.
Comprehensive lifestyle modification	
Comprehensive lifestyle modification [46, 47] Use lifestyle modification every day	Recommended to comprehensively modify their lifestyle, such as lose weight, restrict sodium intake, reduce alcohol consumption, increase physical exercise to a moderate degree, give up cigarette smoking, and learn to manage stress.

TABLE 1: Non-pharmacologic interventions for participants with Hypertension

on lowering BP compared to usual care, which is in keeping with previous meta-analysis.[51]

The World Health Organization has proposed that a 30% reduction in salt or sodium intake may reduce the risk of hypertension.[52] The study has revealed that salt restriction (sodium intake <100 mmol, equivalent to 5.85 g salt) can significantly lower SBP, which is consistent with the result of a previously published meta-analysis.[53]

Non-pharmacologic interventions, including dietary approaches, are a cornerstone for the prevention and treatment of hypertension[3]. Each 2 mm Hg decrease in systolic blood pressure reduces cardiovascular risk by 7 - 10%. All major guidelines have included these measures and most doctors and allied healthcare professionals do not consider these as important adjuncts in their armamentarium to manage high blood pressure. In the modern treatment of hypertension and prehypertension, these measures are a cost effective means to involve patients in their own care.

TABLE 2: Impact of Non-pharmacologic interventions on Blood pressure

Non-pharmacological Intervention		Dose	Approximate impact on SBP Hypertension – Normotension	
Weight loss	Weight / body fat	Best goal is ideal bodyweight, but aim for at least a 1-kg reduction in bodyweight for most adults who are overweight. Expect about 1 mm Hg for every 1-kg reduction in body weight.	-5 mmHg	-2/3 mmHg
Healthy diet	DASH dietary pattern	Consume a diet rich in fruits, vegetables, whole grains, and low-fat dairy products, with reduced content of saturated and total fat.	-11 mmHg	-3 mmHg
Reduced intake of dietary sodium	Dietary sodium	Optimal goal is <1500 mg/day, but aim for at least a 1000-mg/d reduction inmost adults.	-5/6 mmHg	-2/3 mmHg
Enhanced intake of dietary potassium	Dietary potassium	Aim for 3500–5000 mg/day, preferably by consumption of a diet rich in potassium.	-4/5 mmHg	-2 mmHg
Physical activity	Aerobic	90–150 min/week 65%–75% heart rate reserve	-5/8 mmHg	-2/4 mmHg
	Dynamic resistance	90–150 min/week 50%–80% 1 rep maximum and 6 exercises, 3 sets/exercise, 10 repetitions/set	-4 mmHg	-2 mmHg
	Isometric resistance	4 × 2 min (hand grip), 1 min rest between exercises, 30%–40% maximum voluntary contraction, 3 sessions/week 8–10 wk	-5 mmHg	-4 mmHg
Moderation in alcohol intake	Alcohol consumption	In individuals who drink alcohol, reduce alcohol to: Men: ≤2 drinks daily Women: ≤1 drink daily	-4 mmHg	-3 mmHg

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A complete listing of all the 54 references can be provided on application to the Editor.

