bida Journal

Covid-19 Pandemic:

Wake-up call for BAME communities

Frontline Medical Support
Doctors Helping Doctors

Social Isolation and Distancing:
Perils and Benefits

Support for BAME Health Care Workers
Communications with Government and Health Authorities

My Covid-19 Chronicle / Tryst with the Virus
Personal reflections on the Pandemic

NHS
THANK YOU

The Journal of The British International Doctors' Association
Issue No.2, Volume 26 June 2020

www.bidaonline.co.uk

Frontline Medical Support

- Doctors helping Doctors

Dr Amrita Kumar's Story

I am a Consultant Breast Radiologist at Frimley Health NHS Foundation Trust. I completed my undergraduate medical degree at Guy's, King's & St Thomas' Medical School and also have an Intercalated BSc in Management and MSc in Surgical Technology from Imperial College London.

I have a clinical and research interest in breast cancer, medical simulation and Artificial Intelligence, having previously completed an MSc in this area. I am currently leading trust-wide research collaboration to set up AI infrastructure to aid in implementation of AI for improved patient outcomes, and have been appointed AI Clinical Lead in 2019.

I have experienced first-hand the reality of dealing with COVID-19, be it colleagues who develop symptoms requiring isolation or patients needing intensive support for COVID-19. I have also witnessed the evolving nature of this pandemic, by individual healthcare staff who have gone above and beyond their duties, as well as NHS organisations who have rapidly evolved to establish new safer infrastructure. Early on it became clear that as doctors we would need to take on additional responsibility if we wanted to ensure our and our colleagues' safety with appropriate PPE, and to that end we set up Frontline Medical Support fundraiser, as doctors helping other doctors.

Our other fundraiser members include:

Dr Udit Gupta (GP Partner Liverpool), **Dr Arun Saini** (GP Partner Birmingham), **Mr Bal Dhinsa** (Consultant Orthopaedic Surgeon, East Kent Hopsital), **Dr Farzad Entikabi** (GP, London) and **Mr Layth Bunni** (CEO International Supply Logistics).

"Thank you FMS Support for your help and support for our teams at Frimley Health - we are so grateful for your generous support"
Neil Dardis Chief Executive, Frimley Health NHS Foundation Trust

"Thank you for your generosity and willingness to donate personal protective equipment (PPE). We are truly grateful to see the community coming together for support and appreciate you thinking of our healthcare professionals during this crisis."
Allison Kingsbury (on behalf of Partners at Fernville GP Surgery), Hemel Hempstead

"On behalf of our nurses, doctors, staff and patients, thank you so very much for the kind and generous donation of PPE equipment. It has been so important to the hospice to receive such fantastic support from the community in these challenging times and has enabled our staff to carry on with the excellent work they do."
Michelle Gower Manager, Saint Francis Hospice

"You are the true heroes of the NHS. Thank you for your help following the scary announcement by PHE a few weeks ago that there is not sufficient supply of PPE. You were like angels to the frontline NHS staff. Your contribution helped protect our staff, protect our patients."
Dr Sanjay Arya Consultant Cardiologist & Medical Director
Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust

Dr Aman Kumar's Story

Although I left the NHS approximately 9 years ago, many of my family, friends and former colleagues are working on the frontlines right now and have been struggling for equipment (PPE, visors etc.). In my current role as a biotech and medical device investor, I felt well-positioned to help given a network in both the finance and manufacturing sectors in China, Singapore and Hong Kong. I utilised this in the first half of March to establish a trusted supply chain early on and help deliver equipment to those most in need.

Together our team are a group of doctors, most of whom are working frontline in the NHS in the fight against COVID-19. Many of our family, friends, and colleagues are working on the frontlines in the NHS and have been struggling to procure life-saving PPE. After seeing the television pictures from Italy and knowing that the UK would be next, many people we spoke with shared our frustration and so we established a fundraiser and used our network to establish a certified PPE supply chain to provide essential equipment to frontline workers.

Although the NHS is doing its best to order supplies, there are significant shortages at a local level. With a UK and International supply chain already in place, we have been sourcing and delivering PPE, masks, visors and sanitiser directly to staff since the last week of March. We have established a logistics network to supply medics in London, Birmingham, Manchester and Liverpool and we are delivering the equipment directly into the hands of the staff who need it.

Every penny has been spent on PPE and one of the most fulfilling aspects of this initiative has been cutting through the bureaucracy of the system to deliver PPE directly into the hands of doctors and nurses. Deliveries have included: 30,000 respirator masks (N95 or FFP3); 10,000 surgical masks (3-ply); 5,000 face shields and goggles; 2,700 sanitizers and more than 1,400 hot meals.

We still anticipate plenty more to do over the next few weeks as the NHS attempts to restart more elective procedures and the demand for PPE will likely rise.

We have been amazed by the tremendous support from friends and colleagues both in the UK and across the world. In addition to very generous monetary donations, we have received numerous emails from colleagues offering logistical support, contacts, and 'whatever I can do to help' offers, all of which have made a difference.

We need your support to keep the PPE coming as it is likely the situation will get worse in the UK before it gets better. Please give generously.

GoFundMe page:
www.gofundme.com/f/frontline-medical-support

Twitter: **www.twitter.com/frontlinemedic4**

If you are a frontline healthcare worker in need of equipment, please contact us so we can help, email:
fmscovid19@gmail.com.

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bida Journal

Editorial

The NHS has been put under massive strain trying to cope with the many thousands of people needing life-saving treatment for Covid-19. Let us unite first to pay homage to all the NHS warriors, who have sacrificed their lives in this fight.

Mr. Amit Sinha
FRCS (Trauma & Ortho)
Editor, BIDA Journal.
Consultant Orthopaedic Surgeon.

It is unbelievable that an invisible enemy, a small virus, who knows no boundaries and has not respected borders, has shown a huge disparity in involvement of race and ethnicity. It remains an unanswered question as yet, why so many from the BAME group both among the general population and amongst Health Care Workers (HCWs) have been affected and have died during the course of this illness. BIDA along with the BMA would participate in a joint committee with the NHSE to discuss the details to study the factors, which may have led to this dreadful outcome. An article by Mr C.R. Selvasekar and Dr Sanjay Arya outlines these factors. Of all the medical risk factors, diabetes seems to create the highest risk. Of the 22,332 patients who have died in England's hospitals since March 31, when pre-existing conditions began to be recorded, and May 12, some 5,873 – 26 per cent – had either type 1 or type 2 diabetes, providing some explanation for the disproportionately high toll among Indians.

The wellbeing of our Members and International Medical graduates is a priority for BIDA. Our team has worked tirelessly to raise issues pertinent to the BAME group of HCWs, in particular doctors. NHS staff, in particular the BAME staff are supposed to have a personal assessment of their risk of contracting coronavirus, but only 18% of the doctors who responded to the RCP survey said they had received such an assessment. NHS Wales have a risk assessment protocol for all BAME HCWs but NHSE have not yet formulated such a tool.

The Royal College of Physicians (RCP) found that 48% of all doctors who responded to its survey were either concerned or very concerned for their health, a figure that rose to 76% among BAME doctors. Nearly two-thirds were worried about passing the virus on to others at home. Doctors said poor access to personal protective equipment, insufficient training on how to fit masks and lengthy waits for virus testing left them in fear of catching the virus and passing it on to those they lived with. A UK-wide survey undertaken by the Royal College of Nursing (RNC) found that 34 per cent of the 5,000 nurses they polled were working without proper PPE. It is reassuring to know from Dr Abbasi's article that Trusts like Wigan, Wrightington & Leigh Foundation Trust have been proactive in securing adequate supplies for their staff. This brings about confidence and conviction amongst all staff and the management. The government response has been slow but has made efforts to take actions appropriately for everyone's welfare. There have been numerous charity organisations helping out as well.

Dr Abhinav Gupta, as a fresh intern gives us an exciting and a detailed picture of the complexity of the management of this condition in the Intensive Therapy unit. As the pandemic continues, concerns are mounting regarding the health and mental wellbeing of NHS staff. This edition has detailed descriptions together with reflective thoughts from Mr Nikhil Kaushik and Mr Mayur Chawda.

The UN last week warned that the pandemic will likely lead to an "upsurge" in the number and severity of mental illnesses. UK must prepare for the worst, as stigma and fear of burdening NHS stores up a parallel nation-wide epidemic of mental health issues. We need to prepare ourselves by following the advice given by Dr J Srinivasan.

We have a superb article by Mr Ajit Sinha, a Senior Human Resources Consultant with considerable cross continent experience. The article outlines the challenges an individual faces working in a huge organisation like the NHS. Doctors do require HR support. This compliments the efforts being made by all relevant organisations including the DAUK. Dr C Cunningham's reflections are essential to achieve the ideal "Learn not blame" culture in the NHS.

I am sure the COVID-19 global pandemic will impact our daily actions for years. We have learned so much about different ways to live, work and be educated in the process of dealing with the pandemic Will the post Covid era address the disparities? Will the resilience of the NHS staff be impacted? I remain positive. There has never been a more important time to work collaboratively and to sustain our teams through these difficult times. We have already seen incredible teamwork, flexibility and professionalism from clinicians, managers and other NHS staff.

"Overall I have been struck and humbled by the great sense of togetherness and determination, as well as the examples of humour and kindness. I love going for a run and seeing the rainbows in windows and chalk on pavements. We've enjoyed free groceries, Easter eggs, bacon sandwiches and more. It is not hard to be inspired by patients, their friends, families, carers and even by total strangers. Hope is everywhere". (Lawrence Ostlere, Paramedic.).

Amit Sinha
Editor, BIDA Journal.

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Members are asked to ensure that all enquiries and correspondence relating to membership or other matters are sent directly to ODA House, 316A Buxton Road, Great Moor, Stockport SK2 7DD. (T: 0161 456 7828 E: bida@btconnect.com) and not to BIDA Journal.

BIDA's fight for our Healthcare workers

British International Doctors' Association Ltd.

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17th April 2020

The Right Honourable Mr Matt Hancock
Secretary of State, Health and Social Care
39, Victoria Street, London. SW1H 0EU

British International Doctors Association (BIDA) and its members feel proud to be part of this battle against Covid-19 pandemic. Most of our members are working in the frontline fighting against this pandemic BIDA welcomes UK Government's decision to extend lockdown by a minimum of three weeks.

BIDA is extremely concerned with regards to scarce availability of PPE for frontline Health Care Workers and in social care sector staff. This is particularly concerning to us at BIDA in the light of the fact that most of HCW, who have sacrificed their lives, are of BAME origin.

Testing for Covid-19 is one of the most important pillars of our fight against Corona virus and it is now clear beyond doubt that testing is also hugely important in finding a key to unlocking the way out of this pandemic. BIDA remains concerned with regards to the level of testing being carried out currently every day, which stood at approximately 20,000 tests only on 16th April. This puts strong shadow of doubt with regards to the Government's claim for achieving 100,0000 test per day by 30th April.

BIDA would like the government to address the above two issues immediately. With this in mind, BIDA would recommend the following:

1) Ensuring availability of PPEs to frontline Health Care Workers and social care staff should be the government's top priority. In addition, clear updated guidance in line with WHO recommendations with regards to use of PPEs, should be rolled out across the country.

2) Ramp up the testing capacity so that 100,000 tests goal is achievable by the end of this month. This increased capacity should not only be used in testing frontline Health Care and their families but should also be extended to social care workers.

Kind regards,

Dr BK Sinha	Dr Chandra Kanneganti	Dr Ashish Dhawan
BIDA National President	BIDA National Chairman	BIDA National Secretary

cc: Mr Simon Stevens, CEO, NHS; Dr Chand Nagpaul, BMA Chair

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22nd April 2020

The Right Honourable Mr Matt Hancock
Secretary of State, Health and Social Care
39, Victoria Street, London. SW1H 0EU

The British International Doctors Association (BIDA) remains gravely concerned with the rising number of COVID-19 related deaths among Healthcare workers from the BAME backgrounds.

Statistics:

1. Three quarters of the 51 healthcare workers are from BAME group.
2. While BAME workers represent 44% of the NHS workforce, they accounted for 62% of the 82 NHS staff known to have died with the virus (Telegraph 22nd April, 2020).
3. The Nursing Notes website reports of at least 105 deaths.
4. Every one of the 14 doctors reported to have died so far is from an ethnic minority. They are of all different age groups.
5. Recent data suggest BAME doctors are more than 4 times higher risk of dying from Covid-19 infection.

Concerns

1. There is not enough data on why there has been greater severity of illness leading to deaths in the ethic communities.
2. Death certificates do not have any information on ethnicity, which could highlight other related factors.
3. Complete lack of initial action to address the greater risks identified by the BMA and BIDA.
4. NHS England has been asked by the government to investigate. This does not fill us with confidence, as it's the very organisation that should have been leading prompt actions to address this gross disproportionality.

BIDA urges clarity on the details of the investigation of this very sensitive and important matter. We are all aware of the risk factors, affecting a higher proportion of the BAME population, which may well predispose them to be susceptible to the devastating effects of COVID-19 illness.

We urge the government to take a stance and seriously consider the need to:

1. **Risk assess certain groups of NHS workers** if they are older or have other medical conditions.
2. **High risk BAME health workers should be selectively shielded and prevented from exposure to the virus and be allocated to duties, which reduces their exposure to the virus.**

We must do everything we can now to prevent further deaths. The Department of Health, UK has the moral, legal and the ethical obligation to support the NHS Healthcare workers and ensure provision of adequate safe environment and maintain a culture of teamwork, mutual understanding and confidence.

We fully support the BMA, all the respective Royal Colleges of all specialities, the Royal College of Nursing and sister organisations that have all raised the above concerns.

We sincerely hope you would take notes of our concerns and take immediate action for the safety of our frontline warriors.

Kind regards

Dr BK Sinha	Dr Chandra Kanneganti	Dr Ashish Dhawan
BIDA National President	BIDA National Chairman	BIDA National Secretary

cc: Mr Simon Stevens, CEO, NHS; Dr Chand Nagpaul, BMA Chair

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Latest Headlines

Doctors plea to give high-risk ethnic minority health workers PPE at all times amid alarming Covid-19 death rates among black and Asian NHS staff

- BIDA says staff must be protected, even when treating non-coronavirus patients
- Britons of black African heritage are three-and-a-half times more likely to die
- NHS England chief has since written to all trusts urging them to assess the risk
- Here's how to help people impacted by Cov

By PAT HAGAN FOR THE MAIL ON SUNDAY
PUBLISHED: 22:01, 2 May 2020 | UPDATED: 22:05, 2

Plans to tackle alarming Covid-19 death rates ... removing them from the front line do not go ...

A leading medical body is now calling for hi... wear top-end personal protective equipmen... non-coronavirus patients.

British International Doctors' Association Ltd.

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27th April 2020

The Prime Minister,
The Rt. Hon. Boris Johnson
10 Downing Street, Westminster, London SW1A 2AA

We are pleased that you are back in the office now and will be working tirelessly in our fight against corona virus. BIDA admires your gesture in openly appreciating the hard work and sacrifices that Healthcare workers are making in this fight. BIDA and its members are part of this workforce and are contributing to this fight. Combined impact of lockdown and HCWs efforts has been that we are now getting to grips in controlling this pandemic in the UK. We would most humbly request you to consider the following in your discussions:

1) **Ensuring that lifting of Lockdown is not rushed through but is rather a carefully balanced decision.**

BIDA is concerned with the recent mention of lockdown restrictions being lifted. A lot is being talked about this issue already in the press. BIDA would like to bring to your attention the Imperial College Model that has suggested that UK could lose 100,000 lives if we lift restrictions too soon.

