SUSHRUTA

JOURNAL OF HEALTH POLICY & OPINION

VOL 14 | ISSUE 3| OCT 2021

BAPIO 25 YEARS
BRITISH ASSOCIATION OF PHYSICIANS OF INDIAN ORIGIN SILVER JUBILEE 1996-2021

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SILVER JUBILEE EDITION

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SUSHRUTA JOURNAL OF HEALTH POLICY & OPINION

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Sushruta is published as a quarterly, open-access, scholarly journal for professionals and scientists associated with research and delivery of health care and its policy. The scope of this journal includes the full range of diverse, multi-professional health and social care workforce and global partners.
The journal aims to represent the breadth of issues on health policy and opinions which impact the readership, affect them, and the wider healthcare community. The readership includes undergraduates, postgraduates, and established professionals globally.
The views expressed, are of the authors and peer-reviewed (open) by independent global experts. The editorial board does not limit or direct the content except in maintaining professionalism, checking the evidence base for references (where relevant). All care is taken to ensure that articles comply with current UK law and are GDPR compliant.
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SUSHRUTA | VOL 14 | OCT 2021 | ISSUE NO. 3

#BAPIO25
SILVER JUBILEE
Conference Edition

FRIDAY 21 OCTOBER 2021

Registration | 09:00

Breaking Barriers | Bridging Gaps

Inauguration | 09:20

Welcome | Divya Prakash
Opening address | Ramesh Mehta, President, BAPIO
Setting the scene | Marimouttou Coumarassamy, BINA

Keynote | Ruth May | 09:45

Chief Nursing Officer, England

Leading for Excellence | 10:00

Clinical Nursing | Felicia Kwaku | Associate Dir Nursing & Chair (CNO BAMESAG)
Strategic Leadership | Patrick Nyarumbu | Exec Dir People & Culture, BSMHFT
Academic & Research Nursing | Manju C.Pallam | Snr Lect, MMU
Panel Discussion Chairs | Roisin Fallon-Williams, CEO BSHMHT & Suresh Packhiam

Coffee | 11:00

Guest Lecture | Sue Tranka | 11:15

CNO Wales

Breaking Barriers | 11:30

Health inequalities | Habib Naqvi | NHS Race & Health Observatory
Inequalities in Nursing profession | Anton Emmanuel, Director, WRES,NHSE
International Nursing Workforce | Duncan Burton | Dy Dir, Nursing, NHSE
Panel discussion Chairs | Asha Dey & Mahendra Patel

Lunch | 13:00-13:45

#BAPIO25 | SILVER JUBILEE CONFERENCE
EDGBASTON STADIUM, BIRMINGHAM B5 7QU

BAPIO 25 YEARS
BRITISH ASSOCIATION OF PHYSICIANS OF INDIAN ORIGIN
SILVER JUBILEE 1996-2021

FRIDAY 21 OCTOBER 2021

Keynote | Ged Byrne | 13:45

Health Education England - Global

International Fellowship | 14:00-14:45

Radiology, Emerg Med, Radiographers & Paramedics
Panel Discussion | Chairs: Robin Procter & Rose McCarthy

Coffee Break | 14:45

Women's Forum | 15:00 -15:45

Being an ally | Partha Kar
·Women in medicine | Jyothi Srinivas
· Panel Discussion
Malvika Subramaniam, Jheel Vasani, Pooja Arora
Chairs: Bhupinder Sandhu & Neha Sharma

GP Forum | 15:45-16:30

Health for self | Sandesh Gulhane
Health for practice | Katrina Davis
Health for future | Ankur Khandelwal
Chairs | Kalindi Krishna Tumurugoti & Sapna Agrawal

Safety & Wellbeing Forum | 16:30-17:15

Bullying is a curse in the NHS | Raj Mattu
Managers & Inclusivity | Raghuram Ananthakrishnan
Wellbeing of bullied staff | Viju Varadarajan
Q & A - Tackling Bullying & Harassment
Chairs | Sanjay Arya & Bhavana Chawda

Vote of thanks | 17:15

Cherian George

Faculty Dinner | 19:00

SATURDAY 22 OCT 2021

Wellbeing session | 07:00

Hotel Park Regis, Yoga / Health walk / Meditation
Organisers | Saraswati Hosdurga & Rajiv Metri

Morning Session | 08:30

08:30 | Registration, Coffee and Networking
09:30 | Welcome| Achuthan Sajayan
09.35 | President's address | Ramesh Mehta OBE
0945 | Launch of documentary & BAPIO Theme Song

Equity & Fairness | 10:00

Presentations - Abrar Hussain | Anushka Shukla | Hina Shahid
Panel Discussion: Dame Jane Dacre | Anton Emmanuel | David Nicholl | Chaand Nagpaul | Andrew Goddard | Michael Mulholland
Chairs: JS Bamrah and Renu Jainer

Coffee break | 10:50

Keynote | Sir David Nicholson | 11:10

Chair of Sandwell and West Birmingham NHS Trust, past CEO NHS
Chairs: Ramesh Mehta & Uma Gordon

BAPIO Training Academy | 11:40

Swati Goray (LED) | Aakash Sharma (Trainee)
Panel Discussion: Graeme Dewhurst, David Wilkinson, Nihal Fernando, Steve Davies, Andrew Elder & Simon Gregory
Chairs: Parag Singhal & Dame Parveen Kumar

Keynote | Charlie Massey | 12:30

CEO, GMC UK
Chairs - Arvind Shah & Geeta Menon

Lunch | 13:00 - 13:45

SATURDAY 22 OCT 2021

Research & Innovation | Wawickshire Suite | 13:45-16:00

BAPIO Institute for Health Research parallel session of presentations | Chairs - Subarna Chakravorty & Sunil Daga

Keynote | Prerna Issar | 13:45

Chief People's Officer, NHS England
Chairs - CR Selvasekar & Ibrahim Bolaji

Tackling Discrimination | 14:15

Thangamma Katimada (Locum Consultant), K. Gajanan (SAS)
Panel Discussion: Neena Modi | Mala Rao | Habib Naqvi | Helen-Stokes Lampard | Alison Johns | Camilla Kingdon
Chairs: Indranil Chakravorty & Ged Byrne