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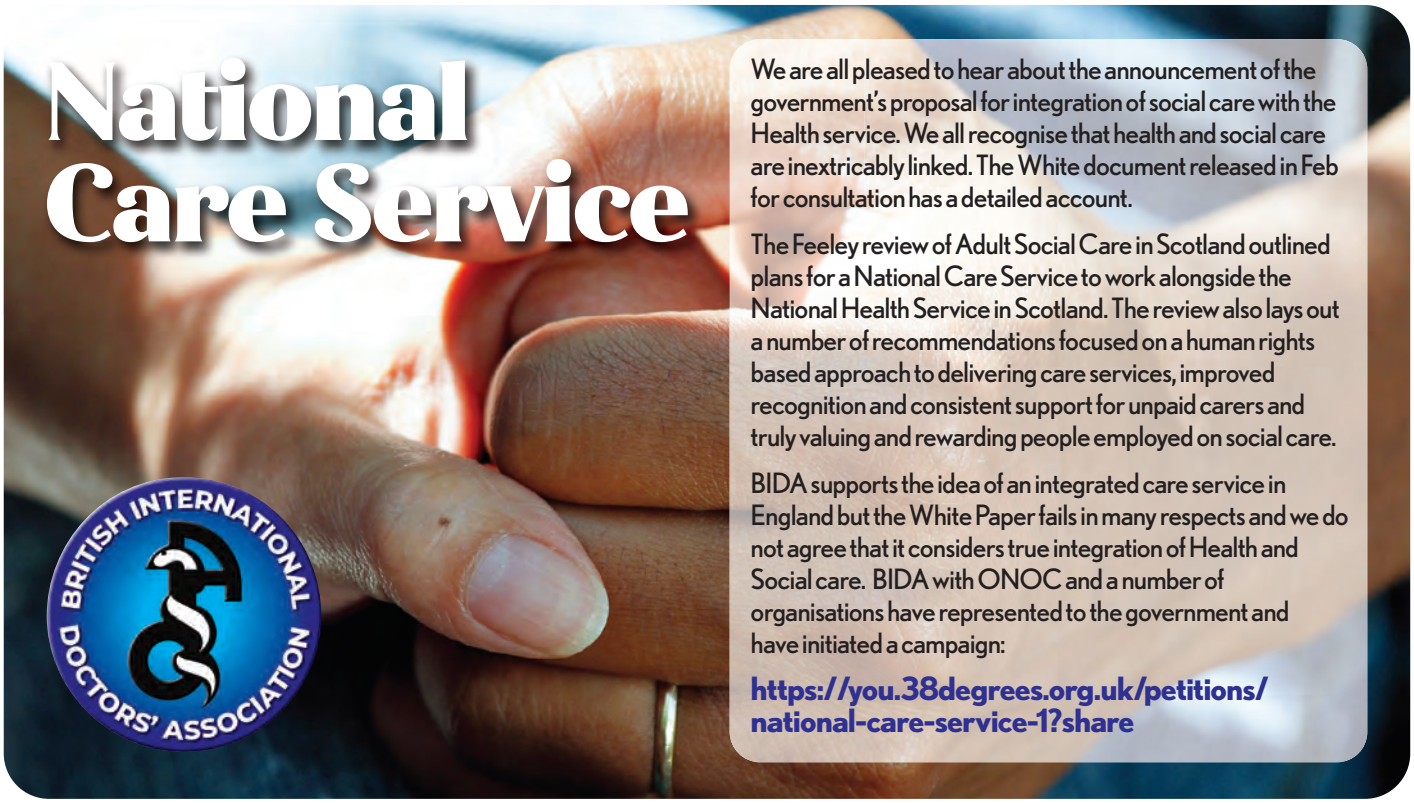


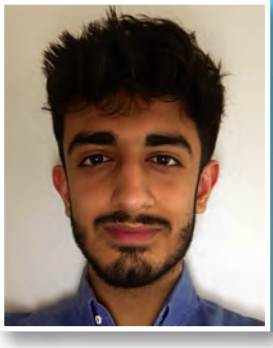
We are all pleased to hear about the announcement of the government's proposal for integration of social care with the Health service. We all recognise that health and social care are inextricably linked. The White document released in Feb for consultation has a detailed account.

The Feeley review of Adult Social Care in Scotland outlined plans for a National Care Service to work alongside the National Health Service in Scotland. The review also lays out a number of recommendations focused on a human rights based approach to delivering care services, improved recognition and consistent support for unpaid carers and truly valuing and rewarding people employed on social care.

BIDA supports the idea of an integrated care service in England but the White Paper fails in many respects and we do not agree that it considers true integration of Health and Social care. BIDA with ONOC and a number of organisations have represented to the government and have initiated a campaign:

https://you.38degrees.org.uk/petitions/national-care-service-1?share

How has medical education been affected during this COVID-19 pandemic? How have you adapted your learning style and/or clinical practice?