Whilst BIDA acknowledges the economic impact and the potential for hardship to some people with an extended lockdown, surely the counterargument that these measures will protect lives and we save NHS resources is too powerful to ignore.

2) **Any lockdown decision should be in consultation with Scientists and Pioneers in this field.**

BIDA would strongly request to the Prime Minister that the timing and methodology of lifting lockdown should be completely guided by Scientists and Pioneers from this field. These people should be part of the panel that is deciding government's strategy.

Dr BK Sinha
BIDA National President

Dr Chandra Kanneganti
BIDA National Chairman

Dr Ashish Dhawan
BIDA National Secretary

cc: Rt. Hon. Matt Hancock, Health Secretary; Dr Chand Nagpaul, BMA Chair; All Press.

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28th April 2020

Chief Executives of NHS Trusts (England)
Chief Executives of Health Boards (Wales and Scotland)
Chief Executives of Social Care Trusts (Northern Ireland)

Dear Colleagues,

Support for BAME Health Care Workers

As you would well be aware that people from BAME backgrounds appear to be disproportionately likely to develop severe coronavirus symptoms. This has been highlighted in an analysis recently published by HSJ. This survey revealed although BAME Health Care Workers make up only 16 per cent of the NHS workforce, 63 per cent of total HCWs who died from Covid 19 were of BAME origin

Taking heed for these findings, Somerset NHS Foundation Trust has included all its BAME staff in the vulnerable and at risk group. The trust is supporting its BAME staff members and is asking managers to have conversations with them and discuss their concerns.

British International Doctors Association would like to request you to follow the same path. The steps to support BAME staff could include

1) Ensuring all BAME staff are allowed to wear FFP3 mask in every area of the hospital
2) Addressing and alleviating the anxieties that they may have following this study. This may involve reassuring or redeploying them wherever possible.
3) Prioritizing testing for them and their families.
4) Ensuring any Covid -19 sickness absence does not have any deleterious impact on them financially o on their career progression.

These are only a few amongst many initiatives that we would expect Trusts to take to protect BAME staff in their organization. These steps will only build staff confidence and help productivity.

Dr BK Sinha
BIDA National President

Dr Chandra Kanneganti
BIDA National Chairman

Dr Ashish Dhawan
BIDA National Secretary

cc: Rt. Hon. Matt Hancock, Health Secretary; Dr Chand Nagpaul, BMA Chair; All Press.

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19th May 2020

The Rt. Hon. Ms Priti Patel
Secretary of State, Home Office
2 Marsham Street, London SW1P 4DF

Dear Ms Patel,

BIDA wishes to bring forth two proposals to your attention to the forefront of current discussion around supporting Health Care Workers through this crisis

1) **Annual Surcharge for Healthcare Workers - A proposal**

It is disheartening to now know that the government has decided not to scrap the surcharge for overseas workers. We had expected to make an exception for all HCWs including those working in care homes.

BIDA proposes alternative solutions to this issue. It requests all the relevant employers like the NHS Trusts, the Health Boards of Wales and Scotland, the Health Education England and the Local NHS England teams to come together to protect their staff that fall in this category and help them by paying for their respective surcharges. I would like to inform you that there are some Trusts who are already paying the surcharges of nurses, who have been recruited from overseas. NHS England are giving newly appointed GPs their visa expenses and Health Education England are recompensing some trainee GP and junior trainees, who have been recruited from overseas.

BIDA would like to call upon NHS Trusts and Health Boards of all UK nations to follow this example. It would be a fitting gesture of appreciation for their contribution to the NHS, so that they feel valued and be proud to work in the NHS. We would very much like you to support our proposal and discuss this further with the respective Dept. of Health. We are writing to the Rt Hon Mr Hancock, Secretary of Health as well.

We strongly feel that it doesn't seem fair for those who are already paying tax and National Insurance to pay twice in face of the enormous contribution this group is making.

2. Proposal for Review of Independent Leave of Residence (ILR) for HCWs from overseas.

We request the government with a proposal to review their policy for ILR regulations for all HCWs. We wish to propose that all overseas HCWs (in particular doctors and nurses) be considered under the category "Global Talent". This proposal wuld lead to consideration of ILR after serving the NHS for 3 years. This accelerated settlement would go a long way at a time when the NHS desperately needs toalleviate continual and chronic staff shortages.

BIDA would earnestly request you to consider our propositions.

News

Government must move faster to protect BAME doctors after COVID-19 deaths

By Luke Haynes on the 28 April 2020

Urgent action must be taken to protect frontline NHS staff who are black, Asian or minority ethnic (BAME) during the COVID-19 pandemic to prevent more deaths, doctors have warned.

The British International Doctors' Association (BIDA) has called for a special task force to be set up to collect data on COVID-19 deaths among frontline workers, to speed up efforts to investigate.

The group has also backed calls from the BMA for doctors to be 'selectively shielded' and has asked for 'more clarity' on the government's investigation.

itv.com

Dr Chandra Kanneganti chair of the British International Doctors Association told ITV News "it doesn't seem fair that those who already pay tax and national insurance" are asked to pay twice.

"You will have seen the enormous contribution of the international healthcare workers to the NHS," he said.

"We have almost 16 to 17 doctors already dying, number of nurses have died, number of other healthcare workers have died who are from overseas have died in the line of duty...that is the kind of contribution international doctors and nurses and other healthcare workers are contributing to the NHS."

"It will be a very good will if the government can consider scrapping the NHS surcharge at least for NHS workers."

theguardian.com

All government policies are continuously kept under review."

After Patel's apparent announcement, there were mounting calls for the surcharge to be permanently ditched. It was introduced in 2015 as part of hostile environment laws designed to discourage illegal immigration and combat health tourism. The surcharge must be paid alongside taxes and national insurance contributions.

Dr Chandra Kanneganti, the national chair of the British International Doctors Association, said: "We know BAME doctors are disproportionately getting ill. To have to pay for the same service that they are putting their lives at risk for doesn't seem fair. This charge needs to be scrapped completely for NHS overseas workers."

Response from Rt. Hon. Matt Hancock MP

Secretary of State for Health and Social Care

Department of Health & Social Care

From the Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care

39 Victoria Street
London
SW1H 0EU

020 7210 4850

POC_1223198

Dr Birendra Sinha
President
British International Doctors' Association Ltd
ODA House
316A Buxton Road
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Stockport SK2 7DD

06 May 2020

Dear Dr Sinha,

Thank you for your letters of 17 April and 22 April. Thank you also for copying me in your letter to the Prime Minister on the 12 April, which I am responding to on his behalf. This response addresses the points raised across your three letters.

Workforce remuneration (raised in 12 April letter)

I absolutely agree with your view that those on the front line of this battle against COVID-19 are our heroes and saviours and it is important that they should know that if the worst happens, the state will help their families. The Government is in the process of setting up a life assurance scheme for frontline NHS and social care staff who contract coronavirus during the course of their work. The scheme is non-contributory and pays a £60,000 lump sum where staff die as a result of coronavirus and had been recently working in frontline roles and locations where personal care is provided to individuals who have contracted COVID-19. The life assurance scheme provides a safety net for the families of NHS and social care staff who have no life assurance cover provided by their employer or a pension scheme.

NHS staff also receive good quality death in service benefits through the NHS Pension Scheme, providing a lump sum and survivor pensions for a partner and dependents for qualifying members. NHS staff who claim their pension are guaranteed five years' worth of pension payments plus ongoing survivor pensions.

Addressing your point around pay awards for NHS workers during this pandemic, it is vital we care for those that we all rely on to care for us, and employers should rightly use maximum flexibility in circumstances where NHS staff may have to care for dependents. It is right that those who work well beyond the call of duty should be paid for every hour they work and receive premium pay rates for working unsocial hours. The independent Review Body for Doctors and Dentists Remuneration (DDRB) has been asked to make recommendations on pay awards for doctors and dentists who are not already part of multi-year deals. The Government published its written evidence to the DDRB on 13 February 2020 and we expect the review body's recommendations in the coming months.

General Medical Practitioners and doctors and dentists in training are subject to multi-year pay deals and therefore we have not asked the DDRB to make pay recommendations for these groups. For Specialty and Associate Specialist (SAS) doctors we are expecting the DDRB's recommendations to be informed by the progress of contract reform talks with the BMA. We want to ensure that the NHS employment offer continues to attract, retain and reward staff and this offer continues to be kept under review.

PPE (raised in 17 April letter)

The full weight of the government is behind the work to source and distribute PPE to NHS and social care workers. We are working round the clock given the global shortage of gowns to secure the NHS and the social care sector the equipment they need. We recognise the huge demand for the stocks, which is why the Government is buying millions more and working with British manufacturers, to secure months of supplies. From 25th February to 27th April we have delivered over 1 billion items of PPE across the health and social care system within England, plus tens of millions more will have been distributed by Devolved Administrations.

The UK government and devolved administrations have also published clear guidance on appropriate PPE for NHS and social care workers. This has been written and reviewed by all 4 UK public health bodies and informed by NHS infection prevention control experts, and is consistent with guidance from the World Health Organization (WHO).

Testing (raised in 17 April letter)

I fully agree that testing is a key part of the UK's response to COVID-19. Earlier this month I set out the government's recently published Testing Strategy, which includes a challenge to provide 100,000 tests a day by the end of April. Throughout this process we have had to prioritise, ensuring that seriously ill patients come first, followed by those working on the frontline to support the sick and the most vulnerable. For these people, a test can mean the difference between life and death.

To help us manage this, we have worked to establish a programme with commercial partners including Amazon, Boots, Thermo Fisher Scientific and Randox to test essential workers, starting with NHS and social care workers and symptomatic members of their household, so those who test negative can return to work as soon as they are able to and continue to provide vital care for those most in need. We have also established a network of regional test sites, and have also delivered mobile testing units which can travel to offer tests in other areas, as they're needed, alongside satellite testing to boost capacity within the NHS.

This is all about helping our essential workers by making the process of getting a test easier, faster and simpler. We have worked to ensure all NHS and social care staff who would like a test can have one, and for this we should be proud. Having met that ambition, we are now able to expand testing out more widely to all essential workers and members of their household, as I announced last week (23 April). From April 24, symptomatic and self-isolating essential workers have been able to book a test directly for themselves or symptomatic members of their household through the new online self-referral portal. This includes the delivery of home testing kits direct to someone's door so they can test themselves, and their family, as required without leaving the house.

Following our latest expansion, announced 28th April, we have now been able to offer testing to all essential workers, anyone in England with symptoms of coronavirus who has to leave home to go to work, and all symptomatic members of the public aged 65 and over. We have also confirmed that NHS staff, care home staff and care home residents will be eligible for testing whether or not they have symptoms. Our ultimate goal remains that anyone who needs a test should have one and we are exploring expansion to other groups balancing capacity with demand.

Effect of COVID-19 on patients and NHS and social care workers from BAME backgrounds (raised in 22 April letter)

Finally, thank you for sharing your concerns about the rising number of COVID-19 related deaths among NHS and social care workers from BAME backgrounds (in your letter of 22nd April). It's critical that we find out which groups are most at risk so we can help protect them. The Chief Medical Officer has commissioned Public Health England (PHE) to further explore the impact of COVID-19 across different population groups. This includes work to analyse confirmed cases, hospitalisations and deaths relating to COVID-19 by ethnicity, where this data is available. We are working hard to ensure that BAME groups are informed and confident about their role in staying safe. Concerning NHS staff from BAME backgrounds, NHS England and NHS Improvement are working with NHS employers to provide updated guidance and to ensure that employers risk assess staff at potentially greater risk and act accordingly.

I hope this goes some way to answering your questions. There is always more progress to be made, and I welcome your views and support as we work to overcome this pandemic.

Yours ever,

Matt

MATT HANCOCK

Covid-19 Infection:

Can this be a wake-up call for British and Minority Ethnic (BAME) Communities?

Mr Chelliah R Selvasekar FRCS
Consultant Colorectal & Laparoscopic Surgeon
The Christie NHS Foundation Trust, Manchester

Dr Sanjay Arya FRCP
Consultant Cardiologist & Medical Director
Wrightington, Wigan & Leigh NHS Foundation Trust

The Covid-19 infection caused by SARS-CoV-2 RNA virus was declared a pandemic by the World Health Organisation in March 2020[1]. This infection started in Wuhan, the capital of Hubei province in China. The first documented case was in December 2019[2]. Since then it has spread around the world, affecting many countries, with over 4 million confirmed cases and over 300,000 deaths worldwide[3]. In the western world the number of infected patients has plateaued but this may be related to the various measures taken by the policy makers such as the lockdown period, social distancing, shielding and measures taken by individuals such as improved hygiene measures and the use of personal protective equipments etc[4]. In the western world, Italy was the most significantly affected, followed by Spain and then the United Kingdom.

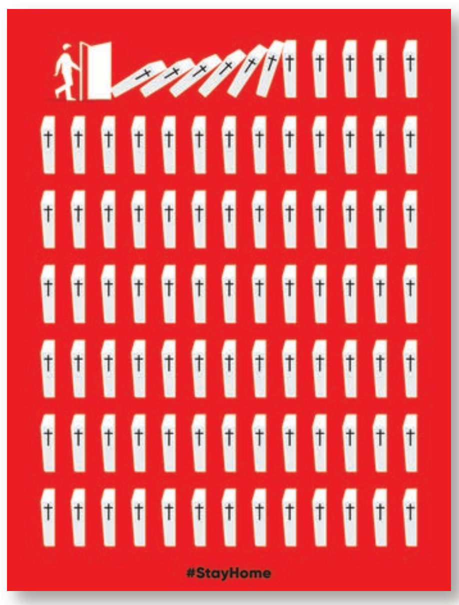
In the United Kingdom, the first reported case was at the end of January in York, followed by a surge in London, which then spread to the rest of the UK[5]. So far in the United Kingdom nearly a quarter of a million infections have been documented with (at the time of writing) nearly 35, 000 deaths[5].

The Covid-19 infection is highly contagious but the complications are only slightly higher than the annual influenza infections[6]. Over 80% of those infected will recover without much sequel following Covid-19 infection. However around 15-20% require hospital admission for additional oxygen support. Of these, on average 5-10% need intensive care support and <5% succumb to the disease[6]. Those who recover following organ support can develop complications related to myocardial dysfunctions, arrhythmias, and renal impairment requiring renal replacement, chronic lung impairment. Those who require ventilatory support require this for a prolonged period. Those who recover have severe exhaustion and myalgia for a prolonged period[6] .

It is well documented that there have been many health care workers (HCWs) who have succumbed to the Covid-19 infection. The first ten HCWs were from a Black & Minority Ethnic (BAME) background and as the pandemic has spread in the UK, among the HCWs who have died, 64% were from the BAME community, even though the BAME community forms around 44% of the NHS health care workforce[5]. There have been a disproportionate number of HCWs in the UK who have succumbed to this infection.

