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The burden of Vitamin D Deficiency on pregnant women of BAME origin in the UK

Inside:

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Editorial

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

We're now six months since lockdown began here in the UK. There have been monumental changes to our society, our workplaces and our way of life. The pace of transformation has been pretty relentless for the majority of us. Many of us have still not readjusted to life with COVID-19. There are now serious concerns of a second wave.

The comforting news is that a coalition of 156 countries has agreed a "landmark" deal to enable the rapid and equitable global distribution of any new coronavirus vaccines to 3% of participating countries' populations, to protect vulnerable healthcare systems, frontline health workers and those in social care settings. The COVID-19 vaccine allocation plan – co-led by the World Heath Organisation and known as Covax – has been set up to ensure that the research, purchase and distribution of any new vaccine is shared equally between the world's richest countries and those in the developing world. We live in hope.

I anticipate that despite the serious challenges that we all continue to face in our day-to-day work, BIDA continues to be a source of advice and support for you. I would like to take this opportunity to acknowledge the efforts that all of our Members have put in during these challenging times, sometimes in very difficult circumstances.

Black and minority ethnic people continue to be more vulnerable to the impact of COVID-19. They are far more likely to say it was difficult to follow the restrictions in place to prevent the spread of infection, according to the survey for the Wellcome Trust. The survey suggests that BAME people were more likely to believe their employer's advice than anything the our Prime Minister, Boris Johnson or the government said, and trusted the NHS and Public Health England (PHE) less than white people did. The findings prompts questions about whether more could have been done to better communicate with different communities. Carla Ross, a researcher at Wellcome said, "A more targeted approach to messaging will be key to ensuring that different groups can access, understand and trust government guidance".

The need of Vitamin D to strengthen our immunity has raised a fresh understanding of how we should look after our health. We must learn to respect Mother Nature a lot more. Sunlight is absolutely essential as a source of energy to everything on our planet. Dr M Siddiqui and Dr P K Sarkar have penned in articles, which include all the latest scientific research and knowledge about this subject.

"Exceptional Leadership" and "Effective communication" are the need at this hour. Ajit Sinha has articulated his thoughts and personal experience in perspective with the essential qualities needed for a good leader. This includes empathy, compassion, communication, ability to "do" things, and to enthuse people with ideas and calmness in the midst of a calamity besides other hidden talents good leaders should have. Dr Popat and Dr Sarkar have shown the way to improve communication skills.

In the midst of this calamity, there is always a ray of hope with organisations like the Rotary establishment. Gary Williams outlines the evolution of a village rotary club to initiate its charity activities from humble beginnings to being a recognised Chartered club. Their ethos, "Service above Self", is indeed complimentary to the principles of BIDA.

Prof Kapur and his team from Imperial remind us of the dedication and sacrifices made by the BAME staff in public services. We wholeheartedly agree with their conclusion that "We owe it to the memory of staff such as nurse Amin Abdullah to show the same urgency and readily available resources to deal with issues, which affect staff wellbeing".

This edition presents a thought provoking experience of Sai Pillariseti. He has written about the struggles vulnerable sections of our society have to endure with issues of mental health.

The Editorial Board wishes to congratulate Sai Pillariseti and his team to take the lead for establishing the BIDA Student wing. They are the first organisation dedicated to representing the International medical students. Well done!

Stay safe.

A. Sinha
Editor, BIDA Journal.

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Instructions for Authors

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

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bida National President's report

Dr Birendra Sinha National President, BIDA

Dear Colleagues,

Firstly I would like to start by wishing that you and your families have all managed to stay safe and well during this Covid-19 Pandemic and continue to do so. All our lives have been somewhat massively transformed during these unprecedented times.

I would like you all to know that BIDA is fully functioning albeit in a slightly different way. Regular National BIDA Educational meetings have been carried out under the Chairmanship of Dr Vinod Gadiyar of Rochdale & Bury Division using the Zoom platform. Our Executive committee meetings have also taken place smoothly. The BIDA Journal has been up and running, thanks to our Editor Mr Amit Sinha and the BIDA Editorial board.

We would all like to express our huge congratulations to our Chairman, Dr Chandra Kanneganti who has recently been elected as Deputy Lord Mayor of Stoke-on-Trent.

Elections, which were due to take place this year, have to be put on hold until next year. We are hoping that by January we will be in a position to start this process.

I would like to remind every member that the new membership year starts from 1st October 2020. Please continue to support us so we can keep our organisation running. Payment can be made either by bank transfer (Alison at Central Office can provide details), card payment or cheque made out to 'British International Doctors' Association Ltd' unless you are already paying by direct debit.

Hopefully next year things will be getting back to normal and we can resume our normal activities such as the International Scientific Congress, ARM/AGM and our Divisional and sporting activities.

In the meantime, please stay safe and well.

Best Wishes

Dr Birendra Sinha
National President, BIDA

bida National Chairman's report

Dr Chandra Kanneganti National Chairman, BIDA

Dear Colleagues,

I hope all of you are working hard and staying safe in the current COVID pandemic. BIDA has been representing its members by both raising essential issues during the pandemic and supporting doctors in the NHS.

In the previous edition, you will have appreciated the actions taken by officers and the EC, which included our representations to the PM, Home Secretary and Health Secretary on a number of issues that have been concerning health care staff in the NHS. We have raised Visa issues, the NHS Immigration Health Surcharge, PPE issues and the disproportionate affect of COVID to BAME communities. We have also offered solutions to these problems, workng collaboratively with the BMA as well as other doctors' associations.

BIDA has raised £17K for supporting stranded International doctors appearing for PLAB examinations, and has supported a number of these doctors with the distribution of money. It's heart-warming to receive warm wishes from these doctors for supporting them in these challenging times. I would like to thank all those who have contributed to BIDA's COVID funds for this act of compassion.

BIDA is also proud to have launched its first international student doctors group as "BIDA Student wing". I would like to thank and congratulate Sai Pillarisetti, Chair of this wing, for initiating this group. BIDA Student wing has already attracted 100 members from 9 medical schools representing 13 different nationalities. Please encourage any international medical students to join this group.

BIDA officers have met regularly in the past few months and have worked hard to raise issues, offer solutions and attend stakeholders' meetings representing our members' views. There are a number of success stories of the innovative ways our members have contributed to support their colleagues in the pandemic, like Dr. Sanjay Arya, Dr. Ishaan Saxena, to name just two.

Let's continue to support others both at work and at home. I hope we can come out of this pandemic much stronger soon. BIDA's EC and officers pledge to continue to work for all our members' interests, and to strive for equality, fairness for all doctors in the NHS.

Dr Chandra Kanneganti
National Chairman, BIDA

bida National Treasurer's report

Dr P K Sarkar MBBS DRCOG MRCOG MOG FRCOG FBIDA Consultant Gynaecologist, Lancashire, UK. National Treasurer, BIDA

Dear Members,

Hope you all are keeping well and safe during this unprecedented COVID-19 pandemic.

You may be aware that due to COVID-19, BIDA central office has been out of bounds for us. However, during this difficult time, BIDA Executives have continued to run BIDA 'business' by holding Zoom meetings for strategic reasons and also responding to the impacts COVID-19 on the lives of members working in the NHS.

Due to circumstances beyond our control, very reluctantly we had to cancel this year's AGM/ARM and as a result we missed the opportunity to present out Annual Financial Report for 2019-20. However, I can assure that our financial report for the period will be prepared soon; and the audited report will be available for the approval of the finance's committee and NEC; and subsequently to our members in due course. I am pleased to report that BIDA's COVID-Fund raising campaign was a success and we would like to thank our members and friends for their support and contributions.

This is the time of the year when we will be requesting our members to pay their annual membership fees. Those members, who pay their membership fees by Direct Debit, would be requested to make sure that their Direct Debit instruction to your bank is in order. Some of you may wish to pay your membership fee with your Debit or Credit Card. As we use 'Worldpay' Card, Alison in the central office will be able to help you with your payment with just one phone call. As you are aware, membership fees are the main source of BIDA's income. Accordingly, for the smooth running of BIDA's business, I am requesting all members to renew their annual membership at the stipulated time.

I would like to take this opportunity to thank Thornton & Ross Pharmaceutical STADA group, Bolton Travel Services and Quilters Financial Advisers for kindly sponsoring a number of BIDA educational activities. I would like to specially thank our accountant Mr Zahur from Altman Smith & Company, or preparing our annual financial report and providing advice on financial matters. Finally, I extend my sincere thanks to Alison at our central office for the hard work in managing our business.

Dr P K Sarkar
National Treasurer, BIDA

bida G.P. Forum Chairperson's report

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

Dear Members,

As we go into probably the worst winters of our professional lives I would like to say a big thanks to each and every one of you for all you do for the profession.

Earlier this month there was media coverage of NHSE letter stating that GP's were not offering face-to-face appointments to patients. We challenged this notion with facts and figures and rebutted this notion and GPC wrote a letter to Simon Stevens calling for an apology and addressing our concerns.

We have been working closely with pharmacy colleagues to reduce burden on general practice and written to the Secretary of State to amend medicines legislation to allow pharmacists to make changes to prescriptions and provide a different quantity, strength, formulation or generic version of the same medicine if it is in short supply.

BMA has co-badged a template letter with the Royal College of GPs that practices can use to write to private providers offering non-approved screening tests. Numerous private companies are offering screening that is not recommended by the UK NSC (UK National Screening Committee), and there is a lack of evidence about how results of private screenings are presented in NHS services and the benefits to patients, which is a cause of serious concern.

We have been raising concerns about the test and trace system and it's effect on general practice. In addition throughout COVID we have raised concerns about the disproportionate effect of COVID on BAME population and doctors and steps needed to protect this cohort. We will keep working on this issue and will continue to do so. Please do not hesitate to contact us if you have any concerns and thanks once again for all you do.

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

Vitamin D deficiency, COVID-19 and the BAME Community

Mashood Siddiqi FRCP Consultant Physician, Liverpool University Hospital Trust, Liverpool.

Introduction

As deaths from COVID-19 rise in the UK, it has become clear that people from Black, Asian, and Minority Ethnic (BAME), are being affected in numbers far beyond their share of the population.[1,2,3,4] The ethnic minority population of the UK was around 13% at the time of the last census in 2011.[5] While the cause of this disparity is probably multifactorial, it may be associated with socioeconomic, cultural, or lifestyle factors, genetic predisposition, or differences in susceptibility or response to infection.[1] Possible reasons also include an increased risk of acute respiratory tract infections,[6] an increased prevalence of Vitamin D deficiency,[7] vaccination policies in their country of birth and its immune effects,[8] increased inflammatory burden, and higher prevalence of cardiovascular risk factors such as insulin resistance, diabetes and obesity than white populations.[9] The only factor which can be easily and safely modified, in the short term, being the Vitamin D deficiency.

Vitamin D

Vitamin D is mainly derived from 7-dehydrocholesterol, present in the skin, which is converted by ultraviolet light band B (UVB) to Vitamin D3 (cholecalciferol), an inactive precursor. More than 90% of Vitamin D originates from the skin and around 10% from food intake.[10]

There are two main forms of Vitamin D, Vitamin D3 (cholecalciferol) and Vitamin D2 (ergocalciferol), which is found in food and some supplements. Following the synthesis by skin or absorption from the intestines, Vitamin D is metabolically converted into 25(OH)D in the liver, and then to the active metabolite, 1,25(OH)2D (calcitriol), in the kidneys or other organs as needed.

Vitamin D was first recognised for its role in bone mineralisation and calcium regulation, with vitamin D deficiency associated with the bone disease rickets.[11] More recently, vitamin D has been reported to exert many extra-skeletal effects[12] with studies linking vitamin D status to a broad range of human health issues. Prominent amongst these is the proposed role of vitamin D in the pathophysiology of autoimmune disease, including insulin-dependent type 1 diabetes mellitus (T1D),[13] autoimmune thyroid disease,[14] multiple sclerosis (MS), inflammatory bowel disease (IBD),[15] systemic lupus erythematosus (SLE)[16] and rheumatoid arthritis (RA).[17]

Most of vitamin D's effect arises from calcitriol entering the nuclear vitamin D receptors, present in various target cells.

Vitamin D Deficiency in the UK and in BAME

The Royal Osteoporosis Society (ROS) proposes that the following pragmatic vitamin D thresholds are adopted by UK clinicians:[18]

plasma 25(OH)D <25 nmol/L is deficient.

plasma 25(OH)D of 25–50 nmol/L may be inadequate in some people.

plasma 25(OH)D >50 nmol/L is sufficient for almost the whole population.

The Department of Health and Social Care have identified the following adult groups at risk of vitamin D deficiency.[19]

- Older people, aged 65 years and over
- People who have low or no exposure to the sun, for example those who cover their skin for cultural reasons, who are housebound or who are confined indoors for long periods
- People who have darker skin, for example people of African, African-Caribbean or South Asian origin, because their bodies are not able to make as much vitamin D as required.

There is evidence to suggest that vitamin D deficiency is widespread in the UK [20,21,22,23,24] especially in the Black Afro-Caribbean, and Asian ethnic groups. In one study from an inner- city population the prevalence of vitamin D deficiency was found in 12% in Caucasians, as compared to 26 and 31% found in Black Afro-Caribbean and Asian individuals respectively.[25]

Other studies have shown even more alarming results in UK South Asian (SA) population regarding Vitamin D deficiency. With one report suggesting that this may be as high as 94% of the SA population in the winter, and 82% in the summer (18). More recent analysis of UK Biobank cohort data showed, very high prevalence of 25-hydroxyvitamin D Deficiency in n 6433 UK South Asian adults. It showed that 29% (n 2105) had 25(OH)D <15 nmol/L (very severe deficiency), 60% (n 4354) had 25(OH)D <25 nmol/L (severe deficiency) and 93% (n 6749) had 25(OH)D < 50 nmol/L (insufficiency).[26]

This high prevalence can be accounted for by several risk factors that are particular to the SA population, including poor dietary intake of vitamin D, as many SAs in the UK have a vegetarian diet, which is low in vitamin D content. The protective effect of melanin in SA skin that limits cutaneous vitamin D synthesis is also compounded by the cultural needs to cover the body amongst many SA women.[27]

The management of Vitamin D Deficiency

In a fair skinned person, 20 to 30 minutes of sunlight exposure on the face and forearms at midday is estimated to generate the equivalent of around 2000 IU of vitamin D. Two or three such exposures a week are sufficient to achieve healthy vitamin D levels in summer.

For individuals with pigmented skin and, to a lesser extent, the elderly, exposure time or frequency need to be increased twofold to 10-fold to get the same level of vitamin D synthesis as fair skinned young individuals.[28]

The Royal Osteoporosis Society recommends a maintenance therapy comprising of vitamin D in doses equivalent to 800–2,000 IU daily (occasionally up to a maximum of 4,000 IU daily), given either daily or intermittently at higher doses.[18]

Safety of Vitamin D

While documented cases of vitamin D toxicity do appear in the literature, these are rare, and invariably relate to extremely high doses taken over an extended period of time.