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Introduction

Undergraduate medical education, prior to the COVID-19 pandemic, involved a meticulous balance between theoretical and practical training. Whilst both types of training are vital in medicine, practical and hands-on education are commonly described to be the most powerful learning tools within medicine.[1,2] Due to this, undergraduate medical education was especially disrupted at the start of the COVID-19 pandemic in the UK. Delivering medical curricula involving practical simulations, patient actors, and clinical examination teaching was a challenge as universities had to ensure student safety whilst not compromising the quality of medical education. However, it is also important to note that in contrast to the disruption, the COVID-19 pandemic has also served as a catalyst to the positive transformation of certain key areas within medical education.[3] In this essay I would like to discuss the implications of COVID-19 on medical education and how this has affected my learning and experience of clinical practice at an undergraduate level.

Changes within medical education

Medical schools throughout the UK have had the overwhelming task to replan the delivery of their entire curricula, including examinations, to students in an incredibly short period. A major change seen within many different medical schools was the adoption of online assessments, instead of traditional written examinations.[4] With regards to the concern surrounding the security of online assessments, universities took certain measures such as limiting the duration of online assessments and randomisation of question order for each student to ensure the validity of these assessments. Overall, this change had a mixed response from the undergraduate medical community as assessments undertaken at home are much more susceptible to disturbances and interruptions if the student is residing with other individuals. Moreover, students who are directly affected by COVID-19 e.g., those who are actively caring for their unwell family members, may be forced to postpone their assessments altogether.

In a similar manner, the vast majority of pre-clinical teaching is now also delivered through online platforms and webinars as opposed to in lecture halls.[5] This is a considerable change from the pre-COVID medical education era. The advantages of this approach involve increased safety for students as it may not be possible to socially distance in a lecture hall, ease of access to lectures and improved time-efficiency as students do not need to travel to and from university. From a clinical teaching perspective, as non-essential surgeries and clinics were initially cancelled at the start of the pandemic, senior medical students on placement may have missed out on vital experience in certain specialities. However, several medical schools have responded to this by providing additional online teaching which was not available to students before. The pandemic has essentially seen an increased dependence on the use of online teaching and resources, perhaps allowing undergraduate curricula to be less focussed on face-to-face teaching in the future. Even though this approach has led to more teaching available to students, it is important to note that practical skills education such as patient examinations need to be practiced and therefore may have suffered as a result of the focus on online lectures.[1] Ultimately, providing more online webinars and resources for students is a step in the right direction and has assisted in the modernisation of undergraduate medical education as a whole.

Personal experience

The COVID-19 pandemic has resulted in numerous changes to my personal learning style. Prior to the pandemic, my colleagues and I had formed a revision group and aimed to discuss a single clinical speciality per week. This would involve booking a room at our university library every week and spending time going over various challenging topics within the chosen speciality for that week. Additionally, we would aim to practice the relevant practical skills within that speciality, e.g., the cardiovascular examination if revising cardiology. For the remainder of the week, I would supplement this learning style through online question banks and lecture slides provided by my medical school. Prior to the pandemic, my clinical attachments involved reviewing patients on wards, surgical exposure in theatre, and shadowing various different secondary care clinics.

Since the pandemic, the biggest change to my learning style has been the inability for our study group to meet in person and practice clinical examination skills. On account of this, we have been utilising group video calls to continue our revision sessions. Due to the difficulty of practising clinical examination skills over video calls, I have been instead focused on practicing these skills individually at home and whenever I get an opportunity on clinical placements. Additionally, due to the pandemic there has been an increase in awareness of online study resources by various different specialist societies available to medical students, and I have been implementing more of these resources within my revision schedule. During our group sessions, we have been alternatively focusing more on medical history taking over video and phone calls, as many of our placements in secondary care clinics and primary care now involve telephone consultations with patients. This had a major effect on my primary care attachment, as a lot of my time with general practitioners was spent listening in to consultations over the phone. In comparison with my peers in the year above, I discovered how different their primary care attachment was prior to the pandemic as they were regularly involved in home visits, visiting care homes, in addition to viewing numerous face-to-face consultations during the day. Nevertheless, my primary care experience was still excellent despite taking place during the pandemic as it placed further emphasis on understanding risk and knowing when it was crucial to meet the patient in person.