It is well known that covid infection is highly contagious and the risks of mortality and significant complications are higher in those over 70 years of age, male and those with compromised immunity.[6,7].

It is also well documented that the BAME community have a higher incidence of modifiable risk factors such as hypertension, diabetes, deranged lipid profile, increased risk of metabolic syndrome[8]. There may be a substantial number of HCWs who may have sub-clinical risk factors but are ignorant due to a lack of awareness and



Illustrated above are some of a series of 'awareness' posters produced by the United Nations at the outbreak of the Covid-19 Pandemic.

testing. Along with these risk factors it is well known that the BAME community has an impoverished lifestyle, including an unhealthy diet and a lack of regular exercise.

These modifiable risk factors have been postulated to be contributing to the increased risk of complications of Covid-19 infections in the BAME HCWs. The BAME population may have a higher risk to the Coronavirus infection due to people living in crowded joint families. There is also sufficient evidence showing that BAME communities are disproportionately from lower socio-economic circumstances.

Although the socio-economic factor needs to be addressed in the medium to longer term, the modifiable risk factors need immediate attention, as it may influence the complications of Covid-19 infection in the BAME HCWs with a more favourable outcome.

This is the "Wake up call" for all the BAME NHS staff (Box 1). They must have formal health assessments which would help them identify and/or optimally manage their underlying modifiable risk factors, including their BMI, blood pressure, HBA1C, lipid profile, renal function, dietetic review, and also have their exercise plans assessed. This will help monitor those who are known to have risk factors and reassure them that these are under control. At the same time this may provide an opportunity to identify individuals who have sub-clinical risk factors and are at risk of cardiovascular complications.

Conclusion

The Covid-19 pandemic has demonstrated that there are some high-risk populations who are prone to increased mortality and morbidity. Unfortunately the BAME population and NHS staff are at twice the risk of dying compared to the local population. Although the precise reason for this higher risk is not clear, there are a number of hypotheses. We believe that some of the hazards may be attributable to underlying cardio-renal-diabetes modifiable risk factors including metabolic syndrome. These must be addressed by a formal objective risk assessment and there must be a clear action plan to manage these risk factors optimally. Although this may not immediately address the current increased risk to Covid-19, it would certainly help to improve the health of the population in general and reduce the risk to coronary artery disease, stroke and renal failure in the future.

- ***Undergo annual health check:***
  Regular check of weight (waist: hip ratio - WHR), blood pressure, pulse (for AF), lipid profile, blood sugar, renal function (eGFR)
- ***Manage cardiovascular risks optimally:***
  See your GP or Specialist regularly and monitor your weight (WHR<0.9 in male and <0.8 in female), hypertension (home BP <135/85), atrial fibrillation (rate <90), hyperlipidaemia (TC<4 and LDL<2 if coronary disease), diabetes (HbA1c <58) and renal function (eGFR>60)
- ***Improve lifestyle:***
  - Healthy balanced diet with at least five fruits / vegetables per day
  - Regular exercise: 30min of moderate exercise at least 5 days per week
  - Reduce weight; Stop smoking; Maintain hydration
  - Drink alcohol in moderation (<14 units/week with two alcohol free days)
  - Buy home BP monitor and monitor BP 3-4 weekly

Box 1: "Wake-up call" for BAME NHS staff

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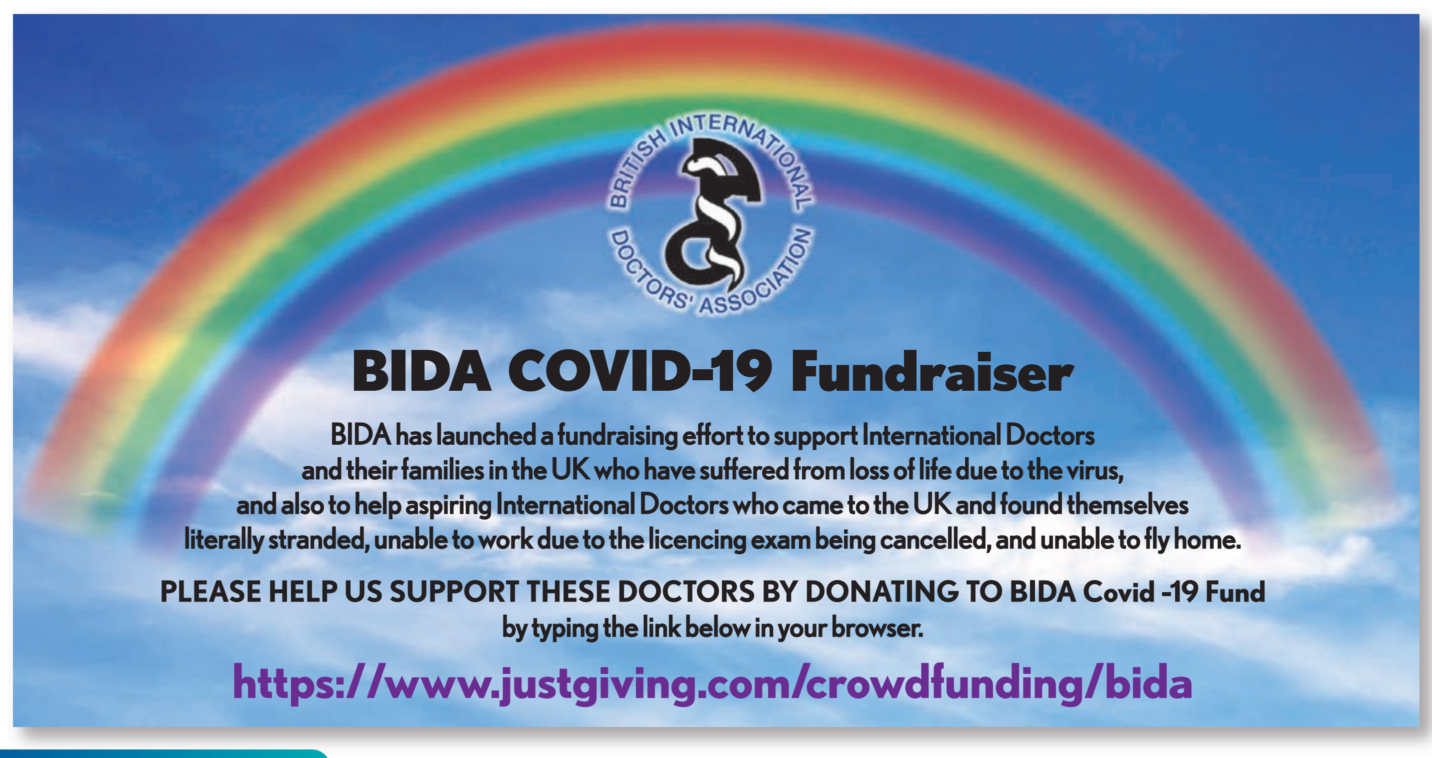
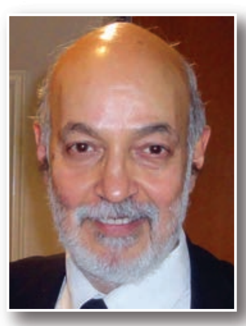




Introduction

As I see a group of medical students and foundation year doctors walk towards the Covid ward, I recall my own tryst with the deadly virus of smallpox. The anxiety on my mother's face, as she saw me off at Delhi Airport in 1974, for a stint of four months in Bihar has stayed with me. As a parent of a doctor and also as a supervisor of many young doctors I worry about their welfare and the lasting impact this pandemic is going to have on them.

Man has co-existed with other biological species and that includes viruses. This fact of life has to be respected and humanly managed with the gift of intellect that nature provides us.

We manage our cohabitation with viruses ranging from the common cold to the most deadly and feared Ebola virus, the list is long. Vaccination and other steps to prevent acquiring and passing it on to others are routine in health care. Most of us have lived through some viral infection that might have left us with lasting effects and also made us immune to further infection. Not all viruses are harmful though, several viruses exist commensally in various species; they may also provide protection against pathogenic infections with other viruses. Unfortunately, some viruses that are commensal with one species may prove to be deadly to another species.

Most viruses affecting us adversely have been introduced to humans from animals at some point. Bats are considered to be the biggest source of such inter-species transfer either directly or through another intermediary animal.

We know that viral, bacterial and other microbial infections have affected the human and other species from time immemorial. Such outbreaks have been responsible for massive loss of life. We have overcome these infections by developing and adhering with principles of hygiene, vaccination, antibiotic use and antiviral use. We have even managed to eradicate certain viral infections such as smallpox and polio. We are able to prevent several viral infections with judicious use of vaccination; measles, mumps and rubella being the classical examples.

So why is there is such a panic this time with Covid-19 Pandemic?

Prof Goura, a virologist from Sheffield, explains: *"When a new virus is introduced for the first time to the human race, no one is immune. The disease runs its course and we get better. Some develop immunity and some may even die."*

The Corona virus, that causes the common cold or seasonal flu, was introduced to the human race in a similar fashion, except that we are not sure when and how. Up until 10-15 years ago we did not have tests to detect a lot of respiratory viruses and even now during the winter season anyone with a cough, cold and fever is told - *'it is just a virus'*.

There are many different families of respiratory viruses and we (virologists) know that the Corona virus family already has four different human strains, which cause common cold or 'flu like' symptoms in winter months. When we test patients with respiratory specimens, not everyone has the same virus.

So Covid-19 is a strain of Corona virus, that is new to human race, it probably was also introduced to humans by bats either directly or through an intermediate animal host.

So if this is just another mutated influenza virus, why is it causing such havoc?

Dr Santokh Singh, a Consultant Anesthetist at Chester, involved with the care of patients with Covid-19 infections says, *"It is a new illness; we are only beginning to understand its natural course. It causes a kind of atypical Acute Respiratory Distress Syndrome, where the patient is hypoxic in spite of the lungs being well aerated. There are two separate phases - a pneumonitis (phenotype L) followed by a more classical ARDS (phenotype H). In addition, Covid-19 is very prothrombotic. The patient suffers pulmonary vascular micro-thrombi; this leads to worsening of gas exchange.*

Understanding the disease pathology of this new infection is paramount to developing accurate treatment support for patients, many of whom require intensive care.

This highly virulent virus is like a match to dry tinder wood that can rip through us all and burn unstopped unless there is some treatment, a vaccine or other means to stop it. The human race has not been exposed to it before and unlike the influenza virus we have no immune memory to protect us"

Several treatment trials are needed and taking place across the world. Although many promises are being talked about, particularly in social media posts, there is no concrete evidence of a definite treatment as yet. Similarly virologists are engaged in trying to develop a vaccine. Almost as we speak there is a trial of a vaccine in human volunteers taking place; but realistically a vaccine is more than one year away.

Meantime, the best we can do is to minimise the exposure to the virus, and try to contain its spread. Social distancing and lockdown are attempts to stop the spread and control the pandemic." says Prof Goura.

What would happen to our economy!!

This pandemic has brought economic activity to a halt globally. The impact of forced shutdown is causing a great deal of concern

amongst nations worrying about immediate and medium to long term effect on trade and business.

Vinayak Salvi, associated with oil industry fears that no industry is going to escape from the effects of this sudden economic halt. In countries like Britain that are predominantly service based economies, the impact is going to be even harder and uncertain.

The British Chancellor has announced many concessions and measures in an attempt to ease the pain for the citizen. The generosity of the British public has translated in a large collection for various charities. But charities are at best a sticking plaster. The ultimate national activities rely on governmental policies and spend.

It should be remembered that the government has no income of its own. It is inevitable that once the situation eases and life returns to normal, there will be demands on the government that it can only meet through direct and indirect taxes and borrowing. It is important therefore that we take an interest in our finances and prepare to meet the inevitable demands that are going to drop through our letter boxes, warns Vinayak.

How do we cope?

Our top priority at the moment is our survival and health. As we emerge from this crisis, we shall have changed. We shall come to terms with the loss of someone we know that have left us before their time. Coping with the loss of someone and to live with a feeling that '...it could have been me, will undoubtedly have an impact on our physical and mental health.

Dr Raj Sambhi, a psychiatrist in North Wales agrees, but is concerned that in our over-zealous focus on treating those infected with Covid-19 in special wards and high tech ICUs, we may be neglecting other aspects of peoples' health. The elderly and other groups who need care and support in their daily living are being left out and may be living with a sense of abandonment.

Dr Sambhi reminds us that patients with significant mental illness have their life span reduced by up to 20 years as compared to general population. This pandemic has the potential to make this even worse as we grapple with prioritising treatment based upon the age and mental health of the patient. This has caused a great deal of concern and a sense of guilt to the front line healthcare staff that may be disadvantaging an elderly patient in face of caring for someone younger.

Similarly patients neglecting other acute and chronic illnesses and regular medication are a real worry. We may be inundated with compounded problems as we emerge from the Covid-19 pandemic, and issues relating to unemployment and social fragmentation will be no lesser a challenge..

In times to come we shall adapt to a non-contact and distant manner of social interactions with our loved ones, friends and family. There will be a heavy demand for support during such a transition in our cultural and social behaviour.

Dr Sambhi fears that the medical profession in general and psychiatrists in particular will face many challenges not experienced before.

Is there an end?

Some believe that we shall see an end of the Pandemic soon, but Prof Goura fears that may not prove to be the case. 'This virus is not going anywhere and nobody has said that it would - but first we have to deal with here and now – and she defends the current strategy that aims to reduce the number of deaths due to this breakout. *'We need to keep the rate of infections low and at a controllable level so the healthcare systems can continue to cope with the bulk of patients. In some way it is like the winter crisis we face every year, but 100 times worse'*, asserts Prof Goura.

So is it all gloom and doom scenario that we have in store for us?

Yes, and No.

Prof Goura is cautiously optimistic and believes that a treatment might be available even before we get a vaccine. *"Remember Tami flu came on the market only in 2009. Even with all the resources we have committed to develop treatment and vaccine, it will not be before 12-18 months that we heave a sigh of relief; and then there will be issues with getting the whole world vaccinated".*

Dr Sambhi hopes that human resilience and history will give us cause for optimism. This is not the first or the last challenge we are facing. Let us not forget that the 1918 Influenza pandemic (Spanish flu) lasted from January 1918 to December 1920, and infected about a third of the world's population with loss of some 50 million lives.

However, the most urgent need of the living should not be dismissed in this race to manage the statistics and graphs. Overall, it will be a different world in terms of communication, interaction, socialization; we shall devise newer ways of working, such as working from home, and the increased use of technology.

As for my foundation year doctors, the reward will be a record in their portfolio that they conquered Corona, just as it is for me in recollecting that I made my little contribution in eradicating smallpox!

A week in the life of an Intern

Dr. Abhinav Gupta
Gen Surg Intern
St Barnabas Medical Centre,
Livingston, New Jersey, USA

(This is a perspective piece, and not a reflection of any official St. Barnabas Medical Center stance.)

Introduction

I am a general surgery intern at the St. Barnabas Medical Centre, Livingston, New Jersey, USA. I worked a week in the ICU there and would like to share my thoughts - particularly, with the fresh batch of interns that will be starting amidst these wild times. Also, these are thoughts generated from my time in the ICU with our sickest COVID patients. I can speak less to how we are treating patients outside of the unit, and even less to how we are treating patients outside of SBMC.