Coffee break | 15:00

Keynote | Baroness Kennedy of The Shaws | 15:15

Chairs: A Sajayan & Viju Varadarajan

Supporting Doctors | 15:45

MDS session - Anjay Pillai | Sanjaya Kalkur | Krishna Lava
Panel discussion: Joydeep Grover | Sarah Dodds | Irfan Akhtar | Iqbal Singh | Marimouttou Coumarassamy
Chairs: Satheesh Mathew & Biju Simon

Chairman's Session | 16:30

Horizon scanning – The Past, The Present, The Future
Amit Gupta | Roshelle Ramkisson | Priyanka Lakhani
Panel discussion: Ramesh Mehta | Romesh Gupta | Raman Bedi | Rajan Madhok | JS Bamrah
Chairs: Mr Kalidasan & Manaswi Dwaraknath

Vote of thanks Subrahmanyan Radhakrishna

Drinks, Awards & Dinner | 18:30

Compère : Ms Anushka Arora, Sunrise Radio
Guest | Farokh Engineer
Entertainment by Navin Kundra

SUNDAY 23 OCT 2021

Health Walk | 08:00

Morning Walk Organisers: Dr Ravi Baikady & Dr Kinnari Mehta(Complimentary BAPIO Tee shirts to walkers)

Registration | 09:00

Welcome - Neeraj Bhala

Research & Innovation | 09:30

BAPIO Institute for Health Research oral presentations
Chairs - Subarna Chakravorty & Sunil Daga

SAS & LED Session | 10:30

Debate: "The new contract will provide Recognition to SAS Doctors"
For: Rajesh Against: tbc
Moderators: Amit Kochhar & Beryl DeSouza
Chairs: Dr GajananChair K Gajanan

Coffee break | 11:00

Faculty of Leadership | 11:15

Navina Evans | Vijay Nayar
Panel Discussion Chairs: Geeta Menon & M Hemadri

Health & Wellbeing Forum | 12:00

Health and wellbeing: Is it a necessity or a luxury? Saraswati Hosdurga
Self-care and healing through creativity - Geetha Upadhyaya
Chairs: Payal Mehta & Ravi Baikady

Paediatric Forum | 12:30

How BACCH and BAPIO can work together to make a difference? - Doug Simkiss
Challenges and opportunities of working in leadership role in the biggest NHS trust in UK.- Anjum Gandhi
Successful working partnerships in paediatrics with India –Leading by example - Satish Rao
Chairs: Neha Sharma & Subramaniam Mahadevan -Bava

Lunch | 13:00

Vote of thanks - CR Chandra

Notes from the Silver Jubilee Team

'We did find the light together..' Renu Jainer

It gives us immense pleasure on behalf of BAPIO Silver jubilee organising committee to invite you to join us in the Heart of England at Edgbaston cricket ground, Birmingham from 22-24 October 2021. This event is the culmination of tireless work of many of us over the last one year despite the challenges of pandemic, to celebrate our achievements and will be a landmark in the history of BAPIO . Though our Annual Conferences have evolved into an important national event in the UK medical calendar this will indeed be a special one.

Since the launch of BAPIO in 1996 it has grown in stature and influence. With 13 divisions across the UK, 10 specialty fora and five arm's length bodies (Medical Defence Shield, BAPIO Training Academy, BAPIO Institute for Health Research, British Indian Nurses Association and BAPIO Faculty of Leadership) our growth has been robust. We have made a significant contribution to the agenda for equality, diversity and inclusion. We have been committed to promoting professional excellence and leadership amongst our members, who are a growing family. The journey of this special event has indeed been incredible for us as we were navigating with lots of ifs and buts, and series of pandemic lockdowns. However we did find the light together with our President Ramesh Mehta, who was our torch bearer though likes to be called the *'foot soldier'*.

Of course it could not have been possible without tremendous effort and discipline by Sajayan, West Midlands Chair. We started off with energetic work in different places, expanding and engaging the divisions and fora. Alongside work was going on for the production of a documentary with Loveena Tandon, a well known journalist and the recording of the BAPIO song with a perfect tune from Sethu, Saras and their team. Indranil Chakravorty and team put in a lot of effort to create this special edition of Sushruta.

We received nearly 100 scientific abstract submissions, contributions from national leaaders and international experts joining the brain storming panel discussions. There will be showcasing of the contributions of the arms-length bodies, regional divisions and fora. To arrange for a real event for around 400 people was a challenge in current circumstances. We were put on the back foot by the COVID19 surge in India in April - May. BAPIO team channelled their energy in supporting the people and medical fraternity in India. Now that challenge has subsided we are back. To add a special *'tadka'* flavour we do have *'mela'* with Henna art, ayurvedic treatments, ethnic apparels and jewellery stalls.

Together we have planned a fantastic programme for new beginnings. Do learn, enjoy, network, dream to reach over and beyond and let's make memories to last.

ORGANISING COMMITTEE

Achuthan Sajayan

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Chair, Org Committee

Ashok Nair

Renu Jainer

Vice-Chair, BAPIO West Midlands

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1996-2021

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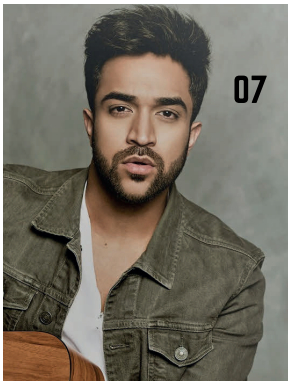
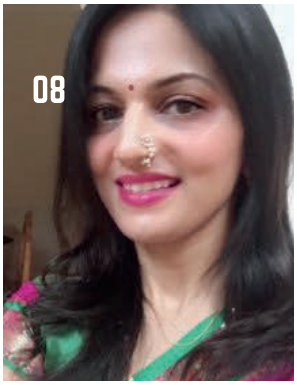
Breaking Barriers