Conclusion

Ultimately, the COVID-19 pandemic has brought many changes and challenges to undergraduate medical education which tutors and medical students are still trying to acclimatise to. My personal learning style is continuously changing, and this flexibility has been further strengthened as a result of the constantly changing landscape of the pandemic.

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Proceedings of the (Online)
BIDA National Conference 2021

Compiled by. **Amit Sinha** and **P.K. Sarkar**

Welcome Address (09:30 – 10:00)

Following a welcome address by **Prof Sanjay Arya**, the President of BIDA, **Dr B K Sinha** and National Chairman, **Dr Chandra Kanneganti** addressed the conference.

The conference was graced by **Rt Hon Nigel Evans,** MP and Deputy Speaker, House of Commons. His recorded message conveyed a thank you to everybody from the House of Commons at Westminster and gave an inspiring hope of the prospect that there was light at the end of the tunnel with the amazing amount of work that had gone on in the past twelve months.

Plenary Session (10:00 – 11:15)

Dr Chaand Nagpaul OBE

General Practitioner & Chair, BMA Council

Protecting, supporting and representing doctors throughout the pandemic and beyond

Dr Nagpaul has been instrumental in raising the issue of the disproportionate involvement of the BAME population including doctors during the pandemic. He alluded to the pre-pandemic state of the NHS, which was already at a crisis point. BMA conducted 9 different Covid 19 tracker surveys to raise the issues affecting all doctors. Doctors have played a pivotal role in looking after patients and their colleagues. The toll on mental health has been enormous affecting >50 % of doctors. It also highlighted that BAME doctors suffered more and not felt protected. The post pandemic predictions are expected to be alarming.

BMA's priority is to protect doctors. This has been a struggle with several measures, which took place during the pandemic with referral to PPEs, ethical guidance, and well-being and now for enhanced PPEs for doctors. BMA's public health committee has emphasized the importance of advocating the use of masks and Test & Tracing systems right from the onset of the pandemic.

BMA has played a vital role in protecting the BAME and IMG doctors by calling to the government for an enquiry into Covid 19's impact on BAME community and the implementation of Risk assessments for all doctors. BMA has played a huge role in "Vaccinating the Nation," asking the government to consider the BAME and the deprived community as priorities.

BMA would continue to contribute to the challenges ahead to support the measures to improve the state of the NHS. BMA advocates a well-funded plan for the future NHS and a strategic recruitment drive. It promotes to value the NHS staff and to make the NHS attractive to the IMGs and end structural race inequalities. We must aim for a collaborative NHS.

Dr Ramesh Mehta OBE

Consultant Paediatrician & President BAPIO

Covid crisis exposes disparities

Dr Mehta emphasised how Covid disease has exposed the disparities in our society due to an inherent structural racism, which is the root cause of increased mortality rates amongst the BAME population. Racism in Medicine has led to discrimination at different levels, which has affected the lives of all BAME HCWs. He presented a change in the culture and leadership in "Management". There have been some "Green Shoots" in various NHS management sectors with the presence of the Work Force Race Equality Standards, Health and Race Observatory, and the appointment of a Chief People Officer.

He was proud to declare the Silver Jubilee plan for BAPIO with the theme of "Bridging the gap" aiming to achieve an "Alliance for equality for Health professionals".

Dr Chris Brookes

Chief Medical Officer /
Deputy Chief Executive Northern Care Alliance, Manchester

Clinical learning from Covid-determining future Clinical priorities

Dr Brookes presented innovative steps taken by the GM Northern Care Alliance as a response to Covid 19. This had a catastrophic effect on several services and needed redesigning to protect specialist services like Cancer care, Major Trauma, and Cardiac care. With the GM Gold Command came transformation of system wide working and looking carefully with all critical care processes. GM developed a vision for cancer care, developed a diagnostic centre at Royal Oldham Hospital. It also brought about transformation of "Urgent and Emergency" care and Outpatients service.

Mrs. Prerana Issar

Chief People Officer, NHS

Leadership during Covid Pandemic

Mrs Issar gave a very positive and an inspiring lecture. It is the leadership's responsibility to acknowledge what staffs have gone through. Her grandfather had said, " Only the wearer knows where the shoe pinches." This is incredibly appropriate and for leaders to understand the physical and emotional upheavals all sections of the NHS staff, in particular the IMGs have gone through.