I'd like to commend the RWJBH system and all of its employees for what has seemed like a rapid & fluid response to a devastating disease process. (RWJBH – Robert Wood Johnson Health Barnabas Health – is the leading health care system in New Jersey).

Intubating early is key, but by doing so every one of these patients immediately requires ICU levels of care. Just about every unit in the hospital has stepped up & developed their ability to care for these patients. I especially commend our nurses and respiratory therapists - the sheer amount of labour & dedication I've seen all of them pour into patient care is astounding.

I could write pages on what an emotional roller-coaster this has been - and maybe I will one day. But for now I'd like to share what we've been doing for these patients, systematically. Again, these are simply observations from an intern, which I have written on the 14th April of this year.

Neurology

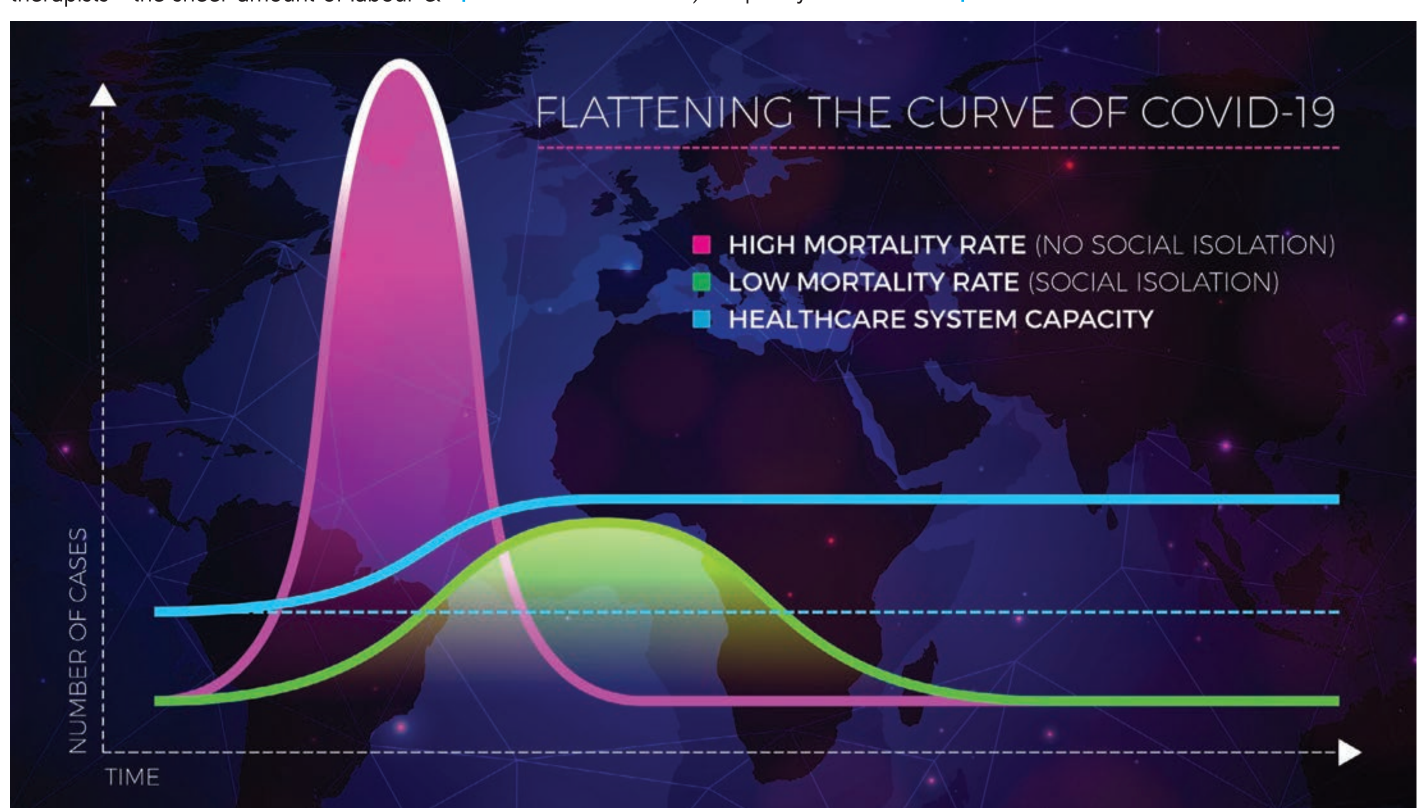
Sedate, sedate, sedate. We can't have these patients fighting the vent. Once intubated, these patients have been requiring relatively high levels of sedation. We typically go for fentanyl and versed drips, but have used / added propofol as well. We also use ketamine drips, and sub out fentanyl for dilaudid drips when necessary. Unfortunately, some of these decisions are driven by what's in stock - fentanyl, versed, and propofol are all in high demand worldwide. The bottom line - sedate the patient however you can. If you're using a BIS monitor, we generally aim for a BIS of 30-60. On a related note, we've also pushed paralytics, and generally start a drip (preferably Nimbex; but we use vecuronium as well) to paralyse all of the intubated patients we prone (more about proning below).

Cardiology

All of these patients immediately get a central TLC and an arterial line after intubation. All of their pressures drop at some point - either secondary to the disease process, positive ventilatory pressure, and/or our own tendency to keep them dry - and at that point, we generally start a norpinephrine (levophed) drip. If we're lucky, all they need is a wee bit of levo (up to 10mcg/min) before weaning it off. If we're not, other pressors we've added include: vasopressin, phenylephrine, and angiotensin II. Of note, we've seen all sorts of arrhythmias develop in these patients. Keep an eye on those rhythm strips.

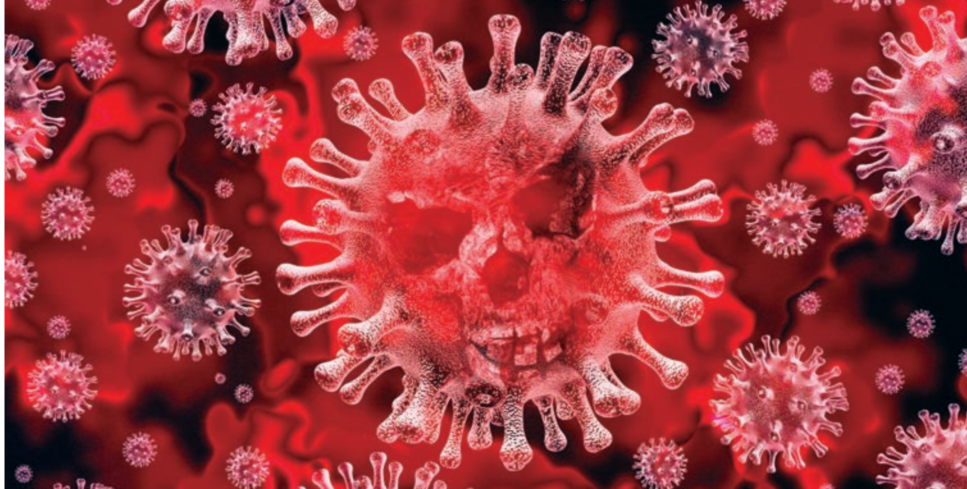
Pulmonary

Obviously the system most attended to, and why you should praise your respiratory therapists every day. These lungs aren't exactly like ARDS lungs - especially in patients with no comorbidities. These lungs tend to hold on to their compliance, at least in the beginning. There still is a lot of debate



regarding ventilator settings, so I can only offer settings I've seen work: pressure control with PEEP at 15 & FiO2 at 100%, aiming for tidal volumes of 450-550, adjust respiratory rate per the ABG and wean (FiO2 before PEEP) as tolerated. Generally speaking, most healthcare providers are more comfortable with volume control and the ARDS protocol - low tidal volumes (4-6 cc/kg) and high PEEPs. I've seen that work too. I honestly don't know enough about pulm / crit care to offer more insight.

I will say, however, that early proning does tend to improve oxygenation in these patients. Unclear whether proning truly affects mortality in the long run. Our criteria for proning has been somewhat nebulous - in general, if FiO2 requirements have not improved and it's within the first 3 days of intubation, we trial proning at least once. Important things to consider when flipping a patient: tubes, lines, and pressure points. We are lucky enough to have a dedicated flip team (consisting of mainly OR staff) that comes by in the AM & the PM.



Gastrointestinal

These patients all get an OGT or NGT at the time of intubation. We start feeds ASAP – ideally concentrated and continuous, or bolus feeds if the pump is unavailable. We start a bowel regimen on all of our patients, since they usually are on high doses of opioids. We use PO pepcid for stress ulcer prophylaxis when we can, but use PPIs as well. Luckily not too many issues on this front - most of our patients tolerate enteral feeding just fine.

Endocrinology

All of our patients have at least a Q6hr insulin lispro sliding scale on board. Some don't need it at all, while others come in with a blood glucose in the 900s requiring an insulin drip. COVID seems to have a pronounced effect on glycaemic control, possibly due to an inflammatory effect on or response by the pancreas. Regardless, watch & treat those sugars - this goes doubly for diabetics.

Genitourinary

This has been the most confounding system for me to grasp in these patients. For some reason, many of our patients develop acute renal failure that appears prerenal in nature. The dilemma lies within adequately hydrating the patient without fluid overloading them and potentially worsening any pulmonary oedema / effusions - a fine line that presents differently for each patient. Some patients we bolus; some patients we diurese; some patients we end up doing both. Insert a Foley and closely monitor fluid balance. We essentially dialyze for only 3 problems - (1) hyperkalaemia (2) fluid overload or (3) severe acidosis. Despite our best efforts, so many of these patients require temporary haemodialysis (HD) vs. continuous renal replacement therapy (CRRT).

Infectious Diseases

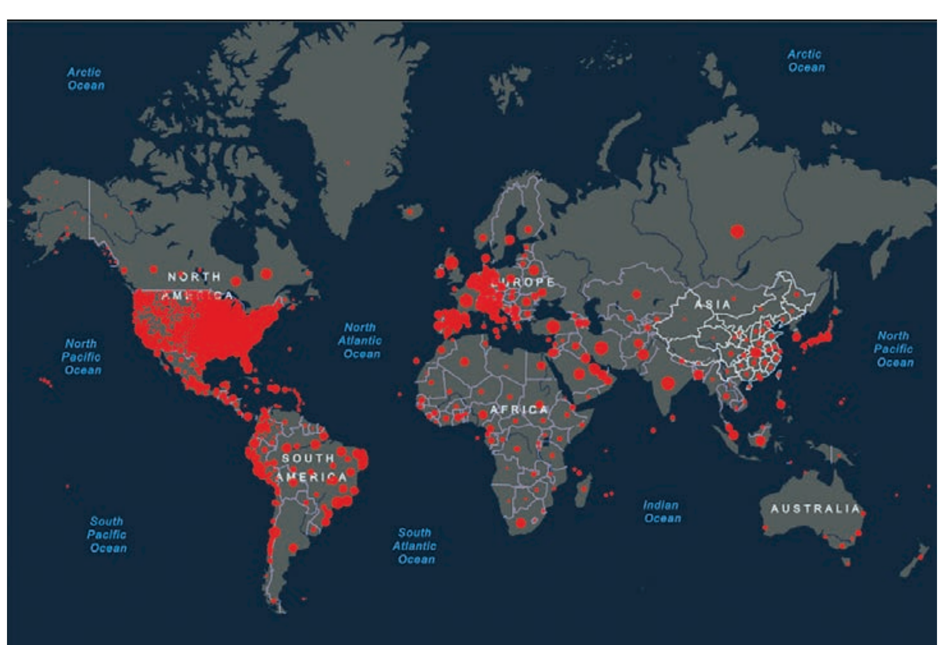
Our Infectious Diseases doctors need special mention and praise for their efforts for tearing through the entire hospital each and every day. Obviously the data is limited here, and we're not quite sure yet what really works. Is this just a viral pneumonia? or is it multiorgan failure secondary to some thrombotic and / or inflammatory cascade? The aetiology doesn't matter as much in the critical care setting, but we obviously try our best to treat the underlying cause. Every patient gets hydroxychloroquine (400mg Q12h for the first two doses, then 400mg daily after that) unless their QTc is well above 500 (I haven't seen anyone go into torsades yet). The rest of the care here has been variable. Some patients get azithromycin if we suspect an atypical infection; most patients get broad spectrum antibiotics if we suspect a superimposed infection. We've started clinical trials on IL-6 antagonists, and more recently have green-lighted convalescent plasma therapy. We'll just have to wait and see what works.

Haemotology

Another confusing piece of the puzzle. Almost all of these patients come in with grossly elevated D-dimer and fibrinogen levels. If these patients need temporary dialysis, most of them have issues with clotting off dialysis filters and catheters. Even though the signs are pointing to an extremely hypercoagulable state, we still haven't seen much benefit to starting these patients on therapeutic anticoagulation. That being said, some of us suspect a large pulmonary embolus might be the final insult for our patients who suddenly desaturate, decompensate and die within minutes. I'm not sure what the right answer is here.

Conclusion

To me, this terrible tale is still unfolding. Treatment strategies are constantly evolving - none of the above should be interpreted as "best practice". I won't lie - people are dying. But we're also seeing people survive the acute phase of their infection, get extubated and subsequently walk out of the hospital. We absolutely cannot lose hope. We will continue our full-court press on this miserable pandemic. Thanks to all of the people outside of hospitals who are supporting us and doing their part. I hope everyone is well.



Left: A world map of cumulative confirmed cases of Covid-19 produced by the Center for Systems Scientific and Engineering (CSSE) at John Hopkins University (JHU), dated 1 June 2020.

Covid-19 Medical Quiz

Dr Kalpana Upadhyay FRCOG
Consultant in O & G,
Wrexham Maelor Hospital
North Wales

***Question 1**. The acronym SARS-CoV-2 stands for:*

a) Serious acute respiratory syndrome corona virus 2
b) Symptomatic acute respiratory syndrome corona virus 2
c) Severe acute respiratory syndrome corona virus 2
d) Severe accelerated respiratory syndrome corona virus 2

***Question 2**.*

Without any mitigation measures like social distancing the Ro (Reproductive number) for Covid 19 has been estimated to be:

a) 2.0 - 5.0
b) 2.2 - 3.3
c) 2.9 - 5.4
d) 1.6 - 2.2

***Question 3**. True or false:*

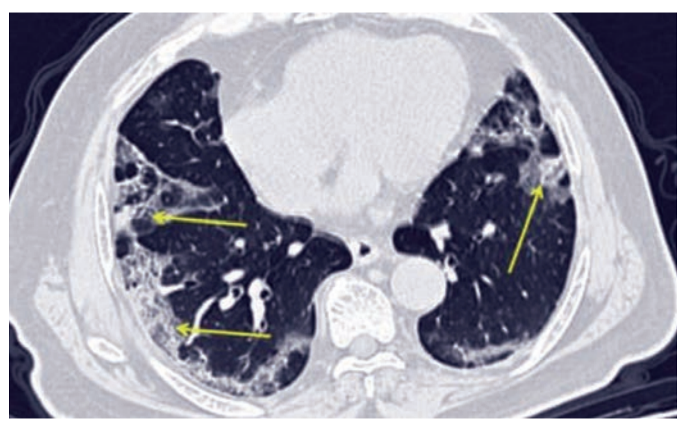
a) Covid 19 survives longer on cardboard than steel
b) Indian women are more at risk of infection than Indian men
c) Lymphopenia is the most characteristic finding in lab test for Covid 19
d) Transmission can be both – via droplets and airborne

***Question 4**. The symptom of loss of taste in Covid 19 is known as:*

a) Akinesia
b) Anosmia
c) Aguesia
d) Achalasia

***Question 5**.*

The picture shows characteristic findings of Covid 19 lung disease on CT scan. Please describe the findings.