Bridging Gaps





RAMESH MEHTA
concept

01 **KARTHIK SARAGUR**
lyricist

02 **SUMATHI SHEKHAR**
vocalist

03 **SANJAY R.A.**
music director

04 **HASTON RODRIGUES**
vocalist

05 **JOY ELVIN DINAKAR**
vocalist

06 **SETHU WARIYER**
vocalist

07 **NAVIN KUNDRA**
vocalist

08 **ASMITA DIXIT**
vocalist

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Uma Gordon
Indranil Chakravorty
Ananta Dave

SARASWATI HOSDURGA
producer

BAPIO25

Sarve Bhavantu Sukhinah
Sarve Santu Niramaya
Sarve Bhandrani Pashyantu
Maa Kashchit Dukkha Bhaarbhavet

From East to West
To build a nest...
We voyaged on a hope
With sea-full of love
And eyes full of dreams
But a thousand challenges to overcome

Waiting to embrace
To nurture with grace
We waited on the banks of the Thames
Our healing hands
Can take away the pain
Of the countless souls and names
We are bapio
Our own bapio

Joining the strings
Of hands and hearts
We unfurl this flag with pride
A boon, A promise and
A pillar of strength
The power that always guides.

We are BAPIO
Our own BAPIO

Conceptions, Birth & First Steps

Raj Kathane
Reproduced from Sushruta 2011

Unlike the Immaculate conception or that of Brooklyn Beckham it is often difficult to determine exactly when the conception took place, especially if it is an idea! We had often tried to pin-point such a date for BAPIO; the nearest we could come to narrow it down, was perhaps the summer of 1994. And it certainly was not done at the first attempt! A group of us, some 10 or 12, used to sit around informally (in not smoke-filled rooms) to discuss many issues that affected the doctors in all different cadres: the GPs, the junior doctors, the middle grade doctors, the Consultants etc.

It was becoming clearer that there was growing frustration and exasperation within the doctors who came to the UK from other countries. There was a perception at that time that there was a greater chance that, if you were an immigrant doctor, that you were likely to be complained against, be referred to the GMC for wrong-doing and be punished, than if you were not. There was frustration amongst the immigrant doctors that the established systems may not always come to the help and rescue fully and that the outcome was often compromised and less than satisfactory. Being Indian, we started to narrow down the remit of such discussions to this context.

There was of course some organisation that did help the immigrant doctors but the name tended to suggest that it was for foreign and overseas doctors rather than the specific context being British, working in Britain and being of Indian Origin. Indian Origin, again, is a broad brush: people from India, Pakistan, Bangladesh, Nepal and Sri Lanka have the same or comparable colour and morphology and it is often difficult to locate where one person may have come from. Thus, there was perhaps a need for such doctors to 'belong' to a specific group.

Ramesh Mehta, for if there is a born leader, that is him (I have known him since 1966 from our medical school days as we were classmates, and I had personally seen many examples of his strong and skillful leadership), got thinking harder about such issues more than the others.

News came that in the USA, there was such an organisation for doctors of Indian Origin, the American Association of Physicians of India (AAPI). It was financially very rich and politically very active and had a great clout. One of their annual conferences was graced by President Bill Clinton. So here was the outline of the vision and the challenge for Ramesh!

Bapio Launch 17 May 1996

The discussions began to crystallise with action plans. That would have been around 1995. A name began to emerge; many variations were suggested; great discussion took place and finally the current name was settled on. A small sub-group worked on the logo. Finally, the British Association of Physicians of Indian Origin was launched at a dinner meeting at a local Indian / Bangladeshi restaurant. That was Friday the 17th May 1996. Much background work was still going on and finally it was time for the National Launch of the Organisation. By now, there was the change of Government to Tony Blair's and Tessa Jowell was the Health Secretary; she was invited and accepted to inaugurate. That function took place in the Harpur Suite, Corn Exchange, Bedford

25 years

In 2021, BAPIO reaches a major landmark in its journey. A journey which builds on a legacy of a quarter of a century of dreams and aspirations for thousands of doctors who have dedicated their professional lives to the service of the United Kingdom.

Ramesh Mehta OBE
President,
British Association of Physicians of Indian Origin

BAPIO was born as an organisation striving to gain equality, justice as well as professional excellence for doctors from the Indian sub-continent. Over its 25 years of actions we have highlighted the huge contribution of not only doctors from the Indian sub-continent, but also all immigrant medical professionals and minority ethnic professionals born and raised in the UK, who are a substantial proportion of the workforce.

BAPIO members have put their versatile talent, innovation and energy towards the sustainability and development of the UK National Health Service. At it's heart, our mission was and remains to promote equality and diversity while supporting doctors to be educators, researchers, leaders and always to provide excellent care to our patients.

As a national voluntary organisation and a valued stakeholder, BAPIO has been playing a major role in helping to shape the future of the NHS, for improving care, tackling inequalities and promoting health. We now have a global outlook. and our strategy is based on four pillars;

- Policy
- Education and Skills
- Support & Wellbeing
- Charity and promoting equality & justice

Our vision for a fair & just society

BAPIO has always been at the forefront of challenging injustice and unfair policies or implementation of discriminatory regulations to seek redress, but always in the spirit of collaboration and cooperation. We have only resorted to formal or legal routes when all negotiations have failed and equality or justice is at stake.