She praised all the Health Care workers of the NHS on how they have come together during the pandemic period and also reflected on the deep inequalities in the NHS. She presented 4 planned measures to tackle this:

i) Formation of Leadership forums with an aim to look after the safety and mental well-being of our people
ii) Promote "Belonging to the NHS", by promoting Equality, Diversity & Inclusion
iii) New Ways of working – Innovation of care, skill mix, Multidisciplinary teams, use of technology etc
iv) Grow our workforce by planning for the future

NHS Staff require certainty and support. How can we normalise health-seeking behaviours? We are aware that healthcare workers are often the last to seek help. There have been now Health and Well-being support resources and several apps. These are of a culturally diverse variety supported and guided by BAME Colleagues, some powered by Samaritans. There are Multicultural Faith and Pastoral groups to tackle the issues of vaccine hesitancy. The Clinical Referencing group monitors risk assessments to reduce the burden of long-standing "mistrust" amongst the BAME population. The Estate and Facility group looks at the workforce precarious contracts.

To promote "Belonging in the NHS", there has to be balanced approach to achieve this aim and also to retain specific protected characteristics. Firstly, there needs to be a change in institutional procedures to overhaul recruitment practices with the aim of improving representation of all diverse groups at all levels. We need to change some of the institutional practices. The second is about Health and well-being conversation, which has been building on from the risk assessments. These conversations will be the building blocks to put in appropriate adjustments. The third plan is to help staff to develop the confidence to speak out and to reduce disciplinary proceedings. Lastly, we expect our leaders to be compassionate and be inclusive. Mrs Issar concluding message is very pertinent, "Activity and People recovery must go hand in hand." We must establish the NHS as an instrument of social justice.

"Living with COVID-19 and life beyond"

Session 1 (11:30 – 12:30)

Prof. Colin Melville

Medical Director & Director of Education and Standards, General Medical Council (UK)

The GMC's Perspective During Covid 19

Prof. Melville outlined a number of measures that the GMC has taken during the pandemic in support of doctors, which included flexibility in the appraisal and revalidation process, organising a framework for ethical decision making. In the event of any concerns brought to the GMC and other regulators, about a doctor's decisions or actions, the challenges and the circumstances the doctor has been working under would be taken into account.

Tremendous work has been done for the Foundation Year Interim posts with early registration on graduation, so that these young doctors started contributing in good time in their placements. During this pandemic >3000 doctors were encouraged to come out of retirement to work back in the NHS. More than 500 new training centres have been created.

Prof. Iqbal Singh

Consultant Geriatrician & Chair CESOP

Advancing Medical Professionalism During the Covid 19 Pandemic

Prof Iqbal Singh talked about the "New normal" environment with challenges and inequalities. It's a test of skill, resilience, and commitment, which would lead to "green shoots". He summarised that as life-long learners, doctors as professionals should adapt and move forward. We cannot predict the future, but following the principles of professionalism and with adequate support and maintaining good health and well-being will help us cope with whatever comes.

Lord Victor Adebowale

Chair, NHS Confederation

Race and Health Observatory – Improving access and experience of BAME communities

He talked about the establishment of the Race and Health Observatory, which has set it's objectives to facilitate new, high-quality and innovative research evidence; make strategic policy recommendations for change; and help facilitate practical implementation of those recommendations. One of it's objectives is to show a mirror to the NHS system.

Ethnic minority doctors and patients still face too many injustices in the NHS including differential attainment and access to healthcare.

The gap in performance between white and ethnic minority students and doctors and the increased likelihood of disciplinary procedures against ethnic minority doctors are all examples of overt racism.

The independent Race and Health Observatory has been established to support the NHS in improving healthcare access, experience and outcomes of black and minority ethnic patients and communities, protect the vulnerable, create an equitable environment, invite innovations for all ages and promote partnership and global working. It takes commitment and deliberate concerted action to change an organisation's culture and make a difference. Lord Adebowale stressed on leadership and engagement.