***Question 6**.*

Which of the following body fluids from infected individuals has not shown to have the presence of Covid 19 viral RNA?

a) Saliva
b) Peritoneal fluid
c) Semen
d) Amniotic fluid

Answers on page 24.

Coping with Anxiety

1 Limit the amount of time you listen to the News.
2. Use trusted sources only for information – Gov.uk / NHS.
3. Limit listening / reading to social media news / WhatsApp – Have frequent breaks / Mute things that triggers.
4. Wash hands – not OCD.
5. Stay connected with people, particularly to those for whom you care.
6. Work through your to-do-list / Read a book.
7. Routine / Do something useful everyday / Have some variety.
8. Access nature and sunlight whenever possible.
9. Eat well/ Keep hydrated.
10. Exercise.

APPLE Technique (UK)

- **Acknowledge:** Notice and acknowledge the uncertainty as it comes to mind.
- **Pause:** Don't react as you normally do. Don't react at all. Pause and breathe.
- **Pull Back:** Tell yourself this is just the worry talking, and this apparent need for certainty is not helpful and not necessary. It is only a thought or feeling. Don't believe everything you think. Thoughts are not statements or facts.
- **Let Go:** Let go of the thought or feeling. It will pass. You don't have to respond to them. You might imagine them floating away in a bubble or cloud.
- **Explore:** Explore the present moment, because right now, in this moment, all is well. Notice your breathing and the sensations of your breathing. Notice the ground beneath you. Look around and notice what you see, what you hear, what you can touch, what you can smell. Right now. Then shift your focus of attention to something else - on what you need to do, on what you were doing before you noticed the worry, or do something else - mindfully with your full attention.

My Covid-19 Chronicle:

Mr Mayur Chawda FRCS
Consultant Trauma & Orthopaedic Surgeon
Ysbyty Gwynedd, Bangor, North Wales. LL57 2PW

My own learning as a human being!

I wrote this over a period of past few weeks since start of the Pandemic. During this time, I fell victim to the disease and experienced a period of self-isolation. I share some of those emotions here with you.

As we go over the first peak of the SARS-CoV-2 virus (COVID-19) in the UK and most of the world, we take a little sigh of relief, soon followed by great deal of anxiety about the future of the post-Covid era. The relentless march of this pandemic has indeed made humankind to go on a bit of retreat; the fragility of human life has been laid bare; we despair but stay resolute in our prose. The glare of ghoul from this virus and creation of makeshift mortuaries, sends shudders down the human skeleton.

The virus has travelled the continents freely, as if national borders are arbitrary. In doing so proving that borders are 'a misguided human creation' and 'Nature' is above and beyond those frivolous segregations! Indeed, teaching a lesson to humans that earth is for every living species and not just for humans alone. This Covid-19 virus has shifted those tectonic plates to create a 'quake', the might of which is beyond human comprehension. The social norms are changing and 'being social' may mean being in 'social isolation'. The loving hug is becoming 'thing of the past' and a 'friendly hand' needs to be 2 metres away - a distance often referred in the yore as the space needed for a grave! The depravity of this 'virus' Armageddon has started to unfold!

The very word 'Lock down' was used in the 1970s for the extended state of 'confinement' for inmates of a prison or a psychiatric hospital. Now that has become the norm over this planet with 'human beings' in confinement - almost akin to a 'human zoo'! In 19th century America, 'lock down' was a wooden peg, which held together the timber of a raft. Isn't it a wistful irony that the present 'human confinement' is named after a mechanism which once ensured safe travel to great outdoors?!

As governments take harsher & mercurial measures, fear grips our psyche, we look into declination of freedom with each passing day. We shelter ourselves indoors, just like those 'cavemen', away from the danger outside, but they continued to be creative by doing 'carvings' in those caves and uplifting their spirits. We used to enjoy visiting those ancient sites and taking pride in those endeavours of 'humanity'! It may reinvigorate ourselves in the knowledge that innate instincts of 'survival' and 'creativity' passed on to us in our genes by those ancient 'cavemen' is irrefutably triggered.

This pandemic has brought out tremendous acts of kindness, or indeed unleashed that constitutional selfish behaviour of some 'individual hoarders' as seen by those empty shelves of super-markets! This virus has unravelled the true 'character code' of human in a shameless way! The French philosopher Rousseau believed that the 'goodness of humanity' is more likely to prevail over misanthropy, as we have seen in the vast majority of acts of kindness and generosity by our fellow human beings!

Increasingly we have started to look at nature for solace in this time of lock down, it never ceases to inspire, continuing its procreation in its own stoic way! People are hearing the dawn chorus of ravens in our inner cities instead of the dull hum of traffic. The visits of foxes, ducklings and badgers to a few suburban gardens makes the days in cocooned suspension more exciting with inter-generational family rituals. Nature continues to nourish us and has enabled us to connect with our 'soulful self'! Those pure sensual experiences may just ignite that primordial human spirit, to join in the efforts to repudiate this martian menace, but with equal measure of humility and reconciliation towards nature.

The sighting of whales in the Bay of Mumbai or the magnificent backdrop of Himalayas being seen in Jalandhar, some 230 km away, is a very grim reminder of the 'planetary price' we pay for our 'progress'. There were pictures of city skylines pre- and post-Covid-19, pollution free, a solemn cognisance of the state of affairs; indeed, the beguiling behaviours of 'mankind' have been unveiled by this ubiquitous virus!

As a hospital trauma & orthopaedic consultant, the personal lesson for me has been a realisation that I am only a minuscule part of the system. The cog wheels, big or small, are so interdependent on each other for ultimate smooth running, with so many other tasks performed by other workers to keep my patients safe. An even more humbling experience was to wind my clock back some 15 years and hold a bleep, doing front-line help to injured patients coming through A&E whilst some junior members of our team were deployed on a Covid ward. The realisation of 'going back to your roots' has its own personal lessons!

The calm and smooth drive to work due to the paucity of vehicles on the road gave me some more reflective moments on the way to work. Listening to the radio, the great acts of humanity displayed by fellow citizens across the country provided me that 'much needed food for soul' to keep me going despite the 'PPE' scare stories. The day starts with total nervousness, but ends with some levels of satisfaction. I don't know what's coming next, but I hope to survive to tell my story when our world has left this pandemic behind.

The depth of gratitude expressed towards the work of so many lesser known elements of the society has been very poignant. Self-less acts of chivalry by so many ordinary human beings and tireless efforts from 'key workers' has kept the lifeline of the nation running.

This crisis has made us think about the value of plenty of low paid workers and other frontline staff, who proved that they are not going to be forgotten... my own humility in recognising their value to society has been a great leveller for satiety of my soul.

The pursuit for cure and vaccine is on, the quest for how this zoonoses had transmission to humans is also on, talk about bats, a scaly anteater creature Pangolin as an intermediate host, or indeed creation of virus in the lab. Perhaps the human quest for the 'exotic food' has something to do with it, or perhaps those exotic food producing farmers were pushed to the very edge to almost wilderness coming in contact with ever more dangerous animal viruses.

So, to prevent any future pandemic mankind will have to address a question about human food production industries and distribution chains. The word 'sustainable' will have to take centre stage. More emphasis on distribution equality, and less on mass-scale profits-driven production. We need to see nature as more than a comfort blanket to grab in the dark. We cannot go back to exploiting nature at current levels, and not expect the dire consequences. That means we will need to change our lives, and lifestyles – not just during lockdown, but for the future too!

Author David Quammen wrote *"we cut the trees, we kill the animals, cage them and send them to market. We disrupt the eco system and shake viruses loose from their natural hosts. When that happens, a virus needs a new host, often we are it".* Never again should we allow a comforting falsehood to trounce a painful truth. Worth remembering wise words of Rudyard Kipling: *"If history were taught in the form of stories, it would never be forgotten".*

People around the world are feeling rudderless and adrift. Our character, resilience and courage are being tested. At such times we get inspiration from Hellenistic Stoicism showed by the great leader of Roman times, Marcus Aurelius, helping millions grappling with the Antonine plague two millennia ago. Many more pandemics have since surfaced and challenged human existence, and perhaps lessons were once learned and then later forgotten!

One thing which never got lost was true sense of '*Amor fati*'.... this Latin phrase means *"love of one's fate"*...but in a deeper sense it is 'acceptance of events', that keeps humanity going.

The German philosopher Fredrick Nietzsche, who studied ancient Indian scripture including Bhagvad Gita and Upanishads, wrote *"That which does not kill us makes us stronger".*

Stoicism, an ancient tool used since Greek-Roman times for remaining calm in adversity, holds very true in modern times too. Stoicism can often be misconstrued as having a stiff upper lip. In fact it is a deep philosophical framework, useful in providing an ethical scaffold for both everyday life and in times of difficulty. The greater the difficulty, the more glory in surmounting it. Skilful pilots gain their reputation from storms and tempests.

The comeuppance from Covid-19 for each nation has been based on preparedness for the pandemic rather than its wealth or might. The author Albert Camus, about 70 years ago, said *"Pestilence is so common, there have been as many plagues as wars in the world, and yet wars and plague always find people unprepared"*. The stark reality of today is a keen reminder of humanity's perpetual inability to learn lessons of history.

The 'lock down' has rejuvenated a lot of homes with quality time amongst loved ones, while others may have descended into a spiral of negative thinking and despair. Here is where the dichotomy is evident between the 'haves and have-nots' of the society. Then again, a basic question of wealth and happiness comes. *'Wealth consists not in having great possessions, but in having few wants'*. Wealthy are those who can find solace in their inner worlds even on limited incomes. Others may be 'materially wealthy' but lonely and completely adrift.

One hopes that future economic modelling will take into account the disproportionate health and economic impact on vulnerable sections of society. Only with an honest acceptance of the need for such social equality measures will we be able to get a better handle on such a pandemic, and be better prepared to deal with any such future outbreaks more fairly.

As we enter a period of possible 'easing' of the 'lock down' with a mixed sense of leery sanguineness and continued consternation, we look upon scientists and experts to find better tests and a vaccine to bring an end to this annihilation. We hope that the technology and human intellect offers those solutions quickly (vaccine rush) but equally, we hope, there is abundance of 'humility' in our endeavours, unlike the 19th century era of 'the gold rush'!

Basic questions are raised. We are learning arts of life as well as the activities of purpose.

According to the Japanese tradition, everyone has an IKIGAI- *'a reason to get up in the morning'*. A reason to enjoy life. Where does my own Ikigai belong? The four circles - that which you love, that which you are good at, that which you can be paid for and that which the world needs. Juxtaposed to the epicentre of these overlapping circles is where we find our Ikigai – passion, profession, vocation and mission.

As we ponder and look more into ourselves, we increasingly realise that our perception of true heroes of this crisis is shifting from well-known to lesser-known people. They are the real heroes of this crisis. Our respect for those people quietly doing their jobs as 'key workers' has been rightfully enshrined in our hearts. We may be less inclined to be enthralled by celebrities, politicians, 'A'-listers or millionaires, and we may just warm up to those other 'real heroes' in the 'after Corona' era! The Thursday evening ritual of 'clapping for the key workers of this crisis' has increased our 'moral capital' greatly. Our society may be heading towards financial deficits of epic proportions, but if society continues to behave in a humane way our 'moral capital' may be just sufficient to cope with any financial hardship that ensues this crisis.

The heart-warming story of 100-year-old veteran Captain Tom Moore's walk, raising more than £32 million (at the time of writing) for the NHS, is a true solace amidst the Coronavirus epoch.

Though humanity is facing atomised existential crisis - untampered by other distractions, we are discovering our own ways of dealing with this. This was Captain Tom's 'inner calling'!

Metaphorically that 'inner calling' is hidden behind that 'mountain of materialistic world'. What a befitting way to end this chronicle by recalling Rudyard Kipling's own 'inner calling', who upon hearing a voice, as bad as conscience, rang interminable changes, which brought about everlasting 'whisper', day and night... this is that 'seminal whisper' of our generation - listen to our inner calling:...

"Something hidden. Go and find it. Go and look behind the Ranges Something lost behind the Ranges. Lost and waiting for you. Go."....

We hope that one day we will return to normal or 'new normal'.... but till then we keep searching our Ikigai!

WWL & Covid-19:
An appreciation

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The one prevailing notion I have regarding the pandemic we find ourselves in is that we have achieved the impossible. To start from the beginning, my earliest memory regarding coronavirus comes courtesy of a particularly panicking nursing colleague who was obsessed over Covid-19 updates when they still seemed a world away and she was planning her own personal crisis management. Very few, of course, could have predicted how our lives would be remodelled by SARS-CoV-2 but what I want to share with you today is not our shortcomings, but what we have managed to do successfully and against all odds.

Working as a junior doctor at Royal Albert Edward Infirmary (part of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust), I experienced a swirl of rumours about confirmed cases and admissions of Covid-19 cases to our hospital when its arrival in the UK was confirmed. Numbers increased precariously from ward to ward, colleagues to colleagues. Working on a negative ward at the time, we all feared coming back to work on Monday and being faced with the reality of FFP3 masks, social distancing and aerosol-generating procedures. More so, we were confronted by the idea of being frontline workers. Our place of work, where people come to be cured, instead being transformed into a battleground where survival seemed unlikely.

In reality, I have only been pleasantly surprised by our hospital's response to this once-in-a-lifetime challenge. We were mentally prepared for the affront, with daily email newsletters providing both advice, updates and stories of defiance. Hospital management held various forums for staff where we were prepped for upcoming changes and our concerns addressed. There was a real feel of teamwork and collaboration, as the virus had struck London and the Midlands first, we could learn from what our colleagues had already experienced. Most dramatic of all, we saw the floorplan for Bryn Ward, an emergency 50 bedded Intensive care/Non-invasive care unit built by the Army in 6 weeks to help provide more beds for critically ill Covid positive patients. With its inauguration this week, it will function as an invaluable asset to the region's fight against COVID-19.

Our one main success story, and the reason why I feel a certain amount of admiration towards WWL, has been PPE. My ward converted into a positive area over the weekend with a healthy supply of full-sleeve gowns, FFP3 masks (mask fit tests which had been carried out well in advance), face visors and disposable gloves. Our safety was prioritised, and staff were encouraged to wear whatever PPE they felt they needed to feel protected in their roles. Our Trust has never been involved in the national conversation around PPE, and I must commend the hospital managers for what must have been an invisible struggle to procure more equipment. Conversing with colleagues in different Trusts, I have found them struggling with dangerous shortages and having to put their own life and livelihood at risk. With the introduction of the reusable respirator masks with replaceable filters, we seem to be ahead of the country's average supply, with it becoming available to staff in negative areas as well.