Toxicity is only likely to occur in chronic over dosage where hypercalcaemia could result.29 Doses above 10,000 IU/day taken for several weeks or months are frequently associated with toxicity, including documented

hypercalcaemia.[30] The European Food Safety Authority (EFSA) advises that an upper limit of 4000 IU/day is safe for adults and children >11 years of age.[31]

Vitamin D and Immunity

Vitamin D modulates innate and adaptive immunity and inflammatory cascade. Vitamin D receptors (VDR), vitamin D responsive elements (VDRE) and CYP27B1 also plays an important role in modulating the immune system.[32] Many immune cells in the human body such as monocytes, macrophages, dendritic cells, T cells, and B cells express VDR, suggesting that vitamin D may have immunomodulatory effects.

Angiotensin converting enzyme 2 (ACE2) is the host receptor for COVID-19 virus entry into intestinal and alveolar cells. Subsequent dysregulation of the renin-angiotensin system may lead to massive cytokine activation resulting in potentially fatal acute respiratory distress syndrome (ARDS). COVID-19 is caused, beside the virus virulence, by the release of pro-inflammatory cytokines.[33]

A large amount of well-established data showed antiviral effects of vitamin D, which can interfere directly with viral replication, but can also act in immunomodulatory and anti-inflammatory way.[34] The latter effect could be crucial for the assumptive beneficial effect of vitamin D, during COVID-19 infection, since it seems that COVID-19 initially uses immune evasion mechanisms, which in some patients is followed by immune hyper-reaction and cytokine storm, which is a common pathogenic mechanism of acute respiratory disease syndrome (ARDS) and systemic inflammatory response syndrome (SIRS) development.[35]

Vitamin D has been found to modulate macrophages' response, preventing them from releasing too many inflammatory cytokines and chemokines.[36]

Vitamin D and COVID-19

Randomised controlled trials of vitamin D supplementation for the prevention of acute respiratory tract infection have yielded conflicting results, but a meta-analysis of 25 randomised controlled trials including 10,933 participants showed an overall protective effect of vitamin D supplementation against acute respiratory tract infection.[7]

There have been several studies from different part of the world indicating the significance of vitamin D levels and the infection rate as well as morbidity and mortality of COVID-19 infection.

In an interesting study the mean levels of vitamin D for 20 European countries and morbidity and mortality caused by COVID-19 were acquired. It showed negative correlations between mean levels of vitamin D (average 56 mmol/L, STDEV 10.61) in each country and the number of COVID-19 cases/1 M (mean 295.95, STDEV 298.7, and mortality/1 M (mean 5.96, STDEV 15.13).[37] Vitamin D levels are severely low in the aging population especially in Spain, Italy and Switzerland. This is also the most vulnerable group of the population in relation to COVID-19.

In an observational study in Ireland it was noted that in patients with SARS-CoV-2 related pneumonia, a baseline serum 25OHD level less than 30 mmol/L was associated with a hazard ratio (HR) for intubation of 3.19 (95percent confidence interval, 1.05 to 9.7,(p=0.03).[38]

In a recently published, population based, study, from Israel, of 7,807 individuals, 782 (10.1%) were COVID-19 positive, and 7,025 (89.9%) COVID-19 negative. The mean plasma vitamin D level was significantly lower among those who tested positive than negative for COVID-19 [19.00 ng/mL (95% confidence interval [CI] 18.41-19.59) vs. 20.55 (95% CI 20.32-20.78)]. Univariate analysis demonstrated an association between low plasma 25(OH)D level and increased likelihood of COVID-19 infection [crude odds ratio (OR) of 1.58 (95% CI 1.24-2.01, p<0.001)], and of hospitalisation due to the SARS-CoV-2 virus [crude odds ratio of 2.09 (95% CI 1.01- 4.30, p<0.05)]. In multivariate analyses that controlled for demographic variables, and psychiatric and somatic disorders, the adjusted odds ratio of COVID-19 infection [1.45 (95% CI 1.08-1.95, p<0.001)], and of hospitalization due to the SARS-CoV-2 virus [1.95 (95% CI 0.98-4.845, p=0.061)] were preserved.[39]

In a recent retrospective cohort study at an urban academic medical centre in Chicago (USA), which included patients with a 25-hydroxycholecalciferol or 1,25-dihydroxycholecalciferol level measured within 1 year before being tested for COVID-19 from March 3 to April 10, 2020 showed that, likely deficient vitamin D status was associated with increased COVID-19 risk, a finding that suggests that randomized trials may be needed to determine whether vitamin D affects COVID-19 risk. It suggested that randomized clinical trials of interventions to reduce vitamin D deficiency are needed to determine if those interventions could reduce COVID-19 incidence, including both broad population interventions and interventions among groups at increased risk of vitamin D deficiency and/or COVID-19.[40]

COVID-19 and BAME

Concerns about a possible association between ethnicity and outcome were raised, very early in the pandemic, after the first 10 doctors in the UK to die from COVID-19 were identified as being from ethnic minorities.[2] This disparity was further evident from the data, released by Office of National Statistics (ONS), on 7th May 2020, which showed that the risk of death involving the COVID-19 among some ethnic groups was significantly higher than that of those of White ethnicity. The analysis showed, that after accounting for age, Black males are 4.2 times more likely to die from a COVID-19-related death and Black females are 4.3 times more likely than White ethnicity males and females. People of Bangladeshi and Pakistani, Indian, and Mixed ethnicities also had statistically significant raised risk of death involving COVID-19 compared with those of White ethnicity.[3] Similar pattern was also seen in the data released on 19th June 2020.[41]

According to a separate UCL analysis of NHS data from hospitals in England in March and April published in Wellcome Open Research, BAME groups are around 2-3 times more likely to die with COVID-19. After adjusting for age and region, the risk of death from COVID-19 for Black African groups was 3.24 times higher than the general population, for Pakistanis was 3.29 times higher, for Bangladeshis was 2.41 times higher, for Black Caribbeans was 2.21 times higher and for Indians was 1.7 times higher.[42]

The more serious nature of the disease in BAME population was also reflected in various studies. These concerns were confirmed by observational data from the Intensive Care National Audit and Research Centre (ICNARC), showing that 33% of COVID-19 patients admitted to critical care units, were from an ethnic minority background.[4]

Public Health England (PHE) data of COVID-19, for week 32 (from 27th July to 2nd Aug.2020) shows that though for the new hospitalisations rate (lower level of care) (n=13,178) for BAME was 20%, ICU/HDU (n=4,979) admission for COVID-19 cases was over 35%, again indicating the more serious nature of disease in BAME.[43]

In another country wide UK study (n=30,693), it was found that critical care admission was more common in South Asian (odds ratio 1.28, 95% confidence interval 1.09 to 1.52), Black (1.36, 1.14 to 1.62), and Other Ethnic Minority (1.29, 1.13 to 1.47) groups compared to the White group, after adjusting for age, sex and location. This was broadly unchanged after adjustment for deprivation and comorbidities. Patterns were similar for invasive mechanical ventilation (IMV). Elevated adjusted mortality was seen in the South Asian (hazard ratio 1.19, 1.05 to 1.36) group. The conclusion drawn was that the Ethnic Minorities in hospital with COVID-19 were more likely to be admitted to critical care and receive IMV than Whites, despite similar disease severity on admission, similar duration of symptoms, and being younger with fewer comorbidities such as chronic heart disease or dementia than the White group.[44]

Lead author of the Wellcome Open Research article,[42] Dr Rob Aldridge, said in a news release: *"Our findings support an urgent need to take action to reduce the risk of death from COVID-19 for BAME groups"*.[45]

Recommendations

Since the COVID-19 outbreak, media reports and some academic publications have suggested that vitamin D supplementation (particularly high doses) could reduce the risk and severity of COVID-19. Unfortunately, no randomised controlled trial has yet been done.

A systematic review and meta-analysis[7] of randomised controlled trials (RCTs), reporting that vitamin D supplementation reduces the risk of acute respiratory tract infections (ARTI), has been widely cited as evidence to support this suggestion.

Various recommendations have been made supporting this assumption and the available data of increased infection rates and seriousness of the condition in population with low vitamin D levels, reflects this.

A recent review recommended that to reduce the risk of infection, people at risk of influenza and/or COVID-19 consider taking 10,000 IU/d of vitamin D3 for a few weeks to rapidly raise 25(OH)D concentrations, followed by 5000 IU/d. The goal should be to raise 25(OH)D concentrations above 40–60 ng/mL (100–150 nmol/L). For treatment of people who become infected with COVID-19, higher vitamin D3 doses might be useful.[46]

Another recent review suggested even higher doses suggesting using vitamin D loading doses of 200,000–300,000 IU in 50,000-IU capsules to reduce the risk and severity of COVID-19.[47]

It has been recommended that all older adults, hospital inpatients, nursing home residents and other vulnerable groups (e.g. those with diabetes mellitus or compromised immune function, those with darker skin, vegetarians and vegans, those who are overweight or obese, smokers and healthcare workers) be urgently supplemented with 20-50 g/d (800 - 2000 I U) of vitamin D to enhance their resistance to COVID-19.[48]

Adrian Martineau (Institute for Population Health Sciences, Barts and The London School of Medicine and Dentistry, Queen Mary University of London) lead author of the 2017 meta-analysis,[3] is pragmatic: *"At best vitamin D deficiency will only be one of many factors involved in determining outcome of COVID-19, but it's a problem that could be corrected safely and cheaply; there is no downside to speak of, and good reason to think there might be a benefit"*.[49]

Rose Anne Kenny (Trinity College Dublin, University of Dublin, Ireland) who led the cross-sectional study into mortality and vitamin D status and is the lead investigator of the Irish Longitudinal Study on Ageing (TILDA)[50], is adamant that the recommendations from all public health bodies should be for the population to take vitamin D supplements during this pandemic. *"The circumstantial evidence is very strong"*, she proclaims regarding the potential effect on COVID-19 outcomes and adds *"we don't have randomised controlled trial evidence, but how long do you want to wait in the context of such a crisis? We know vitamin D is important for musculoskeletal function, so people should be taking it any way"*.[49]

It is also important to note that low vitamin D status may be exacerbated during this COVID-19 crisis (e.g. due to indoor living and hence reduced sun exposure), and anyone who is self-isolating with limited access to sunlight is at increased risk of vitamin D deficiency.

Further research is definitely needed to determine vitamin D deficiency factors in COVID-19 susceptibility, incidence progression and outcomes. In the face of the continuing COVID-19 epidemic, and in the absence of a vaccine or any effective anti-viral drug therapy to treat those infected, these findings call for the prioritised supplementation of all high risk adults with vitamin D at a minimum daily dose of 20-50 micrograms (800-2000 IU) per day and this advice should be quickly disseminated to the general population. Meanwhile, peoples of all ethnicities must continue hand-washing and safe hygiene, social distancing and self-isolation when required. The public should also be encouraged to maintain healthy lifestyles to optimise cardiometabolic and mental health.

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A complete list of all the references used for this article is available from the Editor, BIDA Journal upon application.

Time to focus on the burden of Vitamin D deficiency on pregnant women of BAME origin in the UK

Dr Pranab Kumar Sarkar MBBS DRCOG MRCOG MOG FRCOG FBIDA Consultant Gynaecologist, Lancashire, UK

Introduction

Vitamin D deficiency has been recognised as a common global health issue for several decades. A significant proportion of the world's population is either vitamin D deficient or insufficient (vit D level <25 nmol/L or between 25-30nmol/L respectively) mainly due to inadequate exposure to natural ultra-violet B (UVB) radiation from sunlight and a relatively low supply of foods rich in vitamin D.

In the UK, approximately 50 percent of all pregnant and breastfeeding women, including teenagers and young women, are at risk for vitamin D deficiency[1]. The pregnant women of BAME (Black and Asian Minority Ethnic) group disproportionately are at greater risk of vitamin D deficiency compared with Caucasian women[2]. These women are 'at risk' for a number of adverse pregnancy outcomes including pre-eclampsia, gestational diabetes, preterm birth and small for gestational age (SGA) babies and babies born with impaired bone growth or in severe cases rickets (congenital or infantile) and the development of childhood allergy[3, 4, 5]. Recent Cochrane review provided further evidence of an association between vitamin D deficiency and adverse pregnancy outcomes[6]. The RCOG Scientific Impact Paper No. 43 has discussed the role of vitamin D supplementation in pregnancy[3]. In the UK, Public health guidance has aimed to identify and prevent vitamin D deficiency in 'at risk' populations and has recommended vitamin D supplementation for these high-risk groups[1,7]. The latest UKOSS interim report has suggested that pregnant women of BAME origin are at increased risk of COVID-19 infection, raising the possibility of an association between vitamin D deficiency and severity of COVID-19 in these groups[8]. The research evidence from the USA also has raised the possibility of a link between vitamin D deficiency and the severity of COVID-19 suggesting the potential role of vitamin D in the prevention and treatment of at 'high risk' pregnant women with COVID -19[9].

Prevalence of vitamin D deficiency

It is estimated that in the UK, the prevalence of vitamin D deficiency in all adults is around 14.5%. This may be as high as 94% in otherwise healthy south Asian adults (male and female) [3]. A recent study in the UK has shown that over 25% of females are vitamin D deficient10.

In the UK, vitamin D deficiency is 3 times more common in the winter and spring compared to the summer and autumn due to inadequate exposure to sunshine when UVB level is low[3,11]. The DOH in the UK has recognised that a significant proportion of people in the UK probably are either vitamin D deficient or insufficient due to relatively low levels of sunshine and British diets being deficient in vitamin D. The prevalence of vitamin D deficiency is high in pregnant and lactating women of South Asia, Middle East, Africa and Caribbean ethnic origin living in countries located at latitudes higher than 35 including the United Kingdom where a high prevalence of vitamin D deficiency (vitamin D levels less than 25 nmol/L) has been reported among pregnant women of BAME groups with approximately 50% of Indian Asian women, 64 % middle eastern women, 58% Africa-Caribbean compared to 13% of Caucasian pregnant women[12]. A significant difference in the vitamin D levels between Asian and Caucasians groups has been reported during different seasons during the winter; 54% Asian pregnant women compared to 3.3% of Caucasian pregnant women were vitamin D deficient. During the summer, 38% of the Asians were still vitamin D deficient.

A high prevalence of vitamin D deficiency has been reported among pregnant women of BAME origin of lower socio-economic class. Obesity in pregnant women of BAME group has also been associated with vitamin D deficiency. In one study, over 60 percent women with a BMI over 30 were found to be vitamin D deficient compared to 36 percent of women with BMI less than 25[13].

Causes of vitamin D deficiency

Vitamin D deficiency is a multifactorial condition where the levels of vitamin D are determined by a combination of factors which influence vitamin D synthesis in the skin, such as latitude, skin pigmentation, dietary intake, food fortification and use of supplements in addition to various disease and genetics. The main source of vitamin D (sometimes called 'Sunshine' vitamin) in adults is formed in the skin. Exposure to solar ultraviolet B radiation at wave length 280-315nm facilitates synthesis of vitamin D on exposed skin between mid-October till April, in the UK. It is estimated that half an hour of sunlight exposure delivers 50 000 IU of vitamin D in non-pigmented skin. Dietary intake of vitamin D makes a relatively small contribution to overall vitamin D needs. Individual risk is increased mainly by a diet with insufficient vitamin D in association with inadequate sun exposure, cultural and religious and lifestyle factors, skin pigmentation, individual variations in increased vitamin D metabolism.