Dr J S Bamrah

Consultant Psychiatrist & Chairman, BAPIO (UK)

Top tips for your mental wellbeing during the pandemic

Covid 19 is a physical disease that can also wreak havoc on our mental wellbeing, and the effects could be long-lasting. More than 80% remain worried about covid; more than 50% of adults' well being are being affected. There are several causes of mental health issues which has been made worse by self-isolation, financial losses, insecurity, poor quality of housing, front line occupation, reduced access to mental health care, and loss of coping strategies.

Prof Bamrah advised not to focus on negativity. He gave a number of tips including searching for new activity or learning new skills, breaking addictions, ensuring you have media free zones, looking after your sleep and asking for help or using health lines when needed

Session 2 (12:30 – 13:00)

Dr Sakthi Karunanithi

Director, Public Health, Lancashire

The True, Good and Beautiful Life in Post-Covid 21st Century

He gave a fascinating talk. Life will be true, good, and beautiful after Covid. There is something beyond professional practice. The pandemic had urged us to look for inspiration. There are 3 mutually independent aspects of reality. We have focussed too much on intellectual theory, but the other two aspects of reality are the feelings of emotions and the sensing of our environment. He highlighted the relationship of logic, ethics, and aesthetics, which represents the true, the good and the beautiful.

The pandemic had exposed inequality in the society and also what is happening in the environment. The interface between the imbalanced environment and human behaviour has led to spread of the disease. Dr Karunanithi presented a number of options to tackle this.

Prof Azeem Majeed

Head of Department of Primary Care & Public Health, Imperial College London

Covid-19 in the United Kingdom: Impact on ethnic minority groups

We are all aware of the disproportionate effect of Covid 19 on ethnic minority groups. Possible causes are a mix of conditions, which could be related to racism and social determinants of health. However, we may have to accept some unexplained causes.

Systemic problems such as racism require structural interventions and reforms across the broad spectrum of society, including in healthcare, education, employment, and the criminal justice system. It requires recognition of the causes, a commitment to openness and honesty, leadership, and resources.

Dr Amir Hannan, MBE

General Practitioner and Chair of the Association of GM Local Medical Committees

Real-time Digital Medicine and the Partnership of Trust during the Covid pandemic

Dr. Hannan delves into an exciting field of real-time digital medicine by turning the medical screen around to involve patients and share their information. This is called partnership of trust. The information gives our patients knowledge and changes their attitudes to understand their condition and take charge.

There are various apps, like Evergreen Life PHR app, Patient Access app, NHS app and the Evergreen Life app, which patients can access. Patients can see their records, confirm appointments, see their test results and gain proxy access to the medical records of their children, elderly grandparents and those with severe learning difficulties.

This indeed is exciting when both doctors and patients in our NHS respect and participate in this partnership. Dr. Hannan has been promoting and practising this in his own surgery at Haughton Thornley Medical Centre.

BIDA National Conference 2021

"Living with COVID-19 and life beyond"

Session 3 (13:30 – 14:30)

Dr Taj Hassan

Consultant Emergency Medicine, Leeds teaching Hospitals and Past-President of RCEM

Covid 19- what we have learnt from ourselves? An ED perspective

Dr Taj Hassan reflected on the lessons learnt from present COVID 19 pandemic that would guide them to move ahead. Prompt re-setting of workplace along with changes in working practice (e.g. outcome review, debriefing, reflection) within the staff created a culture of working in collaboration and 'getting things done'. Compassionate leadership helped to build trust and confidence within the team. Human behaviour played a major role towards personal safety, protecting and supporting each other. Virtual (online) communication proved useful for sharing relevant information and for teaching, training and learning.

Ms Lucy Warner

Chief Executive of the NHS Practitioner Health Service

A year of COVID - How 2020 has affected our mental health and what to do about it?

In her presentation, Ms Warner talked about the negative mental health effect of COVID 19 Pandemic on doctors who are faced with extenuating circumstances. The age group for overseas doctors is 40 - 49, on average 10 years older than the local graduates, when they seek help. IMGs have low levels of addictions. The most common themes are loss of control over their lives and stress related insomnia. IMG doctors are loved more by their families by their assessment. She urged the IMG community to seek help early. There is a plethora of support including her own organisation, details of this confidential service will be available in the website.