This, persistent DA across the career cycle had spurred BAPIO to chair the 'Alliance for Equality in Healthcare Professions'

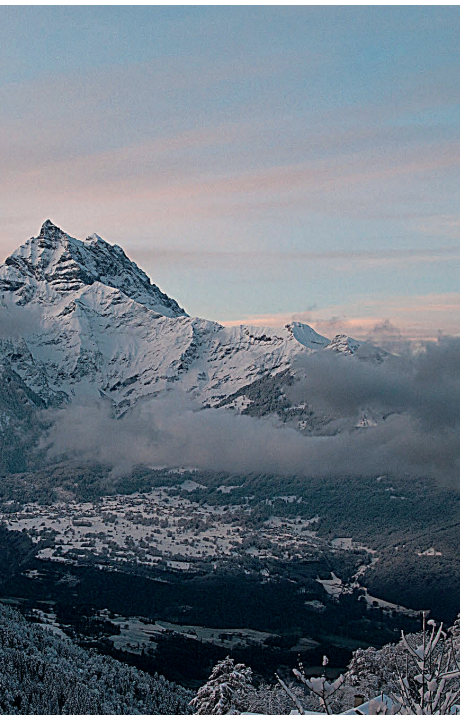
BAPIO challenged the UK Department of Health and the Home Office in 2006 when without any consultation the visa regulations were to be changed retrospectively. Our subsequent victory in the House of Lords was a significant milestone in our journey and unprecedented in the history of this nation.

Over the years we have established respectful, responsive and sustainable relations with the NHS, General Medical Council, the medical Royal Colleges, and Health Education England as well as Health Boards in the four nations. Despite our organisational and mission differences, we have fruitful collaboration with the British Medical Association on issues of common interest to our members.

Our strength lies in the networks developed in the four nations of the UK, making the voice of the minority ethnic doctors and international medical graduates heard through our regional divisions and specialty forums. These are our eyes and ears. They provide vital input into policy and plans with local experience and regional perspectives.

Differential attainment (DA) has been a major concern for us. It is not only demoralising for the doctors concerned, but also a major loss of talent for the nation. Thus, we challenged the Royal College of General Practitioners and the General Medical Council in a judicial review in 2014. Although we lost the case, the honourable Judge was complimentary to BAPIO saying it was a moral victory for the organisation. This case shook off the inertia about DA and the whole establishment started actively looking for solutions.

Unfortunately, seven years on from the landmark BAPIO v/s RCGP ruling in 2014, the differentials are still pronounced by ethnicity and gender over other protected characteristics. This, persistent DA across the career cycle had spurred BAPIO to chair the 'Alliance for Equality in Healthcare Professions' (AEHP). It was a mammoth effort from the AEHP to bring together multiple stakeholder organisations, training providers, academics, researchers, and grass-root professionals across a rigorously designed program of exploration on the lived experience of DA and associated drivers. Over 150 professionals made contributions to this project last year. The recently launched report (BTG21), details the process, outcomes, and recommendations. It critically considers the progress that has been made and asks honest questions about the changing face of challenges that require intervention to make equity in medical careers a reality. The NHS Workforce Race Equality Standards and the Medical Race Equality Standards also mark progress in unearthing longstanding disparity. We hope that the outcome of the AEHP is complimentary to these but bolder in scope. We propose a series of actions to support a systematic shift over the next five years that properly values, celebrates, and makes use of the talent of the diverse workforce providing medical care in the UK. This is our vision for a fair and just society.



25 YEARS ON

VIPIN ZAMVAR

This conference in Birmingham marks the 25th anniversary celebration of BAPIO. This is a special landmark. Much has changed in the UK in the last 25 years. Most of the changes have been for the better, but perhaps the pace of change could have been faster. BAPIO was formed to bring together the physicians of Indian origin under one umbrella; and even though the majority of our members are of Indian origin, there are representations from Pakistan, Bangladesh and Sri Lanka as well. In fact the entire Indian subcontinent is reflected in BAPIO's membership.

The immediate catalyst for the formation of BAPIO was the desire to do something about the clear injustice that some doctors of Indian origin were facing in the NHS. There were obvious systemic barriers to many of them realising their full potential. There were also glaring examples of Indian doctors running into difficulties, while local doctors under similar circumstances had a different, much more supportive experience.

हम आह भी भरते है, तो हो जाते है बदनाम,
वो कत्ल भी करे तो चर्चा नही होती
(My mere sigh defames me, my reputation gets crushed;
But some may commit murder, and it is not even discussed)

Many doctors considered this a part of the game, and chose to accept the situation and move on. Others felt this had to be called out, with the hope that the inequality would be abolished. The latter were those who slowly moved towards the creation of BAPIO. There are still issues that require attention. For example, differential attainment of minority ethnic and doctors who qualified overseas - still exists, which demoralises and demotivates crucial members of the medical workforce. This has moved up the agenda; many organisations now recognise that this is an issue and have set targets for abolishing.

In this issue of Sushruta, Claire Light from the GMC describes the clear, unambiguous target that the GMC has set for itself. Other leaders from the establishment (for example, the Royal Colleges and, the Deaneries) similarly acknowledge the scale of the problem of differential attainment and how they hope to address it.

BAPIO over the years has formalised many of its core objectives. The aim of the organisation is to help its members develop and improve their career prospects, and to achieve professional excellence. It also aims to monitor, highlight, and hopefully help address the difficulties faced by doctors and ensure systems are appropriately modified to facilitate the required change. While initially the organisation focussed on doctors, in recent years, BAPIO has embraced nurses of Indian origin as well (under the auspices of BINA). BAPIO has also increased its involvement in charity work.

As we celebrate the previous 25 years of BAPIO, we should also look forward to the future. Hopefully, by the time we celebrate 50 years of BAPIO, the landscape will have changed for the better. We hope that by the time we reach 2046, our society is one where inequality and injustice would be a thing of the past. To take inspiration from Rabindranath Tagore, "into that world of justice, and equality, let BAPIO celebrate it's 50th anniversary". Let us move on from Akbar Allahabadi's "wo katl bhi karte hai" mentality; and get inspiration from Iqbal's,

खुदी को कर बूलंद ईतना, क़ी हर तकदीर से पहले
खुदा बंदे से खुद पुछे, बता तेरी रज़ा क्या है
(Raise yourself to such heights, that Luck will be on your side, and God himself asks you what do you want)

Let us all be the support network for all in our profession to help us ALL realise our full potential.

BEYOND THE BARRIERS- HIGHWAY TO SUCCESS

JS BAMRAH
National Chairman, BAPIO

As BAPIO celebrates the silver anniversary of its existence this year, it is worth reflecting on where we came from, where we are now, and where our journey might take us.

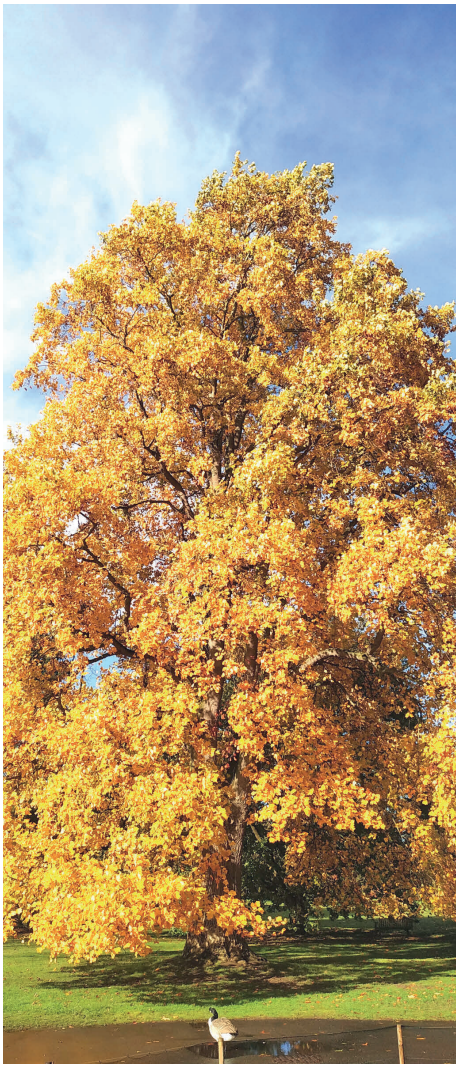
When Ramesh Mehta, founder President, laid the foundations of BAPIO all those years ago, he could not have imagined how the organisation would grow. His visionary prowess had determined even then that there international medical graduates had suffered significant hardship serving the NHS through the structural and institutional racism that he had witnessed. The NHS has had a particular attraction to those like him and me, as an institution that has a basic principle of providing universality and equality of care to all citizens. There is something very unique about this concept of care, something that has attracted many a bright doctor from across the seas. The most fertile ground for recruitment has been from the Commonwealth countries. Colonisation of countries in the Indian subcontinent has had the intended consequence of utilising those countries' human resource for ensuring that United Kingdom has been able to turn on or off the tap of filling jobs depending on its requirements, and in the case of the NHS, the Indian subcontinent has served its purpose in more ways than one.

Indeed, the NHS would not have existed without the vital contribution of those migrant doctors who left their birth countries for achieving professional distinction for themselves, and a better quality of life for their families. But migration, whilst helping many to achieve those objectives, has proven costly to a significant minority. Aspirations of academic or clinical excellence have too often been quashed by less attractive jobs, unequal pay and differential pass rates in College examinations have dogged careers, and disproportionate sanctions have blighted many lives. The cost is unquantifiable, though in the case of some where suicide has been the tragic outcome, such as in the cases of Imran Yousaf and Sridharan Suresh, no compensation can be adequate.

These injustices have energised BAPIO into an organisation that now stands proud of its record. The seed that Ramesh and a handful of his colleagues had sown twenty five ago, has grown into a flourishing tree, with thriving branches, blossoming flowers and fruit that is a testament to its achievements. Four arm's length bodies (Medical Defence Shield [MDS], BAPIO Training Academy [BTA], BAPIO Institute for Health Research [BIHR], British Indian Nurses Association [BINA] and BAPIO Faculty of Leadership), national/regional divisions across England, Wales, Scotland, and Northern Ireland, specialty fora (Women's Forum, SAS Forum, Young Doctors' Forum, and Wellbeing Forum) have contributed to evolving policies and achieving objectives as well as giving some financial stability.

There have been many key moments in our history. In 2006, BAPIO won a Judicial Review (JR) against Her Majesty's Government decision to prioritise speciality training posts for UK's medical school undergraduates which would have rendered thousands of IMGs on the Highly Specialised Migrant Programme visa second class citizens both in training but also future job prospects. A second JR was launched against the Royal College of General Practitioners (RCGP) and the General Medical Council (GMC) in 2014, after a significant number of IMGs contacted us about a disproportionate pass rate in the MRCGP examination. Although the court ruled that the examination was lawful, Mr Justice Mitting nevertheless ruled that 'it was time to act' on the differential attainment and significantly reduced the legal costs awarded to the RCGP.

These were the public facing, high level campaigns, but there have been many others. BAPIO has campaigned on the removal of the Health Surcharge for healthcare workers and their families which was partly successful in that the government last year removed it from the healthcare professional but not their families,



We gave evidence to the Lesley Hamilton enquiry on 'Gross Negligence Manslaughter' in the wake of the court ruling convicting Hadiza Bawa-Garba; together with our legal arm, MDS, we were an 'Interested Party' in the court proceedings at the successful Supreme Court appeal which reinstated her on the medical register; in 2020, the GMC agreed to award a Certificate of Completion of Training (CCT) to CESR (CP) (Certificate of Eligibility for Specialist Registration through the Combined Programme) trainees. Introduced by the GMC in 2007 it was the application route to specialist registration for doctors who were appointed to the specialty training programme above ST1.

But it discriminated against IMGs as they were not awarded CCTs until the GMC overturned its own ruling following our request. There have been many other campaigns which we have either initiated or collaborated with other organisations on. During the pandemic all our officers and many members particularly in the BAPIO WhatsApp ThinkTank group have actively highlighted key issues that affected the NHS workforce.

- BAPIO was the first organisation to the write to the Prime Minister and the NHS about the disproportionate deaths from Covid19 among BAME doctors;
- We were part of the Sir Simon Stevens strategy group on identifying and mitigating against risk to healthcare workers from COVID-19, resulting in a high level campaign on Personal Protective Equipment flaws and vaccine rollout;
- BAPIO Wales collaborated with the Welsh government in the roll out of a risk assessment tool which was also adapted by some English NHS Trusts;
- We were part of the Prime Minister's NHS team spearheaded by Prerana Issar, Chief People's Officer, to support India during the Covid crisis; We launched a successful fund and equipment appeal amounting to over £500,000 with the support of APNA NHS and Doctors Association (UK),
- Our arm's length bodies BTA conducted teleconsultation with Indian colleagues,
- BIHR set up and successfully published research projects,
- BINA actively supported many distressed nurses and
- MDS supported medical litigation cover for PLAB stranded doctors. Indeed, BAPIO were the main organisation which supported 267 of these stranded doctors who had arrived from 27 foreign shores to sit the PLAB exam but had got stuck due to the lockdown in March 2020.

JS BAMRAH
National Chairman, BAPIO

BAPIO/MDS was an 'Interested Party' in the Viz and Joshi vs Her Majesty's Government JR on PPE protection of healthcare workers, which was withdrawn because the government was pushed into action before the case could go to court. There were many novel approaches that our members adopted during the Covid crisis. There were hundreds of virtual meetings, lectures and conferences, there was wide collaboration with other organisations, some of our members set up the BAPIO Wellness Group which continues to thrive, fun but competitive cricket matches across a number of parts of the country with other organisations, and we held two major virtual conferences. BAPIO was an active participant in the setting up of a new all-discipline healthcare workers group, the BAME Consortium which was particularly influential within Public Health England circles. Along with Trent Chambers, the British Medical Association (BMA) and Association of Pakistani Physicians of Northern Europe (APPNE) we have campaigned for the government to overturn its stringent Adult Dependent Rules.

Doubtless I will have missed out many key issues that we have led on or campaigned for. None of these are possible without the vision and energy of many of our leaders and members, most of whom have worked entirely on a voluntary basis. And in a post-Covid world we can no longer work in isolation. Global digitalisation has shrunk the world considerably, and so we have partnered, and will continue to do so, with a number of organisations in the UK as well as abroad.

My sense about the future is that the challenges that we have ahead of us remain significant. Although Black Lives Matter and Covid has shone a spotlight on existing structural and institutional racism in the NHS and society, I remain concerned that we are not focussing on solutions.

As we said in a major article published in the BMJ, we do not want any more enquires or data.

We want action, and so BAPIO will be focusing in the coming years to ensure that policy makers are held accountable on ensuring that there are tangible outcomes from the many enquiries and recommendations that already exist. We still have the challenges of Differential Attainment, and I am very proud to be involved in the Bridging the Gap project which was launched by BIHR at the King's Fund, courtesy of Lord Ajay Kakkar, on the 29th September 2021.

The NHS has an impending crisis in its workforce, and if the government and the NHS are to value our doctors, nurses, pharmacists and other healthcare workers, it must nurture and support them as they would do its majority white population. The gaps in exam successes, jobs, pay and work conditions are no longer acceptable to our migrant and BAME workers. It is now not possible to close the lid on an opened Pandora's box. Regulation has too often failed us, and that is surely unacceptable3.

I like to end on a happy note though! BAPIO's twenty-fifth is a real time to celebrate not just the success of what Ramesh set out to do but also our members and the immigrants and their generations who have contributed to the many achievements of the NHS. We have some of the brightest and best of doctors, nurses and pharmacists and I have no doubts that they are prepared to meet with the challenges of a post-Covid world. I am an optimist by nature, something that, I dare say, I share with the great Indian philosopher Rabindranath Tagore who said: "I have become my own version of an optimist. If I can't make it through one door, I'll go through another door - or I'll make a door. Something terrific will come no matter how dark the present."

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1. The NHS is 72 this year, covid-19 has taught us some tough lessons. BMJ (2020) Bamrah JS, Randhawa G, Chand K, Singh J. https://blogs.bmj.com/bmj/2020/07/31/the-nhs-is-72-this-year-covid-19-has-taught-us-some-tough-lessons/
2. Bridging the Gap Report. https://doi.org/10.38192/btg21
3. Racism and the General Medical Council. Bamrah JS, Mehta R, Everington S, Esmail A. BMJ (2021). Racism and the General Medical Council - The BMJ

Saturday Research & Innovation Session
Chairs
Sunil Daga & Subarna Chakravorty
Judges
Prof A Elder (RCPE), (BIHR)

In this session, the top 24 abstracts will be presented covering innovation, service development, quality improvement, clinical care and research. This session will showcase cutting edge ideas and outcomes from a whole range of clinical arena, from the UK and abroad.

Sunday Plenary Research & Innovation Session
Chairs
Sunil Daga & Subarna Chakravorty
Judges
Prof Indranil Chakravorty (BIHR), Prof Geeta Menon (BFL) and Prof Parag Singhal (BTA)

In this session, the top abstracts will compete for prizes.
Posters will be presented electronically on icloud and plasma screens. All accepted abstracts will be published in the next edition of The Physician Journal of International Health.

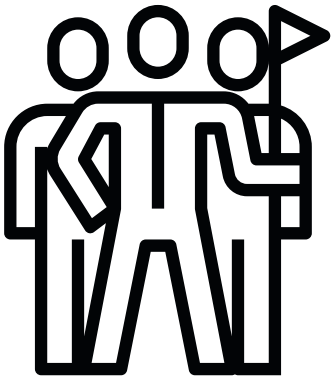
The Research & Innovation session is sponsored by

BTA SESSION

1. Awareness of the challenges facing IMGs
2. How BTA has tried to address those challenges with their programmes
3. What's important in training to enable a young trainee to become a good clinician

LEARNING OBJECTIVES

BAPIO TRAINING ACADEMY



BAPIO FACULTY OF LEADERSHIP

The role of the healthcare professional as leader within the context of the future multidisciplinary team has never been more important. With this aim our objectives for the session are:

- Share the leadership journey of one our most inspiring leaders and her views on the importance of clinical leadership

- Launch of the BAPIO Faculty of Leadership (BFL) which will sit as an arm's length body of BAPIO and thereby complete the pillars of professionalism namely teaching and training (BTA) and research (BIHR). Through the faculty we will provide access to leadership development and courses as well as developing talent panels to help create a database of healthcare professionals.

- Present the outline of our "Leading through Education to Excellent Patient care" (LEEP) program, an inclusive leadership course designed to focus on developing as an individual, your teams and system literacy through the lens of cultural safety.

LEARNING OBJECTIVES

INNOVATIONS IN EDUCATION

THE INDO-UK TRAINING PROGRAMME

PARAG SINGHAL

The Indian Government has shown keen commitment to reforms in medical profession and education by a series of initiatives as National Health Agency (Ayushman Bharat) & National Medical Commission (NMC), New AIIMS etc. in the health sector. Indian medical schools use similar textbooks and curriculum to the UK, which means knowledge and skills are largely transferable between the two systems. Large numbers of doctors of Indian origin already practice in the NHS providing a useful support network for new arrivals. British training is internationally recognised and is attractive to doctors in India, especially to those who are unable to obtain a postgraduate seat there hereby narrowing this alarming gap.

Key features

- **Doctors from India with postgraduate qualifications and who have completed their medical training in English seeking NHS experience at higher specialist levels will be selected.**
- **These doctors will be enrolled in a UK university Masters or Diploma program in their respective specialties or in an MBA (Healthcare) program.**
- **They will receive supervised training in Indian hospitals for 3-6 months (instead of the usual 12 months) after which they will arrive in the UK on a Tier-2 visa, subject to them achieving clinical competencies. BTA plans to have sponsorship for full GMC registration.**
- **They will join a planned NHS hospital at registrar level at the same level as for UK trainees at the ST-3/ST-4 level.**
- **The UK employers will be responsible for relocation and induction of doctors.**
- **The local deanery/HEE will provide a certificate of satisfactory progress and completion of training at the end of the training of 2 years**
- **In addition to their local education and clinical supervisors, each international trainee will also receive a college-appointed and a named BAPIO consultant as a mentor for the duration of their training**

The Indo-UK Training Programme has been designed to assist Indian doctors seeking higher qualification and training and an aspiring career in medicine in India helping realising the dream of Ayushman Bharat. These training programs focus on Innovation, skill development and leadership across all aspects of medical education and empower young doctors to gain mobility between the two countries promoting joint prosperity of India and the UK.

BTA INTERNATIONAL TRAINING PROGRAMS FOR MEDICAL GRADUATES

Advanced Specialty Training Programs comprising of structured clinical training of Indian doctors in BTA approved quality assured Indian Hospitals for 2 years supported by MBA in Healthcare and Leadership from University of South Wales followed by 2-3 years of training in the UK with support for education and pastoral care.
This is a new scheme to provide UK level training in General Medicine /Emergency Medicine/ General Surgery/Paediatrics for interested Indian doctors who want to pursue higher training and gain world class experience but have been unable to obtain postgraduate seat.

- **Programmes offered under this scheme are**
  2+2) International General Medicine Training

2 years of training in General Medicine in BTA accredited hospital in India followed by 2 years of training in UK hospitals with support for passing MRCP and MBA

INDIA IS NOW PRODUCING OVER 83,275 MEDICAL GRADUATES THROUGH ITS NETWORK OF 558 MEDICAL COLLEGES. HOWEVER, THERE ARE LIMITED NUMBERS OF HIGH QUALITY POST GRADUATE TRAINING POSITIONS

- **(2+3) International Emergency Medicine Training**

2 years of training in Emergency Medicine in BTA accredited hospital in India followed by 3 years of training in UK (District General Hospitals & Tertiary Hospitals) with support for passing FRCEM and MBA

- **(2+2) International General Surgery Training**

2 years of training in General Surgery in BTA accredited hospital in India followed by 2 years of training in UK hospitals with support for passing MRCS and MBA
BAPIO Training Academy (BTA) will be the lead organization for this programme and be the link between India and UK. BTA will be responsible for creating a UK visiting faculty, coordinating the faculty visits, induction and mentoring.

- **Quality Assurance**

The programme in India will be closely monitored and audited by experts deputed by the BAPIO Training Academy and HEE. 360-degree feedback and real time intervention will be undertaken to safeguard the standard of the programme.

FOR POST GRADUATES - FAST TRACK PROGRAMS

This special scheme will enable young doctors holding PG qualifications from India (MD/DNB) in different specialties to obtain further training in the UK to enhance their skills in medical leadership, clinical medicine and research
The NHS is one of the best healthcare systems in the world and offers world class training. However, in the recent years, the NHS has seen an acute shortage of trained medical staff with direct consequences on patient care and training. The existing COVID-19 scenario has only exacerbated this problem and brought to light the urgent need for medical staff, now more than ever.
While the UK has vacancies, India has a large pool of well-trained and experienced doctors, having completed their medical training in English, and holding postgraduate qualifications. These doctors can benefit from a period of specialist training in the NHS before returning to India to continue their medical careers.

MEDICAL DEFENCE SHIELD

MDS Session

Being a doctor has many challenges. For some doctors the challenges are compounded due to their origin or characterisitcs, especially women, those from a BME origin and international medical graduates. This session will explore some lived experiences from doctors so we can learn how to tackle challenges. It is always difficult to relive these experiences. Knowing the various issues itself provides an insight into the many pitfalls that usually lead to trouble and guidance on prevention. .

The session will include a question-and-answer session where legal and medical experts including those from Medical Defence Shield will answer questions about employment issues, fitness to practice, MHPS and clinical issues that a doctor may have to face during their career. This session will explore why -

- additional indemnity is necessary for all
- membership of a trade union is important.
- professional legal support may be essential and in what circumstances
- one should be aware of the costs for obtaining legal cover.
- indemnity should include 'category two cover', cover for good Samaritan acts and indemnity cover.

LEARNING OBJECTIVES

MDS
MEDICAL DEFENCE SHIELD

A membership with Medical Defence Shield provides *Professional Support, Without Compromise*

CLINICAL DEFENCE

GMC/GDC REGULATORY:

Professional disciplinary defence

GMC / GDC advice & representation

Defence against patient complaints

EMPLOYMENT

ADVICE/REPRESENTATION:

Terms & Conditions of Service

Grievance procedure

Disciplinary proceedings

The MDS Comprehensive Plan combines both under one roof

JOIN TODAY

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Breaking Barriers

The core founding principle of the NHS in 1948 was that free, high-quality care would be delivered to all who need it regardless of wealth, class, skin colour, ethnicity, and so on. In other words, the core founding values of the NHS were of compassion and inclusion. It is worth remembering that the NHS was founded in the aftermath of World War II when British society came together at a time of massive challenge and austerity, when it was clear that communities needed to be rebuilt. The pandemic has caused global disruption in ways we could never have imagined. Not unlike the aftermath of the 2nd World War, we are moving into a time when we have amazing opportunities to re-evaluate our priorities and give serious consideration to the lessons we have learnt from this disaster. We have clear evidence that people from ethnic minority groups are far more likely to die from Covid-19 and we have seen colleagues from minority groups suffer disproportionately. So, I would argue that we have a powerful driver for taking the time to look closely at these issues as we plan our recovery.

The saying goes that "The road to hell is paved with good intentions". This has never been truer than our approach to breaking barriers. It simply isn't good enough to have a poorly thought through intention to tackle Equality Diversity and Inclusion (EDI) in teams or organisations. Sloppy and poorly thought through EDI programmes probably do more harm than good. There needs to be an intentionality about this work. Time needs to be invested in it. Senior leadership needs to buy into the work and play an active role. It cannot be done in a kneejerk kind of way. Ensuring psychological safety is paramount for this work to succeed and so we need to be intentional, thorough and pay attention to detail, specifically the fears and feelings of the people we lead in our teams.

My sense is that this work needs to be underpinned by compassion and kindness. The concept of "ubuntu" is an African one which literally translates to "I am because you (or we) are". Ubuntu celebrates our shared humanity and, in my opinion, is the foundation from which we should work as we seek to break down barriers and celebrate diversity. When we acknowledge someone else's experiences and perspectives and value them, then we are on the important journey towards creating inclusive groups where "difference" is celebrated rather than seen as a threat.

In the tough world of the workplace, we have to acknowledge that creating inclusive and diverse teams and celebrating difference can be challenging. In my experience, the key ingredient for success is strong and compassionate leadership. Compassionate leadership craves inclusion. I would go further and suggest that the converse is true – if leadership is not inclusive, it is not compassionate. Leaders need to role model inclusion, and they need to create psychologically safe workplaces so that diversity can flourish. Barriers aren't broken by sitting back and waiting for it to happen organically. Leaders need to step up and address tough issues, speak out when equality is not valued, act as allies, use their privilege to help others and above all, be kind.

I am convinced that, in the spirit of ubuntu, we can break down barriers and create inclusive and diverse teams where all can flourish.

Camilla Kingdon
President, Royal College of Paediatrics & Child Health

DIFFERENTIAL

ATTAINMENT

unpacking differential attainment

Dame Jane Dacre

Around 25 years ago, at my first attendance at a UCL medical school examination board meeting, I was part of the panel, tasked with reviewing the list of candidates' examination results, in order of the marks achieved, and making pass fail decisions. It was a very long paper list in those days, of more than 300 names, so I folded the paper to see those at the top and compare them with those at the bottom. I was alarmed to see that the names at the top of the list were mainly traditional European names (usually female), and those at the bottom of this long list were mainly non-European names. This was the first time I had seen for myself what is now well recognised as the concept of differential attainment.

As an academic, working in Medical Education, I was intrigued to investigate this, as clearly something was going on. I was very fortunate at the time to come across an aspiring PhD student, who was interested in this, and who was a phenomenally talented psychometric psychologist. That person was Kath Woolf. Professor Chris McManus and I supervised Kath in her brave and ground-breaking work resulting in a thesis entitled: The academic underperformance of medical students from ethnic minorities. Her work demonstrated the complexity of this problem, and the lack of clear explanations. It also highlighted concerns about minority ethnic students experiences at medical school.
I moved on in my career to working on a range of examination systems, in particular, the MRCP examination, where we agreed to publish data which showed that this differential attainment was still there and was everywhere.

That was when I began to work with colleagues in BAPIO. Whilst working at the Royal College of Physicians (RCP), as vice president, then president, it was clear that there was also a poor representation of people from minority backgrounds, and of women, at the top of organisations, like the RCP which had a diverse membership base. There was inequality wherever I looked, and which needed to be addressed.

In my more recent work focussing on women in medicine, and the gender pay gap, it is clear that there is also an ethnicity pay gap, and if someone happens to be female and from a minority group, then the problems are exaggerated. This needs sorting out too, and we need BAPIO's help here too!
BAPIO is celebrating 25 years this year, and there is still a need to support minority ethnic colleagues in their journey to the top of healthcare system in the UK. BAPIO has been extremely successful in raising the awareness of the extraordinary contribution of doctors from overseas to the UK healthcare environment, and the need to support them equally. BAPIO has been vocal, and brave.

BAPIO has grown in stature as an organisation, and is real force for good, speaking out for equality and fairness for our patients and for our doctors and nurses. The first 25 years have been very impressive and the next 25 years and more will be even better.

I salute all BAPIO members and their leadership for this achievement.

WOMEN & BREAKING BARRIERS

Bhupinder Sandhu OBE

Many congratulations to BAPIO and its inspirational founder Ramesh Mehta, as it celebrates its silver jubilee and all it has achieved in those 25 years. History reminds us of the road women have travelled working to achieve equal recognition and status in societies across the world. The struggle to achieve access to medical education and medical careers by our predecessors inspired me. I was the first Black and Minority Ethnic (BAME) female