Staff safety alongside patient safety has become the pillar of WWL's response to the virus. Testing of staff was introduced early and streamlined at Leigh Infirmary, providing much needed reassurance to apprehensive colleagues. Furthermore, hotel rooms were made accessible to positive staff so they could protect themselves and vulnerable family members. I personally have never felt more valued as a member of the NHS. We have graciously been offered free meals daily in the canteen, alongside abolished parking fees and scrubs donated from local groups. The appreciation from our own hospital alongside the national gratitude expressed every Thursday at 8pm has kept our morale high and our work meaningful.

As a BAME member of staff, I can clearly recall the first three doctors who fell victim to COVID-19. Their ethnicity only became more contentious as ethnic doctors and staff continued to die from the pandemic at a higher rate than their Caucasian counterparts. Various research studies have now been held that illustrate BAME staff's susceptibility to COVID-19. In WWL, 60% of all medical staff were identified as BAME and risk assessments were carried out promptly and actioned. Many were redeployed to Green (negative) areas when staff were identified as being high risk and many have been shielded with arrangements been made for them to work from home. Our hospital has also had the privilege of employing ten international doctors this week, who had been stranded in the UK after passing their PLAB but pending GMC registration. As well as providing these doctors with their income, they will also be risk assessed and will work under the same terms and conditions as local trainees.

Wrightington, Wigan and Leigh NHS Foundation Trust's effort to fight the virus has truly been exemplary, and its efforts to ensure continued patient care together with staff safety should be commended. Our Trust was able to increase ITU capacity from 8 to 50 in the matter of days. We have shown ourselves to be a highly efficient organisation. Personally I was one of the many staff who did catch the virus and I am lucky to have since fully recovered and gone back to work. I have always had the hospital's full support and it has never occurred to me to blame anyone as I know they are doing the best they can.

Covid-19 Pandemic: Social Isolating & Distancing– Perils & Benefits

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The world may never be the same again. We are all gripped by fear of the Covid-19 virus and worry over whether we will be affected and whether the health system will be able to cope[1]. As a result, current public health efforts have focussed on limiting the spread of the infection and expanding the capacity of acute medical care, especially intensive care.

However, this crisis also inevitably affects our mental well-being. It is understandable that during such a crisis, we will all experience some degree of fear and anxiety, with concern about the emerging illness and its consequences, including economic recession have negative impacts on our health. In addition to these anxieties, we also have to learn to adjust to the disruption of our daily lives resulting from the measures that have been implemented to contain the virus. The terms social distancing, self-isolation and quarantine are now familiar to us all.

In addition to the anxiety associated with catching COVID-19, concerns for the safety of friends and loved ones, economic worries and about the health systems, can also be considered indirect traumatic impacts.

Impact of Social Isolation & Loneliness

One of the main measures instituted in the UK, and other countries, to limit the spread of the pandemic is social distancing and self-isolation. Social distancing involves staying at least 2 metres from other people, not to gather in groups, staying out of crowded places and to avoid mass gatherings. Self-isolation involves staying at home; not travelling to work, school or public areas; not using public transport including buses, trains, tubes, trams or taxis; avoiding visitors at home; asking friends, family members or delivery services to carry out errands such as delivering groceries, medications or other shopping. These measures are likely to continue to some degree for a number of months, even as the lockdown is gradually being lifted. There is existing evidence that social isolation and loneliness can have a detrimental effect on mental health and well-being under usual circumstances. Indeed, in recognition of this, the UK Government launched a 'Loneliness Strategy' in October 2018 to try and address this issue.

Disasters and traumatic events are well known to have potential negative effects on mental health. In addition to this, COVID-19 is unique in that it is a global event, whereas disasters are often limited geographically. Measures required to contain the virus such as social distancing mean that individuals and communities cannot utilise their usual coping strategies. It is important that we find other ways to come together as individuals and communities to cope with the mental health impacts of the virus, We have already seen some evidence of this, with the development of COVID-19 mutual aid groups and other local volunteering efforts. Are there also perhaps several unexpected benefits during this time of social distancing that we may wish to hold onto?

Social isolation and loneliness are different but related concepts[2]. Social isolation is an absence of social interaction, social structures, and engagement with wider community activities or structures i.e. it is an objective measure of the number of contacts that people have. It is related to the quantity and not the quality of relationships. Loneliness is an individual's subjective sense of lacking connection and contact with social interactions to the extent they are wanted or needed. Loneliness and social isolation also share many factors that are associated with increasing likelihood of people experiencing each, such as deteriorating health, and sensory and mobility impairments. Social and community policies have struggled to grasp these complex interlocking problems[3].

Arguably, there is a significant overlap between these two concepts with social isolation being one of the biggest predictors of subjective loneliness and both generally having negative effects on health and wellbeing. The impact of social distancing and isolation due to COVID-19 is thought to exacerbate these negative impacts. A recent general population Ipsos MORI survey conducted this year revealed widespread concerns about the COVID-19 pandemic and its potential impact on mental health[4]. A key finding from this study, revealed that just over one in five (21%) of people were concerned about social isolation, and also not being able to go out in general (18%)[4]. Further to this, 4% of people were also worried about loneliness.

Similarly, a recent review on social isolation associated with quarantine in Healthcare Workers and people who work in Isolated, Confined and Extreme settings (ICE) highlighted numerous adverse effects of being quarantined[5]. These included increased emotional disturbance, depression, stress, difficulty sleeping, low mood, irritability and anger. Some of these negative affects persisted even after quarantine was lifted.

Specific stressors included greater duration of confinement, having adequate supplies, difficulty securing medical care and medicines. In the current pandemic, home confinement, shielding of large swathes of the population for indefinite periods with conflicting messages for indefinite periods from Government and Public Health Authorities, will most likely intensify stress.

It is also important to be aware that the impact of COVID-19 on mental health could be direct or indirect (Table 1).

DIRECT	INDIRECT
- Lack of contact with family, friends and community. - Changes to daily routine. - Lack of personal space within a household - Lack of outside space.	- Inability to get to work. - Unemployment. - Financial impact. - Fear of the virus preventing people from taking opportunities to enhance their health.

Table 1. Direct and Indirect impacts of COVID-19 on mental health

A matter of particular concern is the fact that individuals and groups who are being asked to self-isolate for an extended period during the COVID-19 pandemic are potentially those who are already most at risk of social isolation and loneliness such as those living alone, the elderly, or those with pre-existing physical and/or mental health problems, institutionalised persons, and children and adults with learning difficulties.

The usual solutions to tackle loneliness centre on increasing human connections. However, This is not so easily done in the context of the pandemic when we are being urged to remain at home and avoid contact with family, friends and local communities. However, since we are fortunate to live in an era with increasing communication technologies, we need to facilitate innovative ways of allowing those from the most vulnerable groups to utilise these technologies for human connection given the pre-existing disparities in access to or use of digital technologies. One such positive example during these times of lockdown has been a free daily internationally live streamed mindfulness meditation and discussion session led by Jon Kabat-Zinn, founder of the Stress Reduction Clinic and the Center for Mindfulness in Medicine, Health Care, and Society at the University of Massachusetts Medical School.

Coping and Support Strategies

Whilst COVID-19 affects us all, the impact will be different for different groups. The general strategies to support everyone include:

- Clear communication of the risks and plans to manage them by the Government.
- Having meaningful activities to do.
- Trying to develop a routine.
- Ensuring basic supplies including food and medicines.
- Making use of available resources i.e. telephone calls and virtual social connections.
- Minimising consumption of news media.

On the milder end of the spectrum, many socially isolated individuals could be normalised, providing a usual reaction to this kind of stress and pointing out that most people manage even in the worst circumstances.

It may be helpful to make a list of what one can and cannot control right now and focus on what one can do (Table 2).

CONTROLLABLE	UNCONTROLLABLE
- Regular routine setting. - Contacting friends and family. - Switching media off. - Exercise. - Self-care.	- Let go of what I cannot control. - The actions of others. - How long it will last. - Work well from home. - Future predictions.

Table 2. Controllable and uncontrollable factors that may contribute to mental wellbeing

For the High Risk Groups

Health and social Care perspective can now be facilitated online for the majority of people. Online community support groups and networks on social media platforms such as Facebook, Twitter, Skype and WhatsApp have rapidly expanded during the COVID-19 pandemic. Entertainment is also now easily accessible and available through a number of online platforms.

However, many high-risk individuals and groups are economically disadvantaged and may have limited or no access to the internet. These individuals and communities require access to additional support provided by volunteers for assistance not only with basic needs, such as shopping, but also for companionship and community support if needed.

Immediate interventions:

Determine the best way of signposting and delivering mental health services for vulnerable groups including online clinics and/or face-to-face based on need. Some may need admission and assessment.

Long term Interventions:

This should focus on prevention and treatment of mental health symptoms, whilst boosting coping and resilience[6].

The most effective interventions for social isolation and loneliness involve a community development approach, productive engagement and adaptability. However, the quality of evidence for the majority of interventions remains weak. A recent review providing new insights into the treatment of socially isolated individuals has recommended that future interventions should focus on[7]:

- Targeting socially isolated and/or lonely individuals.
- Having a sound theoretical basis.
- Using established therapeutic approaches with specialist facilitators.
- Involving active participation of individuals.

Positives of Social Distancing and Social Isolation.

As discussed, prolonged periods without social contact are usually associated with negative effects on mental and physical wellbeing and there is a wealth of evidence and research demonstrating the psychological downsides of loneliness and social isolation. Despite these psychological truisms, under the right circumstances, solitude can have psychological benefits and be restorative.

Henry David Thoreau, a transcendentalist, best known for his book 'Walden', famously reflects on the virtues of extended periods of solitude. In it he surmises, *'I find it wholesome to be alone the greater part of the time.'*

Indeed, spiritual ascetics from various traditions including Buddhism, Christianity, Hinduism, Islam and Sikhism have long professed the benefits of solitude. Rabindranath Tagore lauded that *'solitude is a world in itself, full of wonders and resources unthought of.'*

Adi Sankara, the great Hindu saint says ***"Nissangatve Nirmohatvam, Nirmohatve Nischalatatvam, Nitchalatatve Satsangatvam, Satsangatve Jeevan Mukthihi"*** *(Self-exile improves self realisation, concentration freedom from desires and steady mind and finally freedom from life bondage).*

Meditative practices, such as mindfulness, Yoga, Pranayama (Breathing Techniques) under the right circumstances, can also lead to a reduction in stress. However, it should be noted that the productive benefits of social isolation, as given in the examples above, are achieved by individuals entering solitude voluntarily. Involuntary social isolation for many individuals during the COVID-19 pandemic may therefore be more likely to have a detrimental mental health effect.

Nevertheless, many of us during this time, will at some point find ourselves with more time for ourselves and with fewer commitments. If possible, we should try and see this as an opportunity to not only introspect but also to explore and develop new skills from gardening to cooking for example.

Conclusion

Emotional instability, stress reactions, anxiety, and other psychological symptoms are commonly observed during and after a disaster including a pandemic. The psychological effects can be profound and have a significant impact at an individual and community level.

Most affected individuals recover with time, and various interventions may facilitate recovery. In some cases, recovery remains incomplete leading to persistent mental health problems. There are a number of factors affecting the population to varying degrees and it is important to focus support and interventions towards identified high risk individuals and communities.

During this period of increased social isolation and social distancing there are numerous adverse mental health effects to be expected. However, there are also some potential psychological benefits that may be cultivated. It is important to understand that the current issue we face is a truly global in nature. We are not in this alone and one should not leave others to think that way either. For individuals who are not self-isolating, think about those who are in your network that you have not heard from in a while and perhaps reach out.

Our way of living may not be the same, and we may be witnessing the start of the new abnormal. Perhaps it is an opportune time to finally co-operate on an unprecedented scale to strive for peace, harmony and truth as per a Vedic prayer from Yajurveda:

Om Dyau Shanti Rantariksha Gwam ShantiPrithvi Shanti Rapah

Shanti Roshadhayah Shanti Vanas Patayah Shanti Vishwed Devah Shanti Brahma Sarvag Wam Shanti Shanti Reva Shanti Sa Ma Shanti Redhi Om Shanti Shanti Shanti

Translation:

May peace radiate there in the whole sky as well as in the vast ethereal space everywhere. May peace reign all over this earth, in water and in all herbs, trees and creepers.

May peace flow over the whole universe.

May peace be in the Supreme Being Brahman.

And may there always exist in all peace and peace alone. Aum peace, peace and peace to us and all beings!

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Do Doctors need HR support?

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This morning, I had to visit my family doctor's clinic for a routine examination and to get a refill of my quarterly medication. Fortunately, his office informed me early in the morning that the "examination" will be on phone due to the COVID-19 pandemic restrictions. The reason was that doctors were required to be present in hospitals and deal with more pressing cases as opposed to tending to patients whose requirements may not be as dire.

The conversation started with:
"Good morning Andy. Good to hear you. How have you been feeling?"
"Hello Doctor – I am fine. Thank you for asking."

The HR View[1]

This casual patient - doctor interaction during a visit to a family doctor shows that doctors make it a point to check the patient's welfare and well-being. Their intent is to make the patient comfortable. All of us who are visitors should make an extra effort to be kind and caring to the person who gives us a patient hearing and is an expert in finding the right solution for our ailment. However, not all interactions are pleasant, not all patients are as thoughtful, not all circumstances as genial. Some turn out to be taxing on the medical professionals both mentally and physically. We all can easily forget what the patient or the doctor has endured before the interaction. For both, a variety of factors need to be taken into account.

What are the challenges?

What are the common issues in any sector? Racism, bullying, harassment, burnout, stress, mental health issues, work load anxiety, work life balance issues, health issues, marital discord, sexual harassment, and many more issues will comprise this list[2]. The COVID-19 pandemic has without an exception proven that frontline workers and in particular the doctors and nurses are performing much more than what is in their job description, spending far more than their normal work hours in hospitals – tending to patients, solving problems, dealing with unprecedented amount of stress and as a result of their ability to do so: saving lives. Each one of us will agree that doctors and nurses need a special call out and recognition for their monumental effort, especially during these difficult times.

Does this sector face human relations issues? Of-course they do. Each country has its own set of problems. Australia in 2018 for example, had four major challenges comprising burden of preventable errors, medical information explosion, slow diffusion of medical knowledge and good care costs less[3]. Human resources should create new avenues and tools. Further, they need to provide solutions to deal with connected stress. At the end of the day, doctors and nurses are human beings and get affected by problems that affect individuals in any other sector. Globally, there may be a different set of problems that the health sector faces. In the US, PwC in an article[4] has listed six major issues being faced in 2019. This article presents a holistic view taking into considerations all sectors. This study presents digital therapeutics and connected care, healthcare skilled workers needed, tax reforms for the healthcare industry, private equity, creating southwest airlines of healthcare and the affordable health care act as the major issues.

Let us study the National Health Service (NHS) in the UK and compare similar organizations or the corporate sector in other countries wherever needed. The most empirical comparison of a hospital to any corporate organization is that the lower level staff comprising intake level nurses, admin staff, janitors who can be compared to the shop floor workers and the senior doctors and nurses to the management. The issues that the commercial sector faces can be found in hospitals and healthcare centers as well: difficult operating conditions, scheduling errors, lack of facilities, inordinate delays in solving issues, favouritism, sexual harassment, generational dissimilarities in choices sought, and most importantly the ethos that the patient, the customer in this scenario, is always "right". The demands on hospital employees lead to as many, if not more, mental issues and complications as can be found in any sector.