Prof Maggie Rae

President of the Faculty of Public Health UK

Better Health for everyone – Leaving no one behind

Prof Maggie Rae gave an overview of the impact of covid-19 on public health of the nation, highlighting how the current pandemic has exposed the deficiencies, exacerbating existing problems, widening health inequalities in some parts of the UK and decreasing life expectancy among deprived communities. She talked about the Marmot report, which illustrate how unemployment and homelessness has risen dramatically. Covid 19 deaths are higher in the deprived BAME communities. She indicated the need for a well-resourced health system, which focuses on equitable access to vaccine and other preventative measures that would pave the way for a healthier society to improve health as well as protect it.

Session 3 – Panel Discussion

A system based wide approach through the ICS targeting the BAME community be cognisant of the needs of the BAME community and ensure that they are not left behind. Dr Taj Hassan and Ms Lucy Warner outlined how the front line is coping with pandemic through intelligent rostering, assurances of breaks and the recognition of early signs of extreme stress to prevent burn-outs.

Session 4 (14:30 – 15:30)

Mr Tinaye Mapako

Chair BMA Medical Students Committee

Representing Students after COVID-19

Mr Tinaye Mapako highlighted how the Covid-19 pandemic has led to unequal opportunities and lack of fairness for students' education and learning. He mentioned why it is important to listen to students' voices as students' views matter and can making things happen. Mr Mapako indicated that the interests & aspirations of the students should be protected. They should be heard as it is their lives and their future. They need to be supported with additional resources deployed to get them back on track.

Dr Jeeves Wijesuria

GP Registrar and CQC specialist advisor

Impact of Covid-19 on Junior Doctors

Dr Jeeves Wijesuria highlighted the overwhelming impact of COVID 19 pandemic on the professional and personal lives of Junior Doctors in the NHS. The prospect of delayed career progressions caused by the training disruptions has impacted on their social and psychological wellbeing. The pandemic has affected moral wellbeing, created huge personal distress and sense of inequality, in addition to financial implications. This issue is likely to impact on Community Care and the NHS. He urges the Government to protect & support the junior doctors in training who have given so much and worked so hard in the process of alleviating huge personal distress and inequality.

Dr Marina Soltan

National Chair for Health Education, Academy of Medical Royal Colleges

Junior Doctors As leaders in the NHS

Dr Marina Soltan talked about the concept of leadership and inspirational leadership qualities. She highlighted the role played by the Junior doctors during the recent COVID pandemic, and by leading the way in research, innovation, education, policy making and influencing decision making. Health Education England should invest to support Junior doctors for Leadership development Training and maximise their contributions to leadership.

She spoke about her own research experience on risk factors for higher ITU admission among Covid patients showing BAME patients are at greater risks than non BAME patients.

Session 4 – Panel Discussion

Covid-19 pandemic has led to an unprecedented impact on medical students' education and learning; and Juniors doctors' career progression caused by disruptions of training with far reaching implications on profession and the NHS. NHS UK and Health Education England need to pay more attention to the effect on medical training and focus on creating novel training resources and adapting processes to enable career progression. The authority should also facilitate developing leadership skills among junior doctors who have proven their ability to lead during the current pandemic.

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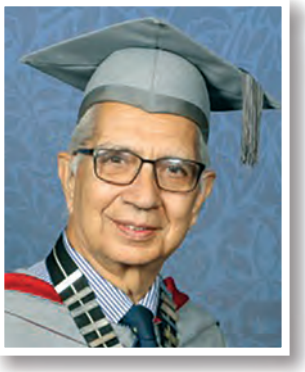
BIDA News

Congratulations!