Insufficient exposure to sunlight: In the UK, the most common cause of vitamin D deficiency is insufficient exposure to sunlight. The amount of vitamin D synthesized in the skin is dependent on skin exposure to solar UVB radiation[11]. Because the UK is located at latitude of above 35 degrees, solar UVB radiation is low due to the reduced level of sunshine it receives during the winter months (November and February). During this time, the angle of the sun is so oblique that latitudes greater than 35-degrees receive almost no ultraviolet rays capable of stimulating vitamin D3 synthesis. This leads to the UK population being at greater risk of vitamin D deficiency. Even during the summer months (between March and October), when solar UVB levels are highest during the middle of the day (between 11am and 3pm), effective UV radiation (60%) level is still insufficient as reduced by cloudy weather. Vitamin D deficiency is 3 times more common during the winter than the summer months. Cultural habit of dressing and heavy sunscreen use can significantly reduce skin expose to sunlight increasing the risk of vitamin D deficiency[11].

Diminished efficiency of cutaneous synthesis of vitamin D: The efficiency of cutaneous synthesis of vitamin D can be affected by the presence of excess melanin pigment which absorbs a proportion of the UVB radiation needed for cutaneous synthesis. In women of BAME origin, high levels of epidermal melanin compete with 7-dehydroxy cholesterol for UVB photons in insufficient sunlight. This reduces the efficiency of vitamin D synthesis[14] and cholecalciferol production significantly by approximately 90%12. The Scientific Advisory Committee on Nutrition in the report 'Vitamin D and Health' has identified BAME origin people with darker skin to be at higher risk of vitamin D deficiency[11].

Inadequate dietary and supplements: Reduced dietary intake of foods containing vitamin D such as oily fish, eggs, red meat, mushrooms (natural D2), fortified fat spread, fortified foods and breakfast cereals can lead to deficiency. The Western diet and poor eating habits are also largely to blame for the deficiency leading to decline of vitamin D status.

Impaired absorption of vitamin D: Intestinal malabsorption syndromes such as coeliac disease, cystic fibrosis and Crohn's disease can impair the absorption of dietary vitamin D leading to decreased bio-availability of vitamin D. Altered vitamin D metabolism caused by increased 25 OHD, 24 hydroxylase activity may cause low 25-OH D3 concentration in BAME (Asian) people.

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Fultium-D$_3$ Capsules: Each Fultium-D$_3$ 800 IU capsule contains colecalciferol 800 IU equivalent to 20 micrograms vitamin D$_3$. Each Fultium-D$_3$ 3,200 IU capsule contains colecalciferol 3,200 IU equivalent to 80 micrograms vitamin D$_3$. Each Fultium-D$_3$ 20,000 IU capsule contains colecalciferol 20,000 IU equivalent to 500 micrograms vitamin D$_3$. **Indication:** Fultium-D$_3$ 800 & 20,000 IU capsules. Prevention and treatment of vitamin D deficiency. As an adjunct to specific therapy for osteoporosis in patients with vitamin D deficiency or at risk of vitamin D insufficiency. Fultium-D$_3$ 3,200 IU capsules only. Treatment of vitamin D deficiency. **Dosage and administration:** Adults and the elderly. Treatment of Vitamin D deficiency (serum levels <25nmol/l (<10ng/ml)). Depending on the severity of the disease and the patient's response to treatment: 1-4 Fultium-D$_3$ 800 IU capsules daily for up to 12 weeks or 1 Fultium-D$_3$ 3,200 IU capsule daily for up to 12 weeks or 2 Fultium-D$_3$ 20,000 IU capsules per week for 7 weeks. Prevention of vitamin D deficiency. 1-2 Fultium-D$_3$ 800 IU capsules (800-1600 IU) daily or 1 Fultium-D$_3$ 20,000 IU capsule per month. Long term maintenance therapy following deficiency treatment or vitamin D insufficiency (serum levels 25-50nmol/l (10-20ng/ml). 1-2 Fultium-D$_3$ 800 IU capsules daily. Children over 12 years. Depending on the severity of the disease and the patient's response to treatment: 1 Fultium-D$_3$ 800 IU capsule daily (for prevention/ treatment), or 1 Fultium-D$_3$ 3,200 IU capsule daily for up to 12 weeks (treatment), or 1 Fultium-D$_3$ 20,000 IU every 6 weeks (prevention), or 1 Fultium-D$_3$ 20,000 IU every 2 weeks to 6 weeks (treatment). Should only be given under medical supervision. **Not recommended for use in children under 12 years.** For oral use. Swallow capsules whole with water. **Contraindications:** Hypersensitivity to vitamin D or any of the excipients in the product; hypervitaminosis D; nephrolithiasis; diseases or conditions resulting in hypercalcaemia and/or hypercalciuria; severe renal impairment. **Warnings and Precautions:** Use with caution in patients with impaired renal function or sarcoidosis and monitor the effect on calcium and phosphate levels. In patients with severe renal insufficiency, vitamin D in the form of colecalciferol is not metabolised normally and other forms of vitamin D should be used. In cases of long-term daily doses exceeding 1,000 IU, monitor serum calcium levels. Use caution in patients receiving treatment for cardiovascular disease. Consider vitamin D supplementation from other sources. **Interactions:** Concomitant treatment with phenytoin, barbiturates and glucocorticoids can decrease the effect of vitamin D. Attenuation of digitalis and other cardiac glycosides. Absorption of vitamin D may be reduced by ion exchange resins and laxatives. **Pregnancy and lactation:** Use only under medical supervision. Studies have shown safe use up to 4,000 IU daily but reproductive toxicity has been seen in animal studies. The 20,000 IU dose should not be used during pregnancy. Vitamin D is excreted in breast milk, when prescribing additional vitamin D to a breast-fed child consider the dose of any additional vitamin D given to the mother. **Undesirable effects:** Allergic reactions are possible. Uncommon adverse reactions include hypercalcaemia and hypercalciuria. Rare adverse reactions include: pruritus rash and urticaria. **Overdose:** Refer to SmPC. **Legal Category:** POM. **Pack size**: Fultium-D$_3$ 800 IU capsules x 30 – NHS Price £3.60. Fultium-D$_3$ 800 IU capsules x90 – NHS Price £8.85. Fultium-D$_3$ 3,200 IU capsules x30 – NHS Price £13.32. Fultium- D$_3$ 3,200IU capsules x90 – NHS Price £39.96. Fultium-D$_3$ 20,000 capsules x15 – NHS Price £17.04. Fultium-D$_3$ 20,000 capsules x30 – NHS Price £29.00. **MA Number:** 40861/0002 [Fultium-D$_3$ 800 IU capsules]. 40861/0003 [Fultium-D$_3$ 3,200 IU capsules]. 40861/0004 [Fultium-D$_3$ 20,000 IU capsules]. **MA Holder:** Internis Pharmaceuticals Ltd. Linthwaite Laboratories, Linthwaite, Huddersfield, West Yorkshire HD7 5QH, UK. *Full Prescribing Information is available from Internis Pharmaceuticals Ltd.* **Date of preparation:** August 2018. unique ID no. FUL-458.

Fultium-D$_3$ Drops Abbreviated Prescribing Information
Please refer to the appropriate Summary of Product Characteristics (SmPC) before prescribing Fultium-D$_3$. Use care when prescribing in pregnancy, as high doses of colecalciferol may affect the fetus.
Fultium-D$_3$ Drops: 1 ml of oral solution contains 2740 IU (68.5 mcg per ml) colecalciferol; 3 drops contains 200 IU colecalciferol. **Indications:** Prevention and treatment of vitamin D deficiency in adults and children, and as an adjunct to specific therapy for osteoporosis in patients with vitamin D deficiency or at risk of vitamin D insufficiency. **Dosage and administration:** For oral use. Can be taken directly or mixed with a small amount of food. *Adults.* Treatment of deficiency: 12-60 drops (800-4000 IU) daily; During pregnancy and breast-feeding: 6-60 drops (400-4000 IU) daily; Osteoporosis adjunctive therapy: 12 drops (800 IU) daily. Maintenance or prevention of deficiency: 12-24 drops (800-1600 IU) daily; During pregnancy and breast-feeding: 6-30 drops (400-2000 IU) daily. Children. Treatment of deficiency: 0-2 years: 6-15 drops (400-1000 IU) daily; 2-11 years: 6-30 drops (400-2000 IU) daily; 12-18 years: 6-60 drops (400-4000 IU) daily. Maintenance or prevention of deficiency: 0-2 years: 3-15 drops (200-1000 IU) daily; 2-11 years: 6-15 drops (400-1000 IU) daily; 12-18 years: 6-24 drops (400-1600 IU) daily. **Contraindications:** Hypersensitivity to vitamin D or any of the excipients; hypervitaminosis D; nephrolithiasis; diseases or conditions resulting in hypercalcaemia and/or hypercalciuria; severe renal impairment. **Warnings and Precautions:** Use caution in patients with impaired renal function or sarcoidosis. Monitor effect on calcium and phosphate levels in these patients. Consider risk of soft tissue calcification. Use other forms of vitamin D in cases of severe renal insufficiency. Consider the need for calcium supplementation in individual patients. Where calcium supplementation is necessary, close medical supervision is required. Use caution in patients receiving treatment for cardiovascular disease. Make allowances for vitamin D supplementation from other sources. Monitor to prevent hypercalcaemia. **Interactions:** Concomitant phenytoin, barbiturates and glucocorticoids can decrease the effect of vitamin D. Ion exchange resins, laxatives, actinomycin and imidazole may also reduce the effect of vitamin D. Oral calcium and vitamin D potentiates the effect of digitalis and other cardiac glycosides. **Pregnancy and lactation:** Limited clinical data in pregnancy. Animal studies have shown reproductive toxicity. RDI in pregnancy is 400 IU. Pregnant women who are vitamin D deficient may need a higher dose. Pregnant women should follow the advice of their GP, as their requirements may vary depending on disease severity and response to treatment. Vitamin D and metabolites are excreted in breast milk. Overdose in nursing infants has not been observed, however, when prescribing additional vitamin D to a breast-fed child, consider the maternal dose of any additional vitamin D. **Undesirable effects:** Hypercalcaemia and hypercalciuria. Refer to the SmPC for the full list of side effects. **Legal Category:** POM. **Pack size**: Fultium-D$_3$ Drops, 1 x 25 ml – NHS Price £10.70. **MA Number:** 40861/0005. **MA Holder:** Internis Pharmaceuticals Ltd. Linthwaite Laboratories, Linthwaite, Huddersfield, West Yorkshire HD7 5QH, UK. *Full Prescribing Information available.* **Date of preparation:** August 2018. *unique ID no.* FUL-263.

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

References: 1. National Pharmacy Association. Dispensing an unlicensed product when a licensed product exists. 13 August, 2015. 2. IQVIA Data (52 weeks RxA and HPA) November 2019.

Thornton & Ross PHARMACEUTICALS STADA GROUP

FUL-526x Date of preparation: March 2020

Impaired activation of Vitamin D: Chronic renal disease or renal failure impairs the production of 1,25-dihydroxyvitamin D. Liver disease can also impair the activation of vitamin D.

Obesity (BMI>30): Fat soluble vitamin D has the potential readily to be stored in the adipose tissue compartment of the body leading to a reduced level of bio-available vitamin D.

Drug interactions: Drugs that reduce fat absorption e.g. Oristat can lead to decreased bioavailability of vitamin D. A number of antiepileptic drugs (Carbamazepine, Phenobarbital, and Phenytoin), Cholestyramine, Rifampicin, Corticosteroid and active antiretroviral treatment (HAART) can actively destroy vitamin D by activating catabolism of 25, OHD and 1,25 OH2D.

Genetic: A genetic influence to vitamin D deficiency has been suggested, however its true role is unclear at this time.

Diagnosis of vitamin D deficiency

Diagnosis of vitamin D deficiency can be achieved by a blood test to assess the levels of serum 25-hydroxyvitamin D. 25-hydroxyvitamin D (25-OHD), the specific metabolite of two distinct forms of vitamin D, vitamin D2 (Ergocalciferol) and D3 (Cholecalciferol), is the circulating vitamin D in the body and is measured to determine vitamin D status. The measures of blood levels, which reflect both dietary intake as well as synthesis from exposure to the sun, are considered to be an accurate representation of the vitamin D status of an individual. Although there is no international consensus on the threshold serum 25-hydroxyvitamin D (25-OHD) concentration used to define vitamin D deficiency in adults, the Institute of Medicine (IOM) in the UK in agreement with the ROS, proposed the following threshold in respect to the bone health[15]:

Deficient: .....25-OHD levels less than 30 nmol/L
.....(DOH, UK: less than 25nmol/L),
Insufficient (inadequate): .....30-50 nmol/L
Sufficient:.....Over 50 nmol/L

These thresholds, which are suitable to define vitamin D deficiency in general population in the UK, have identified 27% of the population with insufficient or deficient levels of Vitamin D, 74% with levels below the optimum levels of wellbeing. On average, women have a slightly lower level than men at 68 nmol/L. When interpreting 25-OHD concentrations in dark-skinned people living in the UK, it is important to consider the seasonal variations in vitamin D synthesis, as the winter season is associated with lower serum 25-OHD concentration and an individual classified as deficient in one month may not be deficient year-round and vice-versa[16].

Consequences of maternal vitamin D deficiency

During pregnancy 25-OH vitamin D diffuses across the placenta to support the needs of the growing foetus who relies entirely on the vitamin D stores of the mother with maternal vitamin D deficiency increasing the risk of neonatal vitamin D deficiency[13]. It has been suggested that vitamin D affects transcription and function of the genes responsible for trophoblast invasion and angiogenesis, two factors critical for placental development. Vitamin D deficiency may predispose to abnormal trophoblast invasion, reduced placental perfusion, an increased inflammatory response and subsequent cascade of events resulting in various negative pregnancy outcomes[5]. In combination with its immunomodulatory and anti-inflammatory properties, vitamin D may play a role in the prevention of preterm birth and small for gestational age neonates.

The RCOG UK published Scientific Impact Paper (No.43) on vitamin D in pregnancy[3, 17] has provided evidence of association between vitamin D deficiency and adverse maternal and neonatal outcomes, which has been shown in Table 1.

Some of the adverse consequences of vitamin D deficiency for the mother and the offspring are manifested early in pregnancy. Even less profound vitamin D deficiency may lead to suboptimal bone size and density after birth without overt rachitic features, with the potential for developing osteoporosis and fracture in later life. A study has shown reduced neonatal cross-sectional bone area and bone mineral content in offspring of mothers with vitamin D levels <30 nmol/L) in late pregnancy.

The association between vitamin D deficiency and maternal impaired glucose intolerance and gestational diabetes mellitus (GDM) caused by increased insulin resistance and reduced insulin secretion has been suggested. However, whether vitamin D deficiency is a risk factor for gestational diabetes itself or if vitamin D supplementation can prevent GDM yet remains unknown.

Table 1: Consequences of maternal vitamin D deficiency

Maternal
Early onset severe Pre-eclampsia – 5-fold increased risk
Gestational impaired glucose tolerance and Gestational Diabetes (GD)
Primary caesarean Section rates – 4-fold increased risk
Bacterial vaginosis
Joint-limb griddle pain,
Proximal myopathy, myalgia
Depression, irritability and fatigue

Neonatal
Small for Gestational Age baby (SGA) – 2.4-fold increased risk
Neonatal/Infantile Seizures (one in ten infants) – 2-fold increased risk
Impaired linear growth and bone development and delayed walking
Infantile rickets
Dental enamel hypoplasia
Congenital cataract
Cardiomyopathy
Respiratory Syncytial virus bronchiolitis and respiratory infections
Childhood allergy, wheeze & asthma

Management of vitamin D deficiency: Supplementation and treatment in pregnancy

In view of the evidence that vitamin D deficiency is associated with a wide range of adverse health outcomes for the mother and her offspring, there are compelling reasons for supporting intervention strategies in terms of vitamin D supplementation and treatment of vitamin D deficiency. The aims of vitamin D supplementation and treatment are for the following reasons:

1. Avoid (or reverse) the consequences of vitamin D deficiency
2. Vitamin D deficiency is detected it can be reversed in a timely manner
3. Maternal vitamin D levels are replenished by the 3rd trimester to prevent the development of negative outcomes particularly infantile rickets

The latest DOH, UK guidance makes recommendations in relation to routine supplementation in pregnancy and breastfeeding but does not address the issue of correction of vitamin D deficiency in these situations[18]. For routine supplementation, the current DOH guidance recommends all pregnant women should receive vitamin D supplements either 400 IU daily from the first trimester or 1000 IU daily during the 3rd trimester which has shown to produce normal 2-hydroxyvitamin D concentration in mothers and infants at term. For pregnant women at high-risk of deficiency (BAME group or obese), a higher supplemental dose (of at least 1000 IU per day) is recommended.

Addressing the need for recognition and management of vitamin D deficiency in pregnancy, NICE, in the UK, recommends that all pregnant and breastfeeding women should be informed about the importance of vitamin D supplementation and treatment and advices that all pregnant women should be advised to take 10 micrograms (400 IU) of vitamin D supplements daily and women belonging to the 'high risk' categories should be considered for a higher dose of vitamin D supplementation (Table 2).

It has been recommended that specialist advice should be sought if vitamin D deficiency is severe with vitamin D levels less than 25 nmol/L7. For this group of women in the 3rd trimester of pregnancy a more vigorous replacement therapy for rapid correction may be required. In severe cases it may be rational to use doses higher than 4000 IU per day (but not more than 10,000IU per day) for up to 11 weeks to provide a cumulative dose of around 150,000 or 300,000 IU in pregnancies that are in the 2nd or 3rd trimester. It might also be reasonable to use a weekly dose of 20,000 IU per week if compliance is a problem with daily use. It has been suggested that 'at risk' women who have a delayed diagnosis of vitamin D deficiency (after 12 weeks gestation) would require more vigorous replacement therapy with the loading doses. In cases where compliance is a problem, a single high dose of vitamin D 100 000-200 000 IU given during the 6th or 7th month gestation may be preferred to

achieve best efficacy and compliance. Research evidence suggests that supplemental doses of 4000 IU cholecalciferol a day is considered safe and more effective compared to the lower doses[19]. Some advocate that women at risk of preeclampsia are advised to take at least 800 IU a day combined with calcium. Because of lack of safety or outcome data in the first trimester, the correction should not begin until the 2nd trimester.

Box 1: The Royal College of Obstetricians and Gynaecologists UK recommendation for Vitamin D supplementation[3].

1. In general, vitamin D 10mcgs (400 IU) a day recommended for all pregnant women according to national guidance1,3. This should be available through the 'Healthy Start' Programme for eligible families. Daily vitamin supplementation with oral Cholecalciferol (Fultium-D3) or ergocalciferol is safe in pregnancy.
2. High risk women (women with increased skin pigmentation, reduced exposure to sunlight, or those who are socially excluded, housebound or remain covered, at risk of preeclampsia or obese with BMI >30 are advised to take at least 1000 IU per day throughout the pregnancy.
3. Treatment: for women who are deficient (serum 25-OUD level <25nmol/L) in vitamin D: treat for 4-6 weeks, either with cholecalciferol 20,000IU in a week or ergocalciferol 10,000IU twice a week, followed by standard supplementation is appropriate. For women who require short-term repletion, 20,000 IU weekly appears to be effective and safe treatment of vitamin D deficiency. A daily dose is likely to be appropriate to maintain subsequent repletion (1000 IU daily). Any higher dosage is not recommended in pregnancy.

Monitoring of vitamin D level: Vitamin D is safe in pregnancy and dosing regimens as recommended in the national guideline in pregnancy are unlikely to cause any toxicity. Accordingly, routine monitoring of vitamin D levels is not necessary in pregnancy and breastfeeding unless there is history of vitamin D deficiency, poor adherence is suspected or a loading regime has been completed for vitamin D deficiency. However, if treated for deficiency with doses over 2000IU per day, should have serum calcium levels checked a month after starting the treatment and 3 months later in order to avoid toxicity. Some advocate that women at moderate or high risk of vitamin D deficiency should be offered blood vitamin D level quantified with their booking blood test and adequately replaced. Measurement of vitamin D in symptomatic woman as part of their treatment continues to be applicable. This includes women with a low calcium concentration, bone pain, gastrointestinal disease, alcohol abuse, a previous child with rickets and those receiving drugs which reduce vitamin D level.

Dietary Supplements: Women receiving vitamin D supplements should also be advised to take a diet rich in vitamin D as vitamin D is not present naturally in sufficient amounts in most foods to meet recommended daily allowance of vitamin D need. In USA and Scandinavian countries, the mean serum levels of vitamin D in the population by food fortification have successfully been increased and appear to have been effective in reducing the prevalence of vitamin D deficiency.

Table 2: Pregnant women at risk group in the UK (NICE 2014)

1. All pregnant women and breastfeeding women, especially teenagers and young women.
2. People who have low or no exposure to sun, for example, people who cover their skin for cultural reasons, or for health reasons (skin photosensitivity or history of skin cancer) or those who are housebound, confined indoors for long periods or who are immobile.
3. People who have darker skin because their bodies are not able to make as much vitamin D. For example, South Asian, Middle-Eastern African and African-Caribbean ethnic origin.
4. Women with BMI over 30. Increased adiposity may affect bioavailability
5. Previous or Family history of vitamin D deficiency
6. People at increased risk of nutritional deficiency, for example vegans and those who do not eat fish or have a poor diet.
7. People with the following conditions: Multiple Sclerosis, Malabsorption syndrome or have had gastric bypass surgery.
8. People on certain drugs that impair vitamin D effect e.g. steroids, antacids, antiepileptics rifampicin, tacrolimus, anti-retroviral, cholestyramine, diuretics.

Discussion

In recent years, vitamin D deficiency status has been identified as a major health problem in a significant proportion of pregnant women of BAME origin who are greater risk of a wide range of adverse (consequences) maternal and neonatal outcomes compared to their Caucasian counterpart.

Emerging research data providing evidence on the potential effect of Vitamin D supplementation on pregnancy and neonatal outcomes, it is now accepted that interventional strategies in terms of vitamin D supplementation and treatment aiming to correct the deficiencies may have a significant short and long-term health benefits with no harmful effects in pregnant women[3]. The latest Cochrane review evaluating the effect of vitamin D supplementation in pregnancy, in relation to the risk of maternal adverse events, has provided evidence that supplementing pregnant women with vitamin D alone probably reduces the risk of preeclampsia, gestational diabetes, Low Birth Weight babies and the risk of severe postpartum haemorrhage[6]. The risk of preterm birth before 37 weeks gestation was not evident. The review has shown that although combined vitamin D and calcium supplements in pregnancy may reduce the risk of developing early onset severe pre-eclampsia, there was a potential harm through increased risk of preterm birth before 37 weeks. Despite this, the authors concluded that the benefits of combined supplementation outweigh the harms.

Accordingly, national guidelines focused on effective prevention strategies have been published that would ensure pregnant and lactating women who are at greater risk of vitamin D deficiency are vitamin D sufficient[3, 7]. The Cochrane review also has demonstrated that benefits of vitamin D supplementation outweighing the risks of the therapy may be helpful in informing any planned upgrades of existing UK guidelines and their local implementation by NHS Commissioning Groups[6]; and in the process may benefit the pregnant women of the BAME group who appear to be at higher risk of vitamin D deficiency.

Recently published UK Obstetric Surveillance System (UKOSS) interim report has shown that most of the pregnant women after being severely affected by COVID-19 admitted to hospital with COVID-19 (in the third trimester of pregnancy) particularly those who were at 28 weeks gestation or above belonged to BAME origin suggesting that pregnant women from BAME groups are particularly at increased risk of being severely unwell and have significant (27%) risk of preterm delivery[8]. The research evidence from the USA has suggested the potential association between vitamin D deficiency and the severity of COVID-19 among Black and Hispanic population groups[9]. However, currently no evidence of a direct link between vitamin D deficient pregnant women of BAME group and the severity of COVID-19 infection has been established. On the basis of this evidence, the authors have supported the use of vitamin D supplementation for the prevention and treatment of COVID-19 infection in pregnant women who are at risk vitamin D deficiency[9]. However, Advisory Statement published by NICE in the UK stated that there is no evidence to support the use of vitamin D supplements to specifically prevent or treat COVID-19 infection[2]. The authors suggested universal screening for vitamin D deficiency and further investigation of vitamin D supplementations in randomised control studies, which may lead to possible treatment or prevention of COVID-19 in pregnant women11.

Although, numerous studies have suggested that vitamin D favourably affects pregnancy and birth outcomes, there is no consensus on the optimal dose of vitamin D supplementation to maximise the prenatal and or postnatal maternal or infant benefits. There is an urgent need for further research to establish the potential benefits and optimal dosing of vitamin of vitamin D supplementation in pregnant women of BAME population. Controversies also surround the universal screening for vitamin D deficiency which offers an opportunity for early detection and interventions that would prevent or halt the progression of disease. However, at present there is no research evidence to support routine screening for vitamin D deficiency in all pregnant and breastfeeding women in terms of health benefit or cost effectiveness. As the test is expensive, offering routine screening may not be cost effective compared to offering universal vitamin D supplementation, especially when the treatment is regarded as being safe and it would be simple to supplement all pregnant women with vitamin D.

BOX 2: NICE guidelines[7] and specific recommendations.

1. NHS service providers should increase access to vitamin supplements containing the recommended dose and the Department of Health to work with the manufacturers of vitamin D supplements to ensure that products contain the recommended daily amount of vitamin D for health.
2. The DOH should also be required to amend existing legislation to allow 'Healthy Start' vitamins to be more widely distributed and sold and encourage manufacturers to sell them direct to pharmacies.
3. Local authorities should ensure supplements containing the recommended amount of vitamin D are widely available for all at-risk groups in local settings such as pharmacies, GP reception areas and children's centres. As the deficiency is usually first identified in the primary care setting it is important for the clinicians to target interventions to prevent deterioration and to better adjust treatments and prevent complications. This may involve referral to a secondary care setting.

It would not be unreasonable to expect that the NHS healthcare providers should be responsive to the vitamin D supplementation policies intended to reduce the burden of vitamin D deficiency-related conditions in vulnerable populations. Healthcare professionals caring for pregnant women in primary and secondary care settings should be aware of the particular needs of pregnant women of the BAME group who are at greater risk of vitamin D deficiency. Assessment of vitamin D deficiency status is an important first step that would guide towards timely interventions and prevent or improve some of the negative outcomes, especially when vitamin D supplementation and treatment of vitamin D deficiency is safe.

Health education, a vital part of management, should be targeted towards 'at risk' pregnant BAME women in order to raise their awareness on the risks of vitamin D deficiency, benefits of interventions and the safety of supplements[20]. In addition to daily vitamin D supplements during winter months, women should be advised on lifestyle changes necessary to maintain optimum vitamin D levels. Factors recognised as a barrier to compliance with supplementation for example, language-barrier, religious/cultural issues, preparations containing gelatine, palatability, frequency of the supplementation, should be taken into account to improve compliance with vitamin D supplementation. It makes sense to prescribe vitamin D alone in order to improve compliance. This is limited by the availability of suitable agent; vitamin D cannot be prescribed at low doses without calcium. Formulations of Cholecalciferol without calcium are available (e,g. Fultium-D3) offers an advantage of having higher concentration of vitamin D3 over in 'Healthy Start' vitamin in each capsule/tablet and the composition is more religion friendly . Patient information leaflets and online information can further facilitate discussion with healthcare professionals regarding individualised pregnancy risk and which supplements will be most beneficial. It cannot be over emphasised that the impact of vitamin D deficiency on pregnant women of BAME origin is recognised, prevented and treated in order to avoid adverse consequences. The healthcare providers should focus on beneficial interventions to improve pregnancy outcomes and reduce the burden of healthcare costs.

Conclusion

Vitamin D deficiency (or insufficiency) in pregnant women particularly of BAME origin, believed to be more common than perceived, is largely preventable. As currently available scientific data provides sufficient evidence of an association between vitamin D deficiency and adverse maternal and neonatal outcomes and the beneficial effect of vitamin D supplementation and treatment; and its safety, the rationale for vitamin D supplementation in 'at risk' group of BAME origin becomes quiet compelling. Despite publications of numerous guidance and recommendations, vitamin D deficiency continues to adversely impact on the pregnant women of BAME origin. Therefore, if our ultimate goal is to reduce the burden of vitamin D deficiency on the pregnant women of BAME heritage, then healthcare providers in the UK should focus on implementing sustained preventable strategies for early recognition, timely interventions with vitamin D supplementation and treatment for these women. It is hoped that would help to minimise the negative impacts of Vitamin D deficiency on pregnancy and in the process lessen the financial burden on the already stretched NHS healthcare costs. In this context, RCOG the 'advocator of Women's Health worldwide' should ensure women specially BAME women are aware of the benefits of Vit D though education and 'empower' them with clear information on the needs for vitamin D supplementation in pregnancy, before and after.

Key Points

1. Pregnant women of BAME group are at greater risk of vitamin D deficiency compared with Caucasian women.
2. Causes of vitamin d deficiency are multifactorial but mainly due to inadequate exposure to natural sunlight and diet deficient in vitamin D.
3. Targeted management of vitamin D deficiency is crucial to avert some of the adverse effects of vitamin D deficiency in pregnancy.
4. Vitamin D supplementation is safe so long as follow the recommended doses.
5. Health Education targeted at the risk group in order to raise awareness of the beneficial role of vitamin D supplementation and improve compliance

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From conception to the present time: How one local Rotary team has evolved and thrived

Gary Williams President, Hawarden Dee Valley Rotary Hawarden, North Wales

Introduction

My name is Gary Williams and I am President of Hawarden Dee Valley Rotary. We are a small club, of some 22 members, and we are a young club; having been chartered in 2019. Hawarden is a small village, in Flintshire, North Wales with an estimated population of just over 2000 people. Whilst we serve our local community, Rotary, an organisation of over 1.2 million members worldwide, is a global community of volunteers. Rotary operates at the international, regional / district and local community level.

The global aim of Rotarians is to bring communities together, foster fellowship, goodwill, friendship and teamwork and inculcate the ethos of giving and sharing. This in turn creates happiness and improves the well-being of ourselves and of our communities. Since its founding, Rotary has carried out good works, and Rotary Charities have given generously to charities doing medical research in all fields, but in particular Cancer, Alzheimer's and disease prevention. Rotary clubs worldwide have played a pivotal role towards the eradication of Polio across the globe. All these roles dovetail the common goal Rotary strives for with the aims of those, who practice in the field of medicine and healthcare, which is to improve the well-being of the society.

As members of the British International Doctors' Association (BIDA), you believe in 'Equality and fairness for all'; as Rotarians, we believe in 'Service above Self'. These beliefs are both complimentary and, I would argue, synergistic. The common interlocutor is people speaking to, and supporting, each other.

Evolution of Hawarden Dee Valley Rotary Club

Hawarden Dee Valley is part of Rotary International District 1180, which covers the whole of North Wales, Merseyside, the Wirral and parts of Cheshire, Shropshire and Lancashire. District 1180 comes under the auspices of Rotary of Great Britain and Ireland, which has some 50000 members. Clearly then, Hawarden Dee Valley is a small cog in a much larger machine, but I believe that we punch well above our weight in ways which I will go on to explain in this contribution to your Journal.

We are a club made up of a group of people with diverse skills, backgrounds and experiences. We range in age from around 40 through to 80, but we sponsor and support 3 local Rotakids clubs, made up of children from age 5 to 10 years and an Interact club comprising of teenagers in their final 2 years of high school. Our reach is multi-generational and this enables us to use our experience to help those younger than ourselves, and learn new skills and trends from them in return. Our links to BIDA go beyond the philanthropic as we have two active BIDA members in our club; Professor David Brigden and Doctor Amit Sinha, your current journal Editor.

What then brings such a diverse group of people together? Simply, I believe, it is about wanting to support others and 'give back' to society in general. Having a common goal is a powerful motivator, and whilst many large organisations enjoy a common goal, it has its greatest effect at the local level, where the real work is done.

I believe organisations such as Rotary are principally organic in their makeup. Rotary, at is best, is an organisation that is flexible and able to adapt to change. I will return to this later. Hawarden Dee Valley is an organisation with little job specific specialisation, but is multi-experiential, with few layers of management, decentralised decision-making - everyone has a voice - and not much direct supervision. We have worked hard, from the day we formed, to be open, inclusive and create a culture of fun, respect for each other, and trust.

In the little under 2 years that we have been together, Hawarden Dee Valley has achieved great things. In late 2018, and through 2019, we have undertaken numerous activities to raise money for good causes and to have some fun. Our first fund raising event comprised of spending four weekends in December 2018, with a small Rotary stand, at the local Greenacres Animal Park as part of their Christmas Extravaganza. We were able to talk to many people and explain what Rotary is all about and raise money for the Alzheimer's Society. This was a good start, but we had bigger plans for the next year.

In 2019, in order to get ourselves known in the community, we organised a St David's Day concert in our local church, St Deiniol's. The evening comprised of classical music, song and verse (all with a Welsh theme). The evening was a great success and we raised sufficient money to be able to give handsomely to the local RNLI boat station, the Church and Rotary charities. We have subsequently held 3 further musical events in the church, including an evening with the Flintshire Male Voice Choir.

In the first half of 2019, we formed a Rotary Interact club at our local high school and 2 Rota Kids clubs in local infant schools. We were beginning to translate our 'mantra' into real action. When we held a fun day out for young children with learning difficulties, at the local Animal Park, we really felt that for the first time we were making a difference in our community. Nothing acts as a greater motivator than success itself, so as our membership grew, we planned more, and supported more, local events, which raised money for Prostate Cancer, the RNLI and Polio Eradication; local action having international impact. A personal highlight for me, during 2019, was an evening of Indian Dance, Music and Culture organised by your (and our) own Doctor Amit Sinha. The colour, the vibrancy, the spectacle of the evening was, I believe, a first in our community - a wonderful celebration of diversity and camaraderie.

We have also undertaken more practical activities such as holding mock interviews for our local high school sixth form students, and holding an interactive workshop for potential Medics, Dentists and Health Care professionals; Doctor Amit and Professor David's experience came to the fore here. We also supported another fundraising evening by one of our Rotakids clubs and the New Mind International Ministries, which raised £3000 for the building of a new school in Uganda.

A CENTURY OF SERVICE — A NEW CENTURY OF SUCCESS
ROTARY INTERNATIONAL
100 Years

We were really beginning to build a head of steam when we formed our third Rotakids club in early 2020 and then COVID-19 hit. I talked earlier in this article about Rotary's ability to adapt to change, and this was never more true than when everyone found themselves in lockdown. One of Rotary's key strengths is its ability to connect people and to support each other. Hawarden Dee Valley acted swiftly and decisively when COVID struck. Lockdown did not have to mean the end for club members being together, we just did it virtually using technology; Zoom to the rescue.

Given some of members are in their later years, it is quite an achievement to have on average 15 to 20 of us talking, laughing and being together every week. We have held several fun and fund-raising activities from online Bingo, quizzes, Cheese & Wine, Whisky Tasting and Appreciation evenings. We have even managed to grow our membership during COVID-19. In our local community, outside the confines of our homes, we have recognised 2 local small businesses for their outstanding work in our community by presenting them with Rotary Community Service awards.

Rotary and BIDA – Two organisations with common principles

Rotary was founded by a Chicago attorney, Paul Harris on 23rd February 1905. The main purpose initially was to bring professionals of different backgrounds to meet and exchange ideas and form long-term meaningful relationships. This extended to humanitarian service, a challenge which the organisation has risen to over the years achieving undoubted successes.

The British International Doctors Association (BIDA) was established 70 years later in the UK on 11th May 1975 by a group of 5 overseas doctors working in the NHS. Its main purpose has always been to bring about greater integration of overseas doctors within the NHS to provide the best possible service to the people of the UK.

Both organisations connect and support people; we provide opportunities for people to develop themselves. We are diverse in our makeup and have a wide range of skills and experiences to share. We are volunteers who respect everyone's race, gender, sexual orientation, religion, and country of origin.

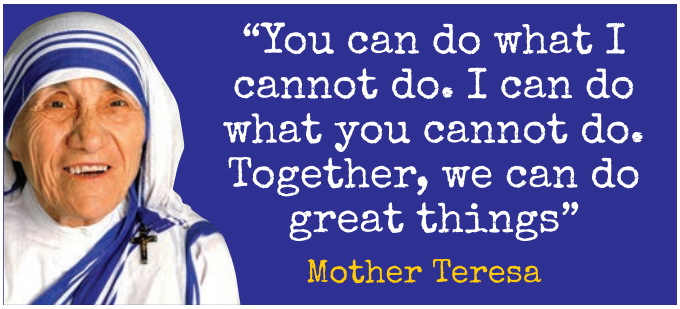
I am certain there is more we can do together because 'Together we are Stronger'. If you wish to find out more about Hawarden Dee Valley Rotary you can find us on Facebook; we would love to talk to you more about what we do.

Rotary | Rotary Opens Opportunities

Exceptional Leadership

Lessons from the jewels we work with

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



Mother Teresa's leadership quotes[1]

Have you had the opportunity to observe your boss in a crisis? Have you seen some leaders commit grave errors under pressure of work or rise to unexpected levels to handle untoward situations? The Pandemic has taught us many things and will continue to drive actions which are innovative. Leaders will continue to be presented with complex situations driving the need to take tougher decisions. Jeff Bezos of Amazon not only prioritised the need to supply essential supplies to customers but also protected them rom price gouging. Hubert Joly, former CEO of Best Buy, wrote in the Harvard Business Review (HBR): *"This is a time when performance will be judged by how a company and its leadership serve everyone and fulfill a higher purpose – and specifically how they have shown up and met the requirements and expectations of its multiple stakeholders*[2]*".* Leaders have owned the responsibility to play their part in supporting the employee community to handle the crisis. I have been fortunate to have worked with several brilliant personalities. What I am today is credited to those inspiring and towering personalities who demonstrated grit, resilience, compassion and strategy to deal with difficult situations and also taught me to remain positive and resilient. A crisis situation differentiates exceptional leaders. They stand out and people gravitate towards them for inspiration, guidance and direction.

The current pandemic has shown us how some led the way in transitioning to the new normal. They were stable and focused in their resolve to support, provided advice for the course of action to choose from, and help calm everyone involved to reduce stress, and focus on the goals and the immediate tasks at hand. They were always there to provide guidance and if they did not know, they would find out what needs to be done and guide others towards the required results. Jacinda Kate Laurell Ardern, the New Zealand Prime Minister, has demonstrated a unique leadership style to drive the success in the fight against the corona virus. Angela Merkel believes in science and the results. US President Donald Trump's briefings are hilarious circus-like events in which he has almost always been far away from the truth. Narendra Modi, the Indian Prime Minister has not held any regular briefings so one does not know the result of the lockdown of the 1.3 billion people he should be looking after. *The 39-year-old prime minister of New Zealand is forging a path of her own. Her leadership style is one of empathy in a crisis that tempts people to fend for themselves. Her messages are clear, consistent, and somehow simultaneously sobering and soothing. And her approach isn't just resonating with her people on an emotional level. It is also working remarkably well.*[3]

Leaders in a crisis work alongside their employees. In total calamity, like the Snowbird crash crisis, Captain Richard MacDougall, when trying to rescue Captain Jennifer Casey, was not worried of own life-threatening injuries but wished to know how Captain Jennifer Casey was? That is what leaders are made of – compassion for people. Captain Richard demonstrated leading the team in a fatal air accident required keeping his subordinate's welfare on priority. Each one of you will have such a story which inspired you. However, not surprisingly the traits leader displays are almost always exceptional.

An exemplary leader's behaviour does not alter when in crisis. In fact, it becomes more focused around 'his/her' people and messages are clear, consistent and soothing. They provide clear guidance and leadership in an ambiguous situation. These leaders set expectations, justify changes, clarify with logical and practical examples. These leaders also convey that they are as much affected by the calamity and crisis as everyone else is. All Canadians had noticed that the Canadian Prime Minister Justin Trudeau gave his daily Corona virus briefings in front of the same door with disheveled hair growing wild on his head. During a Facebook live chat the New Zealand Prime Minister, Jacinda Ardern, *she appeared in a well-worn sweatshirt at her home (she had just put her toddler daughter to bed, she explained) to offer guidance "as we all prepare to hunker down*[2]. On the other hand, President Donald Trump appeared well groomed on every occasion which never resonated with the people. On several occasions, President Trump has got into verbal duels with journalists.

Concern for people's health, physical and mental, always remains priority and does not change because a calamity has struck. Every contribution counts – whether it is coming from the night cleaner, or the security guard or the critical resource manning the front line; everyone's contribution is valued and respected. These leaders address their team mates by their names to demonstrate their warmth and genuineness in relationship. Such acknowledged employees go above and beyond for their organizations in support of the leaders. In my early years as a young Squadron Leader, one winter morning there was a terrorist attack in the civilian populated area we were stationed in, killing ten innocent people. Fearing an attack on the military installation, operations went on 100% alert. The Station Commander commenced visiting the bachelor living quarters of the men communicating that he needed each of them to support the fighting base. This was followed by a visit to the houses meeting the family members of the soldiers assuring them that he will do everything possible for their safety and comfort. He then continued meeting all officers and men at the posts and operational readiness platforms. While he was on his "meeting mission", I had been tasked to get all civilian families living outside the station, into the safe environment of the military compound. I had clear directions. They were a part our family and we had a duty to look after them. For the next three weeks of the alert, this man worked, slept and ate with the men and never let anyone feel that it was a different day. He was the same, as if nothing had happened. The men and the families worshipped him. The local town population adored, respected and listened to him and followed his directions. I am sure very few must have forgotten what he taught us in those weeks. We did not lose any human life in the active engagements during the terrorist attack owing to the exemplary leadership in the unprecedented threat from terrorists.

In emergencies, there is bound to be chaos and confusion. If the employees find their leader by their side available to seek clarity, they remain committed to making efforts to provide the required services to meet the task. This key behavioural trait to go above and beyond to deliver goals is clearly displayed in the armed forces where officers lead their men in war and not relax in comfortable bunkers while the troops perish at the hands of the enemy. In the coronavirus related crisis times, we had several Executive Directors and CEOs who continued to be with their skeleton staff if it was needed. The classic example is of Adam Silver[4], the commissioner of the National Basketball Association (NBA) who cancelled the professional basketball league as early as March 11, 2020. He delivered this decision knowing fully well that $8 billion revenue earned in 2019 will not happen in 2020. Adam galvanized other leaders in the world into action. These leaders were there at their places of work. This behaviour brings meaningful and clear communication for the employees who in times of crisis are subject to rumours and disinformation by vested interests. Leaders in Target[2] took an extraordinary decision to permit high risk employees like pregnant women, seniors and those with compromised immune system to stay home for 30 days and still get paid. These inspiring leaders are not only available to their employees but also continue open communication, giving clarity of purpose of their work. In difficult and demanding times, employees need logic and reason if more is asked from them. If explained well, they do go above and beyond to honour their commitment to deliver[5].

People look at leaders as role models to emulate. How one says and what one says leaves an indelible mark on the psyche of the employees. A couple of years back when I attended a seminar on public speaking, speeches by Martin Luther King Jr, Mahatma Gandhi as well as Barack Obama were shown. All of them had one common thread. They were fabulous orators. These leaders knew that the listeners were pinning their hope on them. Their choice of words had empathy, their style communicated an underlying message of hope and their voice strengthened their resilience to face the problems lying ahead.

In crisis situations like this pandemic, recognition in any form acts like adrenaline to a worker. What is clear is the authenticity of their words, their open honest communication and their intent to not only wish well but do good work for everyone each time. They demonstrate clarity in purpose and do not hesitate to own failures. They are seen to take blame for all failures but apportion success to others. These leaders' commitment to success is appealing to the people engaging them to be able to raise the bar of their abilities. Having them around us accelerates success and ameliorates culture, behaviour, beliefs and values. Recognition and appreciation is a focus area of leaders. Even a simple "thank you" does more than a long winded appreciation sentence does. They never cease to respect and acknowledge the contribution of their team members. I know an Executive Director who continued sending a long email in the pandemic recovery period every Friday recounting tasks achieved in the week, appreciating contribution of specific individuals by name, sharing his personal wins and losses, interwoven with task information and appreciating the results.

These leaders differentiate themselves by "doing" instead of just talking. They admit mistakes and failures. They are specific in their actions and transparent in providing resources to deliver a task. We may have seen many "politicians" in our organizations, who make bold statements in public committing sweeping changes in policies and people related issues. These claims may earn some momentary "fame". These individuals attempt to make feeble progress in their endeavours and slowly wriggle out of any discomforting situation making weak excuses. They are defensive when a mistake or harm is discovered not acknowledging the gross blunders. Exemplary leaders accept faults; deal with the discomfort of failures but remain genuine in their effort to correct, partner and collaborate. When the protests supporting the black community and racism surfaced across every country, an Executive Director shared an open platform virtually with almost all employees seeking their "story" of how they were discriminated against. The backdrop was racism but the stories were from every ethnic background, race, sex, sexual preference including indigenous peoples. The voices were loud and clear that this had happened to them at some point in their lives. He apologised that he was at fault not to have recognized this major defect if it happened in his company. He committed to act with urgency, be transparent, respond promptly, remain engaged, and communicate actively to know the pulse of the team members. The stories indicated that the malaise was systemic and needed to be weeded out from the culture first and then gradually in the system. He acknowledged that there is certainly the need for education, awareness and training. It is unfortunate that some continue to indulge in these dreadful practices without knowing that they were doing it.

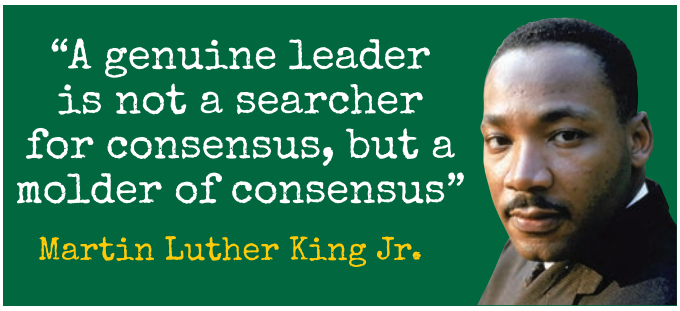
Some leaders in positions of authority or with the power to influence failed to take unpopular decisions. They were likely being dispassionate or simply biding their time for the crisis to get over. For many it was learning as they faced the situation and implemented their unique leadership style. It can be stated that in a situation of importance or urgency, the leader's communication should convey urgency, is transparent and full of empathy. They always recognise good work done and give people their due. Very recently, in an interaction with a person respected in the community, I congratulated her about her emails to all employees. She was quick to respond that it was one of her staff who should be given this recognition. She did not hesitate to make the name known. It was her magnanimity to give her employee the credit for something she was due for. Small acts like these enable leaders like her to get acceptance and admiration for the care and compassion they show for all.

There will be many more traits of exceptional leaders. I picked up a unique trait when I was in my last year of school in India, a month before my final examination. I had taken a break from studying and was out for a walk to clear my head. There was a road construction in progress. A supervisor was passing instructions and encouraging his team of manual labours. Those days we did not have heavy duty machines to do the heavy lifting and movement of bitumen and road filling gravel. In that moment, I watched the supervisor with fascination who seemed to "protect" his charges like a mother will do. At every step, he was there for them. If they made mistakes, he would verbally make vocal statements owning up mistakes for the benefit of his bosses who were also around. It was clear that he was ready to take the flack. Within their closed group, he would calmly explain and make the members understand the mistake and also the effect the mistake will have on result. I stayed back some more time and listened to the fascinating words of wisdom from an illiterate man who was generating awe from his team members. The passion for high quality work and compassion for his team members was palpable. You could see the respect that they had in their eyes. They listened intently and followed his instructions. At some point, he even asked one of his bosses not to scold his team because they committed a mistake because he was there to make amends and take blame. This person left an indelible mark on my conscience.

History is testimony to great leaders who have set standards for others to emulate, and work towards a common purpose. *Incompetence rarely evolves into capability nor will decisive leaders deteriorate into indecision*[6]. This quote defines who effective leaders are. Their behaviour today will define their actions in a crisis. Every situation is unique with the unique set of individuals in the situation. Haven't you heard of the phrase, "She / he will always find a method in madness". One has to analyze deeper in how the leader handled each situation. What has been found common in cases of successful leadership is that the leader operates with a strong conviction and a purpose. President George Bush[6] was listening to second grade students in the presence of parents, press and local dignitaries when he was quietly updated about the attack on the World Trade Centre. He continued to listen and allowed the children to finish

their recital. When the event was over in about ten minutes he quickly moved to the makeshift war room to attend to the crisis.

There is one more situation that we all have faced. Leaders at times become inaccessible. It is completely understandable that they are human beings and need time for themselves with their families. Organizations cannot afford to let them "burnout". Exceptional leaders think and plan ahead of unforeseen circumstances one of which may include them being accessible. For such scenarios, they identify and mentor successors who are coached to take decisions and lead on their behalf. The critical difference is in the actions of the leader in reaching out to you when back. They evaluate what went well and what did not. They do not hesitate to know what improvement is needed. They convey clearly that the work being done is important and critical for the success of the organization. They assess how things went in their absence, make processes/ mechanisms better based on gaps identified and implement changes that would allow for better decision making the next time.



There will also be a situation when you want to give a feedback to your leader but do not get an opportunity to do so or were not given an option to do so. Stellar leaders are those who seek opportunities for honest and critical feedback of their actions[7]. They need to hear the voices from the work floor. If leaders fail to connect with the people, there is a lack of collaboration to improve. With this comes the element of trust and faith. The best companies provide several channels of communication to employees to convey their opinion and thoughts. It is important to understand that a system of communication for one employee may not work for another because of their personal assumptions and experiences. If it is open verbal communication, the success is in listening without disruptions or questions from the leader till the employee is ready to take questions or seek clarification. Unconscious defence of a decision by a leader may either destroy the communication channel or shut down the information channel all together. For example, a question on the future of the company must be answered with simple and copious information about the future plans. The pandemic has destroyed economies across the globe. Several people are either laid off, lost their jobs or looking desperately for a livelihood to survive. Exceptional leaders will take this opportunity to ensure they provide clarity on the strategic plans of the company and what employees can expect.

Over the years, I have learnt the nuances of many traits of effective leaders and think that mastery in being an exceptional leader is still to be reached. I was always communicating at every platform that I was responsible for the team that I led; I was also responsible for their mistakes and was ready to make corrections, take suggestions as well as criticism. My team without fail adored the style and I in turn treated them like family. It was quite an inspiration to experience awe in the eyes of the team members. I saw similar practices by some of the leaders I served under. I do know that on some occasions, this habit of mine to not allow others to directly interact with my team members upset many "bigwigs" in the organizations that I worked in. This trait on some occasions got me plenty of grief and created unpleasantness with "strong" personalities in the hierarchy. The choice was in status quo or toeing the line of the boss. I always chose the former. This at times resulted in my poor performance ratings or not being picked up for rewards or not getting the best hike in pay. But no one stood in the way of the stellar performance by my team. We spoke through the medium of our excellent results which always got those awards and the highest pay rises. Whenever I have faced a crisis, I imagined how those jewels that I worked under would react and toe that line.

Looking at my personal opinion that I have succeeded in life in three different careers, the last being across national borders, I still hold this trait very dear to me. Today I am proud to say that I have, in my career, managed to develop good leaders. A part of one such testimony is pasted below. Today I expect nothing in return. It is just pride that I managed to develop someone who will lead better than me and develop some more individuals who maybe be recognised as exceptional.

"A child holds the fingers/hands of parents and learns to walk.
I also learned to walk and run, learnt how to lead and win the battle in a Corporate environment, lived by the long list of values,
these learnings and values came from none other than :–
Sreeram Pagalla
Wing Commander Ajit Sinha
Major General Kuldip Singh Sindhu[8]*"*
...Vaibhav Gupta, LinkedIn

These Jewels that I have worked under always got results and trained me very well to make a difference in the world. Today more jewels have entered the work force. It is not important that one gets recognised. It is important that your protégés are recognised. I will end with expressing gratitude to the many that helped develop my values, beliefs and work ethic.

Biodata: *Ajit, a people person, enjoys exploring and experimenting. His passion is to challenge norms. He prefers simplicity and determination to solve issues. He takes time to contribute to the community and volunteers in non-profits. His articles are uniquely peppered with his life experiences. Ajit also served in the Indian Air Force. He founded Checkpoint Strategies in 2019 with a goal to provide solutions to inspire, facilitate, engage and succeed.*

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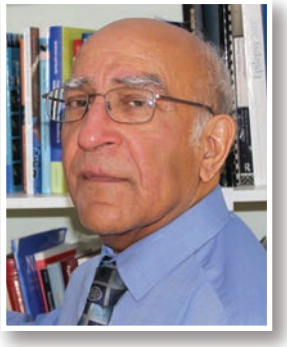
Imperial takes the lead. Others should take heed



Narinder Kapur Visiting Professor of Neuropsychology, University College London *(pictured right)*
Christian Harkensee Consultant Paediatrician, Gateshead Health NHS Foundation Trust
Terry Skitmore Partner of the late Amin Abdullah

The newly published disciplinary policy of Imperial College Healthcare NHS Trust, developed over several years in the light of the findings of the 2018 Independent Inquiry into the self-immolation of nurse Amin Abdullah and subsequent recommendations from NHS Improvement, goes a long way to producing a fairer system for NHS staff, a system that will also save Trusts money in avoiding needless legal claims and associated damage to their reputation. Imperial has taken the lead to ensure excellence and compassion when dealing with issues which affect staff well-being. It behoves other NHS organizations to take heed.

The COVID crisis and the Black Lives Matter movement have together brought into focus the dedication and sacrifices of BAME staff, especially those who work in the public services. Many of those BAME NHS staff who died from COVID-19 came to this country from overseas with aspirations not only for a better life for themselves and their families, but also aspirations to do great things for a public service which they admired and which they loved to work in.

A young man who came to this country in 2003 with such aspirations was Amin Abdullah. Amin grew up in an orphanage in Malaysia. He fulfilled his dream of becoming a nurse in the NHS, and during his training he won an award for clinical excellence from the hospital that later sacked him. On February 9, 2016, not long after he qualified and a few weeks after going through a grossly unfair dismissal procedure, he set himself on fire and burned to death outside Kensington Palace. Amin was 41 years old. A YouTube video of Amin Abdullah's story, A Nurse's Tragic Journey, is available (see www.abetternhs.com).

The 2018 Independent Inquiry Report into his case, and the subsequent recommendations for all NHS Trusts produced by NHS Improvement, brought to light a distressing state of affairs in the NHS – an 'apartheid' system, with one policy for doctors and dentists, and another much less fair policy for other healthcare staff. The latter readily allowed the setting up of 'kangaroo courts' and was a system where clinical staff in management roles were free to play a key part in such 'kangaroo courts'. The absence of accountability in these systems permitted behaviour, which can only be described as the worst form of bullying. It is vulnerable groups, such as BAME staff and whistle-blowers, who suffer the most when unfair systems are in place.[1,2]

What we need now are six things to happen. Firstly, NHS Trusts should follow the excellent lead[3] set by Imperial College Healthcare NHS Trust and put in place a similar system which is fair, and which includes features such as PIE principles in the composition of panels who make major decisions about staff – Plurality, Independence and Expertise, with dismissal decisions requiring executive board approval.[4]

Secondly, all NHS organizations – including the Department of Health, the CQC, and individual Trusts – should reflect on past failings involving staff wellbeing, on what lessons can be learned and why they were not learned earlier (if necessary by getting external advice), and offering an apology and practical redress to those who have suffered.

Thirdly, the government recently set up a Healthcare Safety Investigation Branch to create an independent, specialist body to look at major patient safety issues and events and to learn lessons. There should be a parallel body set up for staff well-being, a Staff Wellbeing Investigation Branch, to investigate and learn lessons from major staff adverse events, such as work-related suicides, which should be classed as 'staff Never Events'. In such investigations, there should be 'proof by disproof' – the burden should be on employers to show that no discrimination of vulnerable individuals took place. Retired NHS staff could contribute (with additional training, as appropriate) to such independent investigations – such staff usually have a wealth of relevant knowledge, skills and experience and, as the COVID crisis showed, are willing to return to work when needed.

Fourthly, the CQC or similar body should be charged to ensure that fair people management systems are in place and enforced. Current Freedom-to-Speak-Up Guardians should have their roles expanded, be totally independent of Trusts, and be called Fairness Guardians.

Fifthly, Health Education England should set up a dedicated training and accreditation scheme so that managers, and clinicians in management roles, are properly trained to ensure excellence and to avoid conscious and unconscious bias in people management settings.

Sixthly, professional and regulatory bodies should as a matter of urgency respond to the November 2019 call from the NHS Chief People Officer to produce Guidance for their members on codes of conduct in people management settings. NHS managers should be no different from other healthcare professionals and should have a regulatory body to whom they refer. There are two sides to the 'fairness coin' – policies and people. The 'policies side of the coin' has taken a major step forward with the NHSI Recommendations and with Imperial's new policy; the 'people side of the coin' means proper training and accountability for healthcare staff in management roles.

In his 2015 report[5] on whistleblowing in the NHS, Sir Robert Francis commented: *"Repeatedly we hear of unaccountable managers protecting themselves and undertaking biased investigations, character assassination, lengthy suspensions, disciplinary hearings which resemble kangaroo courts, and ultimately dismissal of staff who previously had exemplary work records"*. In his introduction to the recent 2019 report into wellbeing of NHS staff,[6] the Chair of the Commission which generated the report, Sir Keith Pearson, noted, *'Mental health can express itself in many ways, and in the most tragic of cases, we discover that the individual has taken their own life behind every statistic is an individual person, a grieving family and friends. One death by suicide in our workforce or among those who are learning in the NHS is one too many'*.

When patient care crises occur, such as the COVID-19 pandemic, the NHS has shown that it can act at speed, with all necessary funding and resources immediately made available, as was evident in the rapid setting up of the Nightingale Hospitals. Research by Professor Michael West and others[7] has shown the close link between staff wellbeing and patient care. We owe it to the memory of staff such as nurse Amin Abdullah to show the same urgency and readily available resources to deal with issues, which affect staff wellbeing.

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Effective Communication

in the provision of quality health care

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Introduction

It is now widely recognised that effective communication is an essential element of high-quality healthcare. Effective communication with patients and colleagues can lead to improved patient safety and patient's satisfaction. A substantial body of research evidence supports the view that effective communication has a measurable good therapeutic value making significant difference to the overall outcome of the clinical care. Although the benefits of good communication and of negative impact of poor communication have been widely recognised, the merit of this is not often fully translated into working practices. Poor communication has been shown to be a significant factor in up to 30 percent NHS hospital complaints, claims and disciplinary matters investigated by the GMC. In the UK, one in three cases reported by the Medical Defence Union also involve poor communication.

As complaints resulting from poor communication can have serious medicolegal consequences, it is the responsibility of the doctors to ensure their communication skill is effective and fit for purpose throughout their professional career. Employers recognise that successful communication between clinicians and patients improve patient experience and reduce complaints. Hence NHS Trusts aiming to provide a high-quality service demand that the healthcare professionals possess good communication skills.

Effective Communication

Effective communication has been recognised as an inherent part of social skills that enhances other two skills e.g. professional and technical that are needed to become a good doctor[1]. Effective communication requires doctors to give patients the information they need in a clear and concise manner and with the right attitude. Effective communication would mean making the most of every opportunity to interact with patients and colleagues; to show empathy and concern to the patients, and to be able to deal with difficult emotions, to be positive and encouraging to the team.

It has been recognised that more satisfying interactions with patients and colleagues helps to manage time better and makes a more effective team member.

Clinicians who developed better rapport with patients, took more time to explain and made themselves available to their patients face fewer legal complaints. When clinicians carefully explain to their patients what was happening, when and why, and respect patients' opinions, understand their issues, encourage them to talk, and also use humour at the appropriate situation, it builds a strong bond of professional relationship.

Effective Communicating with patients and colleagues may be difficult or may not be as easy as it would seem. The best communicators are aware that practise makes perfect, so communicate accordingly. A good communicator listens. However, it has been suggested that 'for both medicolegal and ethical point of view, communication is no longer a nice quality to have, but is essential'[1].

Communicating effectively with patients and relatives

Communication, which is the core aspect of Clinical competence, is vitally important in health care. The objective of effective communication should be patient centred and should be aimed at bringing about safety and enhancing patient satisfactions. Communication may be unethical when it is absent, delayed or when misleading information is intentionally given to the patients. Some style and method of communication may also be harmful and unethical[2]. On the basis of evidence, there is a good correlation between good communication and fewer complaints from patients (Box 1).

- Introduce yourself. This most common communication approach and behaviour of health professionals, which is not always observed by health care staff, could improve patient experience.
- Maintain eye contact (if culturally appropriate), watch your posture, and be polite and considerate.
- Value the power of non-verbal communication
- 'Matching' patients is a powerful way to put them at ease and build rapport. Matching involves reflecting patients' body language, their values in a respectful manner. It is not copying.
- Establish a rapport from the outset with a friendly greeting that sets the tone for future interactions. Recognition and explicit acknowledgement of the emotional content in your patient is important in establishing rapport. Patients will be much more likely to then listen to what you have said in response.
- Listen to the patient and without interruptions, take account of their views and respond honestly to their questions.
- Focus on the patients: by looking at the patient and not at the computer screen.
- Focus on patient-centred care involving patients in decision making. This helps to improve compliance and raises satisfaction; a significant factor in reducing complaints.
- Use clear language. Avoid jargons and tailor your language to your patients' understanding and information needs.
- Establish a dialogue moving from open to closed questions; determine whether patient agrees with the care proposed.
- Use flexible consultation style: a supportive style rather than a directive style.
- Must inform and explain and check patient understood you.
- When on duty be readily available to the patients and colleagues seeking information, advice or support.
- When on duty be readily available to the patients and colleagues seeking information, advice or support.
- Empathy and listen. Establishing professional relationship is vitally important as it facilitates patients expressing their concerns and receive support and advice.
- Apologise when mistakes occur, as this can avert or help end conflict, especially litigation. It is not an admission of liability.
- Must treat patient as individual and Respect patient's dignity and Privacy.
- Be considerate to those close to the patient and be sensitive and responsive in giving them information and support.
- Reflect on outcomes of your interactions with others: offer sufficient explanation and listen to patients and relatives.

Box 1: GMC Recommendations of "Good communication with patients"

Communication partnership and teamwork with colleagues

Doctors have an ethical duty to ensure that their communication with colleagues is promotes best practice and excellence in patient care. The Quality of Patients care depends on open and honest communication between doctors. Complaints, claims for medical negligence, suspension/dismissal, and criminal convictions can arise as a result of poor communication between doctors and colleagues[3]. Doctor's Fitness to practice may be called into question when communication between colleagues is poor as this can lead to sub-optimal (delays and wrong) care, which often lead to harmful effects on patients. The GMC can investigate a doctor's fitness to practice if they have been reported to have harmed patients by failing to communicate appropriately or adequately with colleagues. As healthcare professionals we must be aware of GMC published recommendations (Box 2)[2];

- Must work collaboratively with colleagues respecting their skills and contributions
- Must treat colleagues fairly and with respect.
- Must avoid malicious or unfounded criticism of colleagues that could undermine patient's trust.
- Should act as a positive role model and try to motivate and inspire colleagues
- Should promote a climate of openness in the department where colleagues of all grades trust each other.
- Must be aware of how own's behaviour may influence others within and outside the team.
- Should encourage an atmosphere of honest dialogue and respect for colleagues that would demonstrate medicine practice that benefit patients and doctors alike.
- Should endeavour to foster a culture of positive constructive communication that enables safe and effective clinical care.
- Should adopt a clear and appropriate communication methods (written and verbal) shared with colleagues in order to reduce the occurrence of unforeseen harm to patients.
- Consultants should ensure that juniors have understood instructions correctly, perhaps by summarising key action points at the end of discussion and encouraging questions.

Box 2: GMC Recommendations of "Effective communication with healthcare professionals"

Improving Communication Skill

It is been suggested that 'good communication skill in medical practice are not innates and need to be learned, and always be enhanced"[1]. Communication skill training is recognised as one of the cornerstones of being a good doctor. Research has also provided evidence that training in communication skill can be instrumental in helping to change the attitudes and skills that underlie the way doctors communicate. It is no longer an option, it is essential. The art of clear communication and the steps that doctors can take to improve their communication with patients, family and colleagues have been explored [4].

Communication skill training should be a continuous and recurring process throughout our professional career and at no stages in our career we should stop developing and learning about communication skill. It is the doctor's professional and ethical responsibility to ensure their communication skills are kept up to date. Self -analysis of communication skills and being able to identify the ways in which better communication can lead to better outcomes would help doctors to maximise their personal effectiveness. Self- satisfaction that doing well may not be enough. MDU recommends on honest assessment of personal communication style for approachability and openness. In this regard, 360-degree Multi Source Feedback (MSF) from patients and colleagues can be useful in assessing the quality of communication skills. Communication skill training (Basic and Advanced) is needed to address the skill 'gap'.

Virtual Communication with Patients and Colleagues

Traditionally in the NHS, 'Face to face' communication with patients and colleagues is considered as a standard 'normal' practice. During the unprecedented times of ongoing COVID-19 pandemic, virtual communication with patients and the colleagues using video has opened up a new frontier in the field of communication. Virtual communication has been recognised as an effective means of communicating with patients in the clinical settings; and with colleagues in different strategic multi-disciplinary team (MDT) meetings, collaborative workshop and educational and training meetings (e-Learning) etc. It has been suggested that virtual communication will become a standard component of future clinical practice in term of communicating with patients and colleagues.

Conclusions

This cannot be over-emphasized that good communication has a positive impact on all aspects of professional care in the NHS. Maximising effectiveness in communication not only enhances doctor's personal performance and many different spheres but also improves doctor's relationship with patients, their relatives and colleagues and facilitates success. Research evidence also suggests that good communication has a therapeutic value in terms of symptoms relief, reduced need for medications, reduced anxiety and depression and a feel good factor for patients and their relatives.

Poor or ineffective communication is the single largest factor that may have significant consequences in terms of complaints and claims, litigations, disciplinary actions, allegations of gross negligence manslaughter, exclusion, dismissal and GMC investigations. Good communication can help to avert many medicolegal problems. It is, therefore, of paramount importance that NHS staff at all levels communicate effectively.

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The modern-day clinician and **life-long learning**

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The GMC has a clear requirement for all doctors to "keep their skills up to date", this is the essence of life learning.

Life long learning for doctors is encouraged at the outset of medical training. Life long learning is not only a postgraduate requirement for healthcare professionals, but also forms the cornerstone of modern day medical school philosophies.

In tomorrow's Doctors (GMC 2003) the GMC states that medical students should be able to:-

1. Gain, assess, apply and integrate new knowledge and have the ability to adapt to changing circumstances throughout their professional life.
2. Take part in continuing professional development to make sure they maintain high levels of clinical competence and knowledge.
3. Respond constructively to the outcome of appraisal, performance review and assessment.

Practitioners at all levels must be aware of the need for lifelong learning. This article discusses and focuses on how to integrate lifelong learning into your clinical practice.

Lifelong learning has the ability to keep abreast of developments and changes in professional standards and evidence based healthcare. However, it also involves the clinician understanding the skills he/she possesses and how these can be transferred from one situation to another.

To be lifelong learners doctors have to rely on methods of learning, which may or may not be congruous with those used at undergraduate level; those graduates who had a problem based learning or self directional medication education tend to be better prepared for post-graduate development. However, postgraduate learning can be difficult and must be considered in the context of caring directly for patients. Both hospital doctors and GPs have to be clinicians and managers in their daily practice and are able, along with their team, to adapt and react to change.

It is worth noting the importance of peer review as an instrument for self-improvement; this tool can help reflective practitioners provide the highest standards of care for their patients. Peer review can also help clinicians identify personal strengths and weaknesses; this then identifies areas for personal improvement.

One principle that often supports and encourages lifelong learning is the opportunity of choice and flexibility about what is to be learnt. We may choose to learn at work or outside of it – the choice is often ours, but are we responsible for our learning and skills development?

Lifelong learning recognises the workplace as a powerful learning environment in which we all can learn, either individually or together. In many hospitals and practices emphasis on learning is the key strategy for managing change and future developments, for both the individual and the organisation.

Organisations that support and encourage questioning and exploration of ideas and beliefs tend to be dynamic and progressive; a workforce comprising lifelong learners is more likely to be energised, creative and empowered.

Sadly there is a wide variation in access to education across trusts. Where a clinician has a paucity of lifelong learning opportunities, it would be easy to see why that clinician had a negative view of lifelong learning. It is vital therefore that all clinicians are given ample opportunities to learn and develop in the clinical setting.

Lifelong learning builds on what you bring to the workplace as well as recognising all your skills. The ability to access electronic resources is vital for the execution of efficient lifelong learning. However, informal learning often contributes most to your personal development.

Doctors and other healthcare professionals may feel overwhelmed when adjusting to lifelong learning and the idea of continual change. The changing science of medicine seems to go through a 10 year cycle, in which practitioners not only have to become aware of new ideas and developments, but also apply them to clinical practice for the wellbeing of their patients. Add this to changes in bureaucracy of management, and it could he argued that doctors who have not developed lifelong learning will struggle both in clinical and management terms.

So who are lifelong learners?

They are autonomous practitioners who are able to evaluate their own performance and value their own and others' opinions within and without their speciality. They are reflective practitioners who use reflection to guide their clinical care - so do not need to receive academic training about lifelong learning. In a sense, all clinicians are lifelong learners; we all should be aware of that, when providing individual care that is supported by evidence-based practice, we are in fact using lifelong learning skills.

Mental Health and our Society:

A medical student's perspectives and experience

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Introduction

There are higher rates of mental health issues for those in low-income groups compared to high-income groups. These disadvantaged groups are more likely to live in debt, live in areas with high crime rates and have less access to health services and subsequently, poor physical health.[1]

After interacting with mental health patients at Stubbylee Greenhouses, it became apparent to me how poor housing conditions could be linked with deterioration of both their physical and mental health.[2] Living in deprived areas limits their opportunities to accept certain jobs and living in damp, dirty and poorly maintained areas may exacerbate existing medical conditions further.[3] It has also been shown that poverty and unemployment tend to increase the duration of ill health, which leads to a vicious cycle.[4]

Barriers

Those with mental health issues experience several barriers to care, which play a pivotal role in the way that they access healthcare and are crucial when examining ways to better deliver care to them. These issues raise further concern when looking at statistics that 35% of those with mental health or emotional issues don't seek any formal or informal help.[4]

Some of these barriers may be overall low self-confidence and no determination to seek help, which could be due to lack of education and absence of an emotional support network at home during their formative years.[5, 6] Some other issues raised were concerns of confidentiality, trust and that the prescription charge is often too expensive for them, which can be related to previously mentioned issues of income and unemployment. After spending time at Stubbylee Greenhouses and interacting with participants there, I discovered that those with mental health issues felt that care workers exhibit judgemental attitudes towards them and that this further deters them from seeking help. One of the members at Stubbylee mentioned that he was afraid to seek help and lived in a state of being 'comfortably numb' through binge drinking through his bipolar disease.

I feel that the key to addressing these barriers will stem from actively listening to patients and coming up with practical proposals such as creating awareness about existing mental health helplines and increasing the number of support workers available on these hotlines. These changes will help fearful patients access support without having to physically go to a clinic.

Financial barriers such as expensive prescription charges also hinder access to health care, which can be related to previously mentioned issues of income and unemployment. This supports the inverse care law that states that "the availability of good medical care tends to vary inversely with the need for it in the population served".[7] Most mental health patients I interacted with were living on various welfare schemes and found it expensive to travel to their GP.[4] The healthcare organisation could tackle this barrier by introducing GP camps in mobile vans which rotate around different localities, increasing accessibility.

Another way to improve their access to care would be to improve services of organisations such as Minds Matter, which, in my experience, were understaffed and take several weeks for first contact with a patient to be made.

Third Sector Organisations

Third sector organisations are non-governmental, non-profit, volunteer-run organisations aimed at providing services for the community that they find are lacking from traditional health and social care organisations.[8]

The NHS often uses them as intermediaries for delivering care. While I was at university placement in a GP surgery in Lancashire, I learnt that the team of doctors were very well informed of the services Stubbylee offers and encouraged those with mental health issues to explore the various activities and support groups available. This would also reduce the burden on NHS funded services and other social organisations like Minds Matter, which are extremely oversubscribed.

Third sector organisations bring tremendous value to their service

users and the entire community in ways in which other organisations often struggle. As they are generally small, locally managed organisations they can deliver services efficiently by offering greater flexibility and adapting very quickly to what their service users require through innovative means.

They also actively campaign to raise awareness on issues their users face through traditional and social media. This can be aimed at both educating the general public and attempting to bring changes to existing government policies. They also aim to conduct their own research as they have access to vast amounts of data on their participants.[9]

During my placement, I experienced this first-hand as the third sector organisation actively supported its participants through providing them the opportunity to a fresh start by offering them diploma level courses on-site in horticulture. The aim of this is to get them interested

in higher education in the hope that they will pursue this further by potentially enrolling into a university course or to simply enhance their job prospects.

I also noticed that staff at Stubbylee provided additional support to their participants by assisting them with their applications for universal credit and played a key role in the appeal process. They also provided non-salaried jobs at their cafe for service users who could not find employment anywhere else. The barista at the café explained how she values the job immensely as it has helped improve her mental and physical health by interacting with people all day and gives her a sense of purpose.

Although Stubbylee provides these life-changing services, they do not have a dedicated helpline that users can call if they are struggling with an acute problem that they need support with. Stubbylee could also do more to increase awareness of mental health in the community and campaign to influence legislation and other activities on the national level in addition to their invaluable work in the community.

Another similar third sector organisation called 'Mind', offers additional therapies such as support groups, counselling sessions aimed at students and other alternative therapies such as yoga and meditation. They also have dedicated telephone helplines which play a vital role in offering support to those in acute periods of distress and those who cannot go physically to meet their 'Mind teams'.[10]

In conclusion, third sector organisations play an integral role in delivering care to vulnerable groups of people across the UK and relieve excess burden from the NHS and other social sector organisations.

Stubbylee Community Greenhouse – my placement

Stubbylee Community Greenhouses, a third sector organisation is located in Bacup, Lancashire. Established in 2004, this community greenhouse centre is designed to make the participants feel safe and provide them with a non-judgemental and encouraging environment to heal and connect with others in the community.[2]

Stubbylee organises a plethora of activities and courses such as gardening, woodwork and crafts which help in providing their participants with a sense of satisfaction and accomplishment which is key in improving their mood and mental health.[11]

An interesting activity that I participated in was a community beautification project where a group of volunteers from Stubbylee and I went to a nearby church's graveyard where we cut overgrown thorn covering old graves. After clearing almost half the graveyard in a couple of hours, I felt an immense feeling of satisfaction and accomplishment, which I realised would be even more pronounced on my colleagues who struggle with depression, anxiety and suicidal tendencies.

Stubbylee also offer regular 'tree plan assessments' every few months to help participants measure their progress and re-evaluate their goals. These assessments are distinct from other mental assessments as it encourages deep reflection.

They play a vital role in gauging how much support participants require as well as evaluating their progress. Most of the participants I met had previous experiences of being evaluated in clinical settings where they were assessed through laborious interviews and clinical assessments. In contrast, they felt that this evaluation was more casual and they expressed that they felt more comfortable and less intimidated.

On my first day, the clinical supervisor performed a tree plan assessment on me and I was surprised by the deep self-reflection and engaging conversation the assessment stimulated. After I chose an answer to each category, I was asked why I felt that choice was most appropriate and why the others were not. I was encouraged to delve into events from my past to help support my choices and this helped me understand myself better. I was often challenged by my choice of answer and asked to explain myself.

Conclusion

My time at Stubbylee made me appreciate the struggles other sections of society go through. I appreciated the fact that many people may not have grown up in a safe and encouraging environment, which may have influenced their development and progress in their adult lives. I have learnt first-hand how important the biopsychosocial model is in treating patients; it is crucial to treat the patient as a whole and not just through medications and treatment.[12] In my clinical practice in the future, I will strive to be sensitive to vulnerable individuals and recognise their feelings and endeavour to support them to the best of my ability.

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A crushing forklift injury: traumatic abdominal wall hernia: Case Report

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History

A 60-year-old gentleman presented having sustained blunt trauma to the abdomen, whilst at work, after becoming accidentally crushed between the side of a stationary forklift truck and the fork of an advancing truck (travelling at approximately 1 mile per hour). He remained trapped in between the two trucks for a few seconds. He sustained no injuries to his head, chest or limbs.

Clinical Presentation

Upon presentation, his main complaint was dull, central abdominal pain, worse on movement. There was no history of loss of consciousness, nausea or vomiting. On examination he was haemodynamically stable. There was a small area (1-3cm) on his anterior abdominal wall of skin discolouration and mottling over the site of the defect with localised swelling, likely superficial haematoma. The skin at the site of fork impact was intact. There was mild abdominal distension with associated tenderness.

Investigation

A computed tomography (CT) scan of his abdomen and pelvis revealed a 55mm paraumbilical hernia defect containing bowel (Figure 1 and 2), with no evidence of a collection, blood or any underlying visceral injury.

Treatment

He underwent an emergency open primary suture repair of traumatic abdominal wall rupture. Intra-operatively the anterior abdominal wall defect was cruciate-shaped, irregular with frayed edges suggesting an acute trauma. The defect was found to be larger than predicted on imaging (8-10cm maximal length). There was no evidence of intra-abdominal injury. There was no tissue loss and the sheath was repaired with loop PDS. There were no immediate post-operative complications and he was discharged home after 5 days.

A CT scan was done 2 weeks after the repair, which showed no collection and no concerns from the point of view of our surgical repair.

Discussion

Traumatic abdominal wall hernias are uncommon, and may present with subtle clinical findings.[1] CT imaging appears to be the imaging modality of choice for identifying such injuries, due to its widespread role in the management of trauma patients.[2] Both emergency, and delayed surgical repair of traumatic abdominal wall hernias is described in the literature, and the choice of timing, and approach, appears related to a number of factors including size of the abdominal wall defect and presence of associated intra-abdominal injury.[1]

Take Home Messages

1. Abdominal wall hernias post blunt trauma are rare
2. A high index of suspicion, and computed tomography (CT) imaging, are important in the diagnosis of traumatic abdominal wall hernias
3. In the absence of features mandating a laparotomy, asymptomatic cases may be managed conservatively, or with delayed surgical repair.

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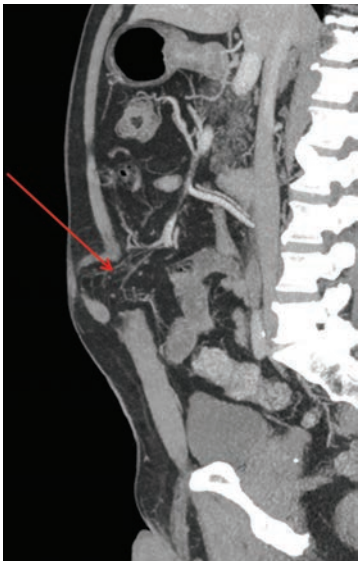

Figure 1: Sagittal view CT imaging showing the anterior abdominal wall traumatic hernia defect.

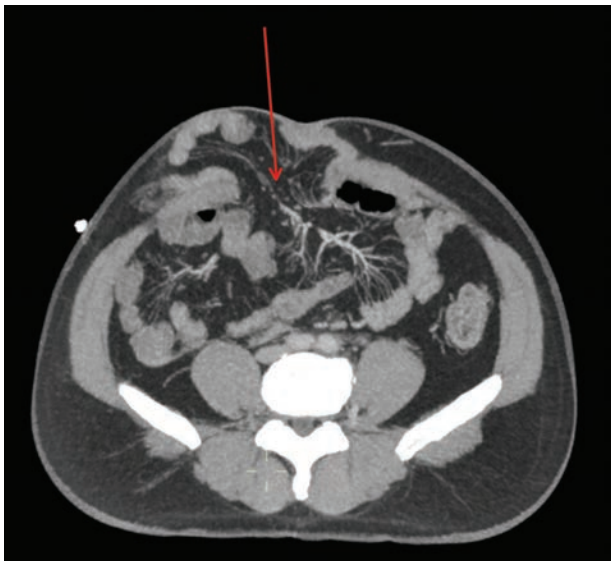

Figure 2: Axial view CT imaging showing the anterior abdominal wall traumatic hernia defect

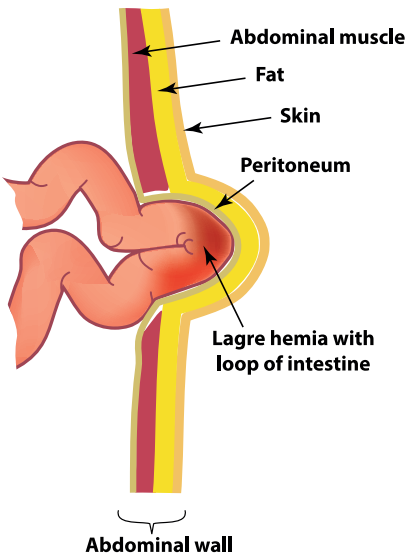

Illustration of an Abdominal Hernia.

Letter *to the Editor*

Dr H K Khokhar GPST1, Macclesfield General Hospital

"WWL – A story of hope"

Dear Editor,

I remember the sight of desolate streets; a sense of panic and a feeling of disbelief very much appreciable through the news. The images broadcast from the city of Wuhan in the month of January seemed nothing short of post-apocalyptic. A part of me believed that the spread of the virus would exhaust in a few weeks but in all honesty the thought of 'what if this is the start?' sent chills down my spine.

I believe I was not the only one!

Fast forward to March 2020. The anxiety levels in the air underwent a daily uptick. By now the spread in Italy had truly shattered any belief that the UK was untouchable. COVID-19 was surely here and without us even knowing. My personal reserve of denial finally emptied when one morning early March, walking into our accident and emergency department, I saw construction workers at our entrance wearing FFP3 masks! The worry was becoming palpable in the country. It fast became clear that the outbreak in Wuhan was the start.

As health care professionals we practice evidence based medicine. Our greatest challenge was separating facts from myths. We had scanty evidence and little guidance to deter the virus and to protect our patients. Amidst our inertia, COVID-19 had assumed a position of control but while others waited, WWL got going.

As a junior doctor working at Wrightington, Wigan and Leigh NHS Trust I feel our trust has been an organization of action. Thousands of health care staff across the globe has worked with inadequate PPE, a lack of guidance and changing guidelines. We go into daily service unable to quantify the risk we pose to ourselves or the families we go home to. Many work as overseas doctors in the NHS far from their families in these unprecedented times. Early in the pandemic at our trust, risks to staff were recognized especially considering 60% of our staff belongs to BAME communities. Steps were taken; risk assessments performed of all its employees resulting in our colleagues being deployed at COVID negative sites and arranging work from home where possible. A feeling of confidence and assurance began to settle in. Hotel accommodations were arranged for those testing positive, protecting not only the work force but also their families.

The lack of adequate PPE in the UK has been well documented. However, at WWL all working staff in the COVID environments continues to have all necessary equipment including full sleeve gowns, respirator masks, face visors and disposable gloves. This was arranged by the trust independently. This single step gave not only confidence to all working at the front line but more importantly instilled togetherness. I sincerely believe this generated amongst us a feeling of empathy shared across the breadth of the WWL family giving us a renewed vigour.

Further actions, although small in appearance but significant in building this feeling of camaraderie have continued. Parking fees have been abolished. All staff have free lunch and dinner at the trust. Further procurement of masks with reusable filters has taken place for all front line staff. We continue to fulfill our duty to not only our patients but also our fellow colleagues. International doctors who have recently passed their PLAB exams but remain stranded in the UK due to travel restrictions have been meaningfully employed at Wigan Infirmary. Up to date 10 doctors have been employed, risk assessed and are working on the same terms and conditions as local doctors. As an international medical graduate working in the NHS this action gives me great pride in knowing I belong to the WWL family.

The threat of a pandemic to the scale being currently witnessed was always present. However, for that threat to manifest in our lifetime was unexpected. This outbreak has brought health care services across the globe to its knees. However, we must dare to stand. The strength we must the draw upon is in togetherness; a feeling of shared struggle. We at WWL have dared to take the initiative and encapsulate the spirit of the NHS. This dynamic approach will continue to make a positive impact and leave a precedent for future challenges. This is a success story in difficult times. Let our story be one of hope!

H K Khokhar

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Tackling Childhood Obesity Webinar

Convenors: **Dr. Vinod Gadiyar** Consultant Pain Specialist and Anaesthetist, Northern-Care Alliance NHS Trust
Mr. Mohamed Alasmar Senior Clinical Fellow in Upper GI Surgery, Salford Royal Hospital

27 November 2020

9:00- 9:05 Welcome, Introductions and Purpose
Jack Carne Co-Chair OASIS-GB

Session 1: Context And Challenges

9:05-9:15 Setting The Scene
Prof. Siba Senapati
Consultant Bariatric Surgeon at Salford Royal Hospital, Chairman of OASIS-GB

9:15-9:30 Current stats, medical management and serious case review
Dr. Kalpesh Dixit Consultant Paediatrician at Salford Royal NHS Trust

9:30-9:40 Current Public Health Guidance of England On Childhood Obesity
Deborah Thompson Consultant in Public Health

9:40-9:55 Media Portrayal of Childhood Obesity
Dr. Stuart W. Flint Associate Professor of the Psychology of Obesity at University of Leeds
President, Scaled Insights and Director of Obesity UK

9:55-10:25 Role Of Nutrition, Exercise And Behaviour
Dr. Anna Robin Programme Lead Nutrition and Exercise as Medicine, The University of Salford
Dr Paul Sindall Senior Lecturer in Exercise Science, The University of Salford
Dr Phil Gray Lecturer in Exercise and Health Psychology, The University of Salford

10:25-10:45 Panel Discussion and Questions And Answers
Mr. Kevin Fitzpatrick BBC Reporter
Dr Akheel Sayed Co-Chair OASIS-GB and Consultant Endocrinologist and Bariatric Physician
Dr. J S Bamarah Consultant Psychiatrist and National Chair of BAPIO
Dr. Sanjay Arya Consultant Cardiologist and Medical Director of Wigan and Wrightington Hospital
Dr. Pradeep Subudhi Consultant Microbiologist at Royal Bolton Hospital

Session 2: What's Happening Locally To Tackle Childhood Obesity?

10:45-11:15 What's Happening In Salford Schools?
(Presentations from four different schools)
Jude Scrutton, Lucy Bird, Ross Sutherland, Mark Bossons

11:15-11:45 What's Happening in the Community?
How can physical exercise work alongside Education and Environment?
Alison Page, Jack Carne

11:25-11:35 What's Happening Through Mutual Aid Groups?
Tom Waring

11:35-11:45 What Are The Perspectives Of Young People?
Presenters from the Youth Alliance

11:45-12:00 Panel Discussion and Questions And Answers

12:00-12:20 Open Forum, Vote of Thanks and Close

What do the findings mean for each of us in our respective roles?
How can we reconcile our own targets and budgets with what have been identified as positive solutions?
Can we collectively make any pledges to ensure long-term sustainability?

Please join and participate in this event by mailing the following:

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Jcarney171@gmail.com

Together, we are stronger!

The British International Doctors' Association (BIDA) is a professional doctors' association. Its sole objective is promoting equality and fairness for all doctors and dentists working throughout the United Kingdom.

BIDA's mission is to achieve equal treatment of all doctors and dentists based on their competence and merit, irrespective of their race, gender, sexual orientation, religion, country of origin or school of graduation.

If you believe in this mission, join us!

You will make professional contacts, gaining the opportunity to network with people who can impact your profession, and giving you access to new opportunities, friends and information. We also encourage you to attend BIDA-organised international, national and regional conferences and seminars, Divisional meetings, and to join in the many social activities arranged throughout the year. We offer constant access to pastoral support, nomnations for Excellence Awards, and you'll have the recognition of your peers in being part of a like-minded group of professionals.

If you are interested in joining BIDA, or would simply like to know more about us, please either write to **BIDA, ODA House, 316A Buxton Road, Great Moor, Stockport, Cheshire SK2 7DD, U.K.,** e-mail us at **bida@btconnect.com**, or contact us through our website at **www.bidaonline.co.uk**.