What we need to understand and remember is that doctors are human beings and get affected by similar issues tormenting people in other sectors. They have their own personal problem areas to handle, sometimes individually and sometimes as a team. Let us examine what some of those issues are:

- Handling patient tantrums and complaints
- Improving communication with patients and organization
- Understanding and implementing technology and its tools
- Dealing with violence by patients, visitors in work environment
- Explaining to patients limitations of the available systems and cure
- Work stress due to demands of the Health Service department
- Remaining above lucrative offers from interested third party service providers in the health sector like drug and insurance companies
- Racism and Bullying by seniors and colleagues
- Maintaining calm and peaceful behaviour in stressful work environment
- Mental health issues
- Lack of well-being for doctors and nurses

Focus Areas

Let us examine some of the major problem areas to understand issues in the health sector and compare them with what we witness in the corporate environment. The observations are from an HR lens which captures difficulties sans the examples and will certainly indicate wins and failures.

Bullying and Harassment - Across the globe, we may hear cases of bullying but no one accepts that it happens until a case surfaces to prove otherwise. Developed countries take a lead in claiming that they are above such degradation of human values in a civilised educated world. In reality, cases do emerge in the modern developed world too and discussed in hushed whispers. Bullying is a serious issue in many workplaces[5]. If cases are reported, they are most certainly heard but expeditiously attended to before the negative publicity hits the ceiling. Whether it is the US, Canada or the UK, the best of minds work overtime to understand the issue but have not been able to control these cases from happening. A video[6] that was circulated on March 06, 2020 on social media depicts a young student being attacked by another student at Riverview High School in Sydney, Nova Scotia, Canada. Bullying could be a part of the motive for violence. Someone

has filmed the entire incident instead of stopping the horrific beating and helping the victim.

In the NHS itself, data shows that reports of bullying and harassment in England rose from 420 in 2013-14 to 585 in 2017-18[7]. Some research links bullying to work related pressures and some due to the personality of the employees involved. The problem is not only for doctors but affects all levels of the staff. The senior leadership is worried because this directly leads to decline in the quality of services provided and patient care. A classic example is that a doctor after finishing his 24 hours shift is "told" to cover an absence / another shift. This results in a tired medical professional at work who is certainly not in a position to provide the best of medical care. The greater worry is the dissatisfaction level of such resources. A patient of Fenton, UK, died after he was mistakenly discharged by a "tired" physician who claimed that he was not made aware of the need of further treatment by the patient when it was clearly stated in the patient notes[8]. The physician had had two hours of sleep before he was called back at work. Who is to blame - The Management or the physician?

Racism – Unison, a public service union, brought out a study on equality and racism in the NHS on October 31, 2019. Of those surveyed, almost 11% – 879 in total – reported experiencing racist behaviour in the workplace in the last year. This compares to 15% of Black staff (and 6.6% of white staff) reporting that they experienced discrimination in 2018, in that year's NHS workforce race equality standard[9]. The NHS has introduced tough measures including withdrawing treatment to patients[10]. It is a known fact that Ethnicity is one of the prime reasons of discrimination due to racism at work. The receiving person gets it from both the customer and the superior. In the health sector, it is the patient and the senior doctors / nurses who perpetrate such a hateful practice. The presence of racism at work, leads to absenteeism, high number of sick leaves and mental health issues amongst employees. Canada too faces similar issues and therefore is quite cognisant to implement tough disciplinary measures in such cases reported. A detailed study by Sheryl Nestel, PhD in the Wellesly Institute has captured the why and how of racism and made the sector aware that stringent measures are required to be in place[11]. In December 2018, the Canadian Public Health Association presented a policy statement acknowledging that *"a person's colour, religion, culture or ethnic origin are determinants of health that result in inequities in social inclusion economic outcomes, personal health, and access to and quality of health and social services[12]."* The critical issue is that incidents are not reported for fear of reprisal. The ones, who face the indignity, depend on the NHS for their livelihood and a path to achieve their and their families' dreams. Guardian has reported that the current number of cases reported for racism in the NHS is just a tip of the iceberg[7].

Aging Workforce – In another couple of years, more than 60% of the work force will comprise of Millennials, Gen Y and Gen Z. This change in the composition of the workforce in all sectors will force all organizations to start thinking differently about how they attract, train and retain these professionals. The leaders and senior managers today are the baby boomers who continue to remain in service. However, they will eventually transition out of the service. This brings up the question of succession plan, staffing, recruitment as well as facilities, processes and practices at work to enable Millennials, Gen Y and Gen Z to handle the rigours of their role and project the attractiveness for their loyalty and retention. Contrary to misconceptions, the younger generation does wish to work. However, it would do well to remember that the vision and wants of each generation are different. The values and purpose they seek in their careers are different. Some dream of owning a shining Mercedes or a villa but others are overjoyed with freedom. A perfect work life balance for them is a win.

Ashira Prossack wrote in Forbes in May 2019 that *"Managing a multi-generational workforce requires a more flexible style of management and a willingness to embrace change[13]"*. The senior leadership is required to be prepared to listen and understand them and set expectations. The work culture should be frank, open and respectful, comprising free communication. The business in any sector including the health sector is to be run by a set of rules, regulations, processes and procedures. Once these generations understand and accept the values and culture, productivity with excellence will most certainly be delivered. Till then, chaos, distrust and confusion will prevail. Let us accept that generational diversity has become a new norm and organizations must be ready to be flexible to handle the situation.

Technology and Resources – While talking about the top 10 HR trends in Forbes magazine[14], Jeanne Meister has explained that currently we use Artificial Intelligence in some form or the other. We do see the future where humans and bots will be working side by side. Whether it is the corporate world or the health sector, there has been continuous research in finding "smart" solutions. This has led to flexible work conditions in the corporate world and harnessing the versatile use of technology. What is important is the need to reskill. There will be a need to retrain a large number of employees' right from the lowest line of workers to the C-suite. Technology has helped reduce transactional task but training comes at a cost. There is burden on the doctors too to acquire this training to enable them to function efficiently. Technology facilitates flexible working choices both for the employers and the employees. However, majority of the workers in hospitals and the health sector offices have no choice but to be at work.

To keep pace with these developments, there is an inherent requirement to check the work environment to evaluate the availability of facilities for physical, emotional and mental support. For example, surgeons need to be well rested to enable efficient use of the high end machines. This brings us to examine whether there are rooms to rest, dining facility and places to relax for the critical staff. In reality, these resources are not there in many medical facilities. The pressure of just digitising patient records can be stressful for some medical professional. Digitizing health records is an inescapable requirement, making retention and access simpler. Additionally digitizing aids to streamline processes, improve patient outcomes, and reduce costs[15]. With patient information available "online", informed decisions can be taken for patient health care. This prolific use of technology takes us to the next level of patient care where we see that the future is virtual care, ability to consult medical specialists anywhere, ability to analyze large volumes of data for doctors and lastly use of robotics and nanotechnology in medical care[16].

Burnout – Sandy Buchman, president-elect of the Canadian Medical Association stated in September 2018, that he was doing more and more with less and less support[17]. Many doctors like Buchman see their colleagues end up in hospital beds fatigued and sick due to excessive work related stress. The quality of patient care provided is directly proportional to the health and well-being of the doctors and nurses. In October 2019, the Washington Post published an article presenting that burnout is a reality in America's broken heath care system. *"It's a moral issue, a patient-care issue and a financial issue,"* said Christine K. Cassel, professor of medicine at the University of California at San Francisco, who co-chaired the committee of experts that wrote the report[18]. It is claimed that nearly half the doctors in the UK, are considering leaving the profession to improve personal well-being. Medscape, in an article on April 09, 2020, has published a survey report of 2018 which acknowledges that burnout continues to be a pervasive issue among doctors[19].

I am fortunate to be actively associated with two non-profits. In this hour of unprecedented measures in a pandemic, both of them are

contributing to the community in their own way. While most of us are working and supporting from the safe confines of our homes, these social sector front line workers are on the road, in the office, in the transition homes, with the seniors and infirm while maintaining safe distance and precautions. The doctors, nurses, health care workers and the emergency staff are there every day where they are needed. Human Resources Specialists will say that recognition in these times is essential for their well-being[20]. Burnout in these situations is a risk. For these specialized personnel, every work day is a challenge.

In all occasions and more so in tough times, leaders need to step up their communication, listen, say thank you to those who go above and beyond, and be available to the employees when they need them. Leaders need to be prepared to rejoice the small and the big victories and make use of all available recognition tools to let the employees know that they are valued and critical to the organization. This recognition for health care workers is happening in many countries including the UK. The Queen herself acknowledged the dedication and excellent service by doctors and nurses in the fifth national address to all British subjects on April 05, 2020. This supports the dictum that engaged employees deliver excellence and more value.

The actions taken

It is acknowledged that all countries have already covered a lot of ground in meeting the needs of the health sector. From an HR perspective, the most critical area of importance is the well-being of the doctor in the health sector[21]. In the corporate world, it is the employee. We need to accept the necessity of balancing human skills with technological tools. These tools have been designed to drive efficiency at work. Through this use, we need to maintain the ethical norms so that more AI techniques and devices can be innovatively created. In all these developments, the need for improving soft skills cannot be ignored. Both digital skills and soft skills together can drive the next levels of efficiency. Every avenue of resources must be challenged to arrive at the best solutions for optimum resources.

Every country has been striving to improve their health services. On 13 Aug, 2019, Patrice A. Harris, MD, MA, President, American Medical Association (AMA) has written about the need of Health Reform in the USA in the AMA Journal[22]. Although, health care in the USA is not what they wish to have, they do desire to have the highest-quality and most affordable health care for patients. Their first task is to make the health coverage affordable. On the other hand, Canada's publicly funded health care system is dynamic. Reforms have been made over the past four decades and will continue in response to changes within medicine and throughout society.

The NHS in the UK is no exception. It must be stated that the NHS's efforts in improving the conditions of service for doctors has been exemplary and the results encouraging. In 2018, the General Medical Council had asked Professor Michael West and Dame Denise Coia to carry out a study and present the impact on the mental health and well-being of medical students and doctors. The report[23] is exhaustive and educating. What is important to note is that the NHS has acknowledged the need to transform the UK healthcare environment to support doctors to take care of patients. The need for compassionate, caring and inclusive leadership has been emphasized and seen to be essential to drive efficiency and excellence in NHS. This exhaustive study has researched and put forward comprehensive initiatives comprising eight action plans arrived at after several supporting case studies. The research team has done a phenomenal job of presenting a well-researched set of initiatives especially in the area of culture and leadership, workload and working conditions. A large portion of the NHS workforce comprises immigrants and it is essentially this component of the human assets which needs training, voice and acknowledgement. Additionally it is prudent to suggest to the senior management to accept the younger employees as they are and not drive any action to mould them to be like what they are expected to be. The doctors of Gen X, Y and Z drive creative thoughts and innovate their way. They should be expected to challenge the status quo and demand what they desire.

The greatest tool in improving doctor's efficiency is recognition of their phenomenal work. Specifically during the current pandemic, doctors and healthcare workers are undoubtedly the most precious resource in the entire world, and every country, province, city and organisation is going above and beyond in appreciating the work they are doing. The contribution to the well-being and health of the people is far reaching. The NHS must invest in appreciating the doctors and nurses. This recognition pays dividends[20]. Recognition connects the doctors to the purpose and goal of the NHS. The leaders need to reach out to doctors and demonstrate their compassion and care. Any improvement work in the area of health care is directly affecting the patients as well.

The current pandemic has highlighted how critical the health care system and care workers are for a country. Our doctors and nurses literally save lives - on a regular basis. The NHS needs to build and cater for staffing and sourcing talent, be more cognisant of the issues that plague the care workers, realize the importance of their mental and physical health - specially, at a time where they are performing above and beyond their job requirements. Further, the NHS has to invest time, effort and care to ensure that the care workers can perform their assigned tasks to the best of their abilities. Furthermore, institutionalisation and structure, for care workers and the patients, will also need to be addressed for virtual health care and tele medicine. At the end of the day, if doctors, nurses and care workers are happy, well trained, cared for and focused in their role of providing excellence in patient care, the NHS will attain its goal.

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About the author:

Ajit Sinha *has an extensive background in human resources in both Canada and India, working with Alcatel-Lucent, IBM and in Canada as the Human Resources Manager for Sears and Home Depot. During his years in India, Ajit was also in the military and led HR and administration support across India in both peace and field formations. He is a Chartered Professional in Human Resources (Canada) and has SHRM-SCP accreditation from USA. He has been an Assistant Business Coach with Dale Carnegie Training. He continues to learn and collaborate.*

Beyond a culture of Civility

Mr Buddhdev Pandya MBE
Director of Policy-BAPIO
Managing Editor - Swasthya Health Journal
(pictured right)

Mr Amit Sinha FRCS (T&O)
Consultant Orthopaedic Surgeon
Editor, BIDA Journal

Institutional racism and structural inequality

Recently, the debate about Civility in the NHS has been gathering some attention. It is said that a medical environment where staff are good to each other is a safer one; and there's research to back it up.[1]

Dr Chris Turner, a consultant in emergency medicine in Coventry when he started looking at research into how colleagues in medical settings treat each other, noted that the word 'civility' came up time and time again. He said, *"It sits nicely with 'professionalism, you could use 'kindness' or 'respect' but in the end kindness is a virtue whereas civility is a behaviour."*

He explained that there is scope to change how civil people are to each other – if you can persuade them to make a conscious decision about how they behave. A 'soft skill', but respect and courtesy can mean the difference between life and death, says the Civility Saves Lives campaign.

Respect, professional courtesy and valuing each other are one of those important elements of collectiveness and collaboration working in the NHS.

Mere rudeness (incivility) can have serious negative impact in health-care, and then imagine experiencing disadvantages in daily working-lives for being of a different skin colour or culture or ethnic origin. Devalued and demoralised, full of frustration seeing yourself suffering in silence is an unsafe working environment. And that is exactly what the doctors of minority ethnic background feel in the NHS.

Those lower in the ranks of doctors face much more sinister working conditions. *"The rise in reported discrimination towards BME staff is truly appalling and shows just how far we have yet to go,"* said Professor Dame Donna Kinnair, Acting Chief Executive of the Royal College of Nursing (2019). "It is a disgrace that BME staff experience racism, lower pay, harassment and limited career progression within our health service."[2]

Let us be brutal and acknowledge that without the doctors and nurses from outside the country the National Health Service would have virtually collapsed. And, so is the story in 2019, almost seven decades after the creation of the public service, the NHS needs these professionals to come and work in the system to cope with the needs and expectations. So, we need to rest the argument; 'there are too many of them coming to this country!'. This is precisely a 'dog whistle' for those massaging their sense of superiority and nationalism without realising that Britain has a history of migration for centuries and it has benefited from it. Enough of lesions in the history and navel gazing exercise.

The British Parliament introduced the Race Relations legation in 1965, which was subsequently strengthened over the decades. Defined and redefined many times, there are enough guidance and case-law reference available to avoid any confusion over what constitutes racial discrimination in areas of employment and service provisions. Particularly, the work of the former Commission for Racial Equality; now somewhat diluted with the Equal Opportunities Commission (Founded May 1996) to keep up with the political climate!

In 2015, the NHS introduced Workforce Race Equality Standard (WRES). Its report in 2018 indicated that the BME staff make up 19.1% of the workforce in NHS trusts; there were 10,407 more BME staff in 2018 compared to the previous year. It noted that closing the gaps in workplace inequalities between black and minority ethnic (BME) and white staff working in the NHS is critical. Its evidence showed that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient.[3]

The concept of Embracing diversity is beyond the culture of 'behaviour in civility'. The ugliness non-compliance impacts not on the productivity of the NHS but affronts the very norms of 'humanity'. The NHS is one of the largest employers in the world and repeatedly pronounces 'zero tolerance' on racial discrimination and issues such as bullying. Yet, in practice at the grass-root levels manifests saturation of 'tick-box' and 'soundbite and slogans' culture to camouflage bad management practices.

The main challenge for the NHS Trusts is to tackle the subtle but highly practiced 'club culture' that allows many senior managers to collude to an extent to condone bad management practices. A report commissioned by the General Medical Council (GMC)[4] indicated that at the heart of the problem appears to be a club culture in some parts of the NHS. The report describes an insider/outsider dynamics; those most likely to be left on the outside are foreign-born and trained doctors. It said that the doctors from ethnic minorities are too often treated as outsiders by their NHS bosses and peers and not given the support they need, according to an investigation into why they are twice as likely to face disciplinary action as white doctors.

Many BME doctors would confide that when they have expressed views and recommendations based on their experiences, the system conveniently seemed to be bypassing them. While, the painful observation is very upsetting when juniors and admin staff closer to the 'club' are given more favoured options and weight to their views. The other areas of commonly shared concerns are the training and promotion when a BME doctors faces disproportionate barriers. They often find out that while they have to follow a process, while some of their white counterparts slide into positions; perhaps as a favour for being a 'fitting-in-to system'!

The findings of the 'Fair to Refer' report published 25 June 2019[5] has some interesting six key factors that can help to explain the higher rates of referrals the GMC receive from employers of certain groups of doctors;

- **Lack of Feedback:** Doctors in diverse groups do not always receive effective, honest or timely feedback because some managers avoid difficult conversations, particularly where that manager is from a different ethnic group to the doctor. This means that concerns may not be addressed early and can therefore develop further.

- **Inadequate induction:** Some doctors are provided with inadequate induction and/or ongoing support in transitioning to new social, cultural and professional environments.
- **Working pattern:** Doctors working in isolated or segregated roles or locations lack exposure to learning experiences, senior mentors, support and resources.
- **Impact of Leadership:** Some leadership teams are remote and inaccessible, not seeking the views of less senior staff and not welcoming challenge and this can allow divisive cultures to develop.
- **Blame Culture:** Some organisational cultures respond to things going wrong by trying to identify who to blame rather than focusing on learning. This creates particular risks for doctors who are 'outsiders'.
- **Insider & Outsider dynamics:** "In groups" and "out groups" exist in medicine including relating to qualifications (including by country and within the UK by medical school) and ethnicity (including within BME populations). Members of ingroups can receive favourable treatment and those in out groups are at risk of bias and stereotyping.

Based on these observations, the report made recommendations for further remedial actions.

Undervaluing most experience BME doctors, including consultants is not new in the NHS. Such practices titter at the edges of potential breach of discrimination laws. The club culture has inherited trait to work against those who are seen to be not 'fitting in' to the system; often punished for raising their head above the parapet. Knowing the void of monitoring and any realistic threat of sections practices to disadvantage the minority workforce flourish. It generates more 'hot-spots' for toxic workers relationship, bubbling under the surface for the NHS Trust to manage before the trouble surfaces.

In 2018, Dr Chaand Nagpaul, respected GP and chair of the BMA, raised issue of racism and inequality in how the NHS treats and chooses staff when he spoke to The Daily Telegraph paper in London. One of his major concerns was that he believes that the careers of black and minority ethnic (BAME) doctors are often slowed down or halted by an underlying racism. In particular he stated, was that the BAME doctors are being overlooked for senior posts. Dr Nagpaul, the British Medical Association's first non-white chair said, *"There is probably a subconscious bias that needs to be addressed."* He noted at the year's BMA summit that, at every stage in his career he had to prepare and work much harder than he would have needed to in order to secure positions.

This was also reinforced by Yvonne Coghill, Director of the NHS Workforce Race Equality Standard (WRES) director. Ms Coghil said, The low numbers of BME staff in senior roles was explained by institutional racism and structural inequality and these barriers must be *"systematically dismantled or else we are not going to get anywhere."* We must acknowledge that the WRES team have contacted all BME forums including BIDA to contact all their members to share any COVID-19 related issues with NHS England. We are aware of several concerns, but it is doubtful whether they can exert any influence to tackle these concerns.

Taking lessons from the recent highly publicised case of 'Bawa-Garba', the whole medical fraternity had to wait for an 'independent' inquiry to resolve the issue and set up solutions. When pushed, it was proclaimed to be due to 'systemic failures' but there is no doubt that the original decision of the GMC reeked of underlying 'institutional racism'. Most of the time, the reports are filed and left unopened till the next incident arises.

The expectations are that non-Executive Board members of the NHS Trusts ensure that the Chief executive Officer, Medical Director and Human Resources leadership deliver a culture of practice that embraces diversity where the BME professionals are 'valued' for their knowledge, skills and experiences. As public sector employers it makes sense to adopt high standards for the benefit of the patent; 'a Happy Doctor, means a happy patient'.

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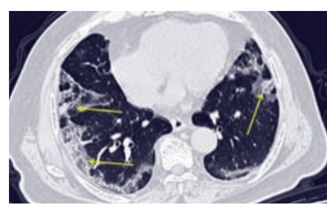
Covid-19 Medical Quiz Answers

1. C (Severe acute respiratory syndrome corona virus 2)
2. B (2.2 -3.3) The Ro (pronounced as R naught) is a mathematical term indicating how many new people can get infected from one person in the absence of any mitigation strategy like social distancing or vaccination. For Covid 19 the typical Ro rate is approximately 2.5.
3. (A) False. The virus can survive up to 72 hours on steel as compared to 24 hours on cardboard. (B) True. Among the BAME community, Indian women are more at risk than men in contrast to others. (C) True. (D) False. So far there has been no evidence that the virus can be transmitted by airborne particles. It is mainly transmitted by droplets.
4. C (Aguesia)
5. The typical features on CT scan are multiple bilateral lobular and sub-segmental areas of ground – glass opacity or consolidation (usually peripheral or posterior, mainly in lower lobes). There is no cavitation, calcification or lympha-denopathy noted.



6. D (Amniotic fluid). So far there has been no evidence that there is presence of viral RNA in amniotic fluid.

Learn, not Blame – reflections for 2020

Dr Cicely Cunningham is the co-founder of the Learn Not Blame campaign, and formerly held the position of Learn Not Blame Campaign Lead for The Doctors' Association UK. This position is now held by Dr Jenny Vaughan. This article documents her reflections on the campaign she co-founded.

Dr Cicely Cunningham
ST6 Trainee, Clinical Oncology, Glasgow

It is two years now since a wave of anger and outrage erupted in the medical world, about the unjust treatment meted out to Dr Hadiza Bawa-Garba – a hijab-wearing woman of colour. At that time it seemed like the whole profession had united around her – the common perception that each and any one of us could have found ourselves in her situation. At the heart of this was the tragic death of a young boy who was failed by the NHS – a catalogue of failures which spanned individual acts and omissions and significant system failures. The criminal courts found that Dr Hadiza Bawa-Garba (and nurse Isabel Amaro) were responsible for gross negligence manslaughter, and the General Medical Council further compounded the hurt and sense of injustice in the profession when it argued through the courts that she should never be able to practise medicine again.

Out of this seething sense of injustice came The Doctors' Association UK – a campaigning and lobbying organisation which seeks to speak up on issues that matter to UK doctors and the NHS as a whole – and the Learn Not Blame campaign. This campaign seeks to drive forward a movement within the NHS calling for a just culture, for a move away from blame, towards an NHS where staff work in psychological safety, both patients and staff are treated fairly, and real learning can happen.

The campaign was launched at an event in November 2018 in the Palace of Westminster, which was hosted by Dr Philippa Whitford MP and attended by the Secretary of State for Health and Social Care, the Rt. Hon. Matt Hancock MP. Speakers included Scott Morrish, a bereaved father and campaigner for a just culture in the NHS, whistleblower and campaigner Edwin Jesudason, and broadcaster Nick Ross.

The Learn Not Blame campaign has achieved world-wide interest and acclaim. It was praised by Don Berwick, President Emeritus and Senior Fellow of the Institute of Healthcare Improvement, who said: *"Blame, pressure, trying harder, poisons the effort for learning. And until we learn that – until leaders and all of us working in healthcare understand – that it is the joint endeavour of learning that will get us to the healthcare we want, there's no way we can make the progress we need to make. So your campaign is crucial."* The campaign has featured in mainstream and medical media, including being the subject of an article in the British Medical Journal in June 2019, entitled "Learn Not Blame: how a grassroots campaign struck a chord". It has been discussed in numerous conferences and meetings – not least, the British International Doctors' Association Annual Meeting in Preston last year.

I have now handed over the reigns of this campaign to Dr Jenny Vaughan, a seasoned campaigner who is well known to many as a voice for justice. So what are my reflections on what I learnt while spearheading the campaign?

Firstly – it is hard, but I think necessary, to hear and bring into the discussions the voices of those who have been harmed by the NHS as patients and family members. Those such as Scott Morrish, who lost his son Sam aged 3 to sepsis because of failures in NHS care. Or Susanna Stanford, who experienced a Caesarean section without a working anaesthetic. Both of these people, and many others, now devote significant amounts of time to advocating a just culture to improve patient safety. But there are also many whose voices have been less welcomed – their emotion too raw, their commentary too direct to be comfortable, perhaps, or those who are marginalised because of their ethnicity and the uncomfortable discussions that this provokes. It is important that we as health professionals who care about a just culture try to enable just access to the debate.

Secondly – real learning feels hard to come by in the NHS, and blame seems to abound, landing more on those from BAME groups than others – witness the differential levels of referrals by employers to the GMC because of Fitness to Practise concerns. For these reasons, the campaign slogan can seem hollow to some. To those who have lost loved ones in the NHS because of failings in care. To those who have risked or sacrificed their careers as whistleblowers, and have been vilified for their actions or unable to return to their previous employment. But also for those caught up in lingering conflicts in the workplace and fall out from situations where racism may have played a part. Acknowledging this is important. But just because it has proved difficult to embed learning and move away from blame doesn't mean we shouldn't try.

Lastly – this stuff is really hard. The Learn Not Blame campaign is founded on the idea that each of us can play a role in changing the culture within our own sphere of influence. All of us can create a little bit of psychological safety around us. We can listen without prejudice to all of our patients and colleagues. We can always try to see the human behind the actions and not make assumptions. We can be aware of our emotional reactions to situations and people and ensure that we don't allow this to impact unnecessarily on others. This is often referred to as the "soft and fluffy" stuff. It's not. It's hard and tiring on an individual level. Not only this, but it sometimes feels overwhelming and impossible to see this impacting at a system level, especially with entrenched biases that exist.

Despite all this, I feel that there remains a key place for this campaign in 2020. We can all be part of this movement, now ably led by Dr Jenny Vaughan at The Doctors' Association UK. Sign up at **dauk.org.uk/learnnotblame**.

Letter *to the Editor*

"Changing Face of NHS GPs – Learning new ways of Consultations"

Dr Shikha Pitalia
GP and Director of SSP Health, Secretary Wigan BIDA Division

Dear Editor,

The transformation that our GP practices have had to make during the COVID-19 outbreak has surpassed the entirety of changes I have seen in primary care over almost 30 years as a family doctor.

As a GP and Director of SSP Health, the largest GP federation in the north of England, I have been incredibly heartened by the positivity that our staff, and our patients, have shown towards these very necessary alterations to how community care is provided.

Along with many other GP surgeries across the nation, we moved swiftly to limit the number of face-to-face appointments our clinicians were carrying out to cut their potential exposure to Coronavirus and also to keep our patients safe. Within just a few days, almost all our appointments, be it with a GP, pharmacist, AP, ANP, practice nurse or other clinician, were being done via the phone or through video. Many of these appointments are now carried out from home to prevent as many staff as possible having to travel unnecessarily.

Our federated model of GP practices working together under one senior leadership team allowed us to implement change with impressive speed. Our priority was to ensure staff that needed to be shielded at home, or in many cases preferred to self-isolate, could do, and we were still able to provide staffing in our surgeries through cross-working between practices. We were also able to swiftly consolidate services successfully at another SSP practice where this was necessitated due to staffing problems.

Some of our clinicians who previously had reservations about telephone appointments understood that the pandemic necessitated this new way to treat patients. Each has embraced and adapted to the changes with professionalism and positivity.

Despite the shift away from routine face-to-face appointments, vital services such as childhood immunisations and post-natal checks continue. With our centralised team approach, we are pleased to report that we continued to be on target to achieve our usual high QoF scores, with extremely low levels of exception reporting. For 2019-20, 23 of our practices achieved 100%, four were above 99% and one was on 97.5%. Our data team continues to track these quality standards and NHS targets, as they will provide an invaluable measure of how telephone appointments have performed. Initial analysis – and anecdotal evidence from our GPs – shows they have been incredibly successful.

The Coronavirus pandemic has created an unprecedented requirement to alter the way patients have traditionally accessed local primary care services. Almost all of our patients have been happy with this. Instead of formerly insisting they see a GP; many are now insisting they do not. Of course, there are some situations where a face-to-face appointment is unavoidable and measures have been put in place to do this as safely as possible.

Our federated, super-practice model with cross-site working, centralised leadership and robust infrastructure has been instrumental in keeping our staff safe while maintaining high levels of patient satisfaction with the new ways of working.

We are still in the middle of the pandemic and it is too early to consider how primary care may have permanently transformed due to COVID-19, but it seems likely that some of the changes that have been implemented could and should be here to stay.

Dr Shikha Pitalia

GP and Director of SSP Health,
Secretary Wigan BIDA Division

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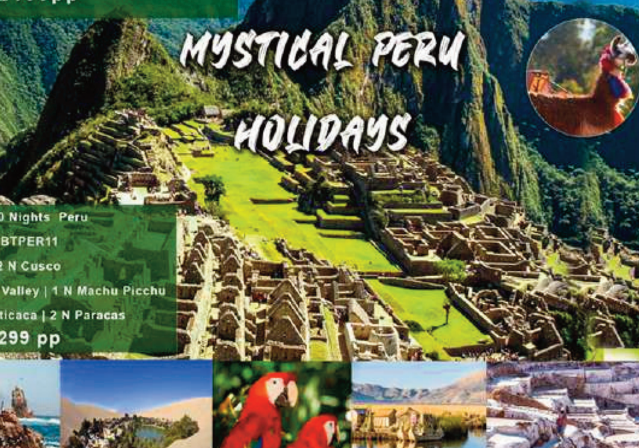

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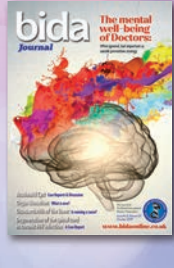

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