Prof. Shiv Pande



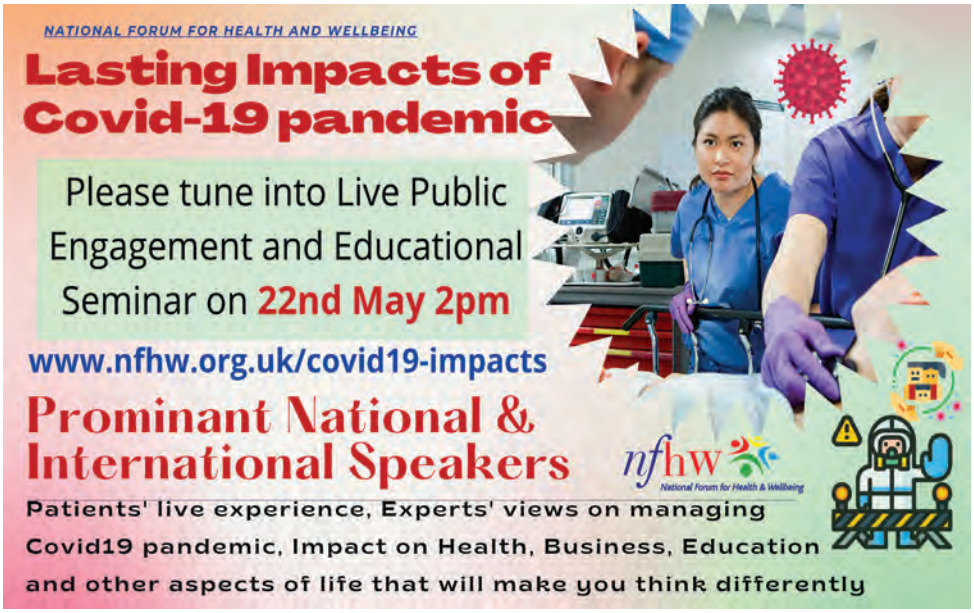
Prof. Shiv Pande has become the first Asian to be made a '**Citizen of Honour**' by the North-Western English city of Liverpool. He was previously appointed a Member of the Order of the British Empire (UK) in the UK's honours list. A 'Citizen of Honour' recognition is extended to individuals who have made *"significant, exceptional or unique contributions to enrich the image of Liverpool and / or its citizens".*

The President's Cup Cricket Tournament 2021 Update

Dr Raghu Hedge National Sports Coordinator

With the 2020 competition having had to be cancelled owing to the COVID-19 pandemic, at the time of writing, it looks quite promising that restrictions for outdoor games will be lifted from 21st June and we'll be able to restart our cricket tournament.

Entries have been invited from all interested Divisions - and we would encourage more Divisions to enter the competition this year. Entries should be submitted as soon as possible, with the deadline for entries now having been extended until the last day in May. That will allow enough time to send out the fixtures and commence the Tournament from the first week in July. The final usually takes place in the later part of August. ***We look forward to hearing from you!***



National Forum of Health & Wellbeing (NFHW - www.nfhw.org.uk)

Founder Chair of the NFHW, Professor Romesh Gupta OBE, set the scene for "**Coping with COVID 19**", the Forum's latest seminar which was presented live on the web on Saturday 27 February. It is still available to view on YouTube using the following link:

https://youtu.be/UWDldJCBX7g

The seminar should be of great interest to those personally or professionally concerned with the wider effects of the coronavirus outbreak, and it offers a wealth of information on the effects of COVID-19 on the mental health of individuals and communities.

4th National BIDA Oncology Conference

This one-day conference is aimed at providing general practitioners and practicing hospital clinicians with an educational update on current trends in cancers and Covid-19 impact. The wide spectrum of topics covered will provide the attendee with a sound understanding of the advances in the management of common adult cancers pertinent to their practice. There will be a session for oral and poster presentations for medical students and junior clinicians. There will also be updates on the current issues in the NHS and discussion on training issues for international healthcare graduates.

Please visit **www.bidaonline.co.uk/bida-oncology-conference** for information and instructions for submission of abstracts for Junior doctors and medical students. Full details of the Conference's programme can be found on page 2 of this issue of BIDA Journal.

SAVE THE DATE! 22 – 24 October 2021, Stoke-on-Trent

BIDA ARM / AGM 2021

We are looking forward to the first venture following the pandemic for a face-to-face meeting provided the pandemic is safely controlled and government regulations permit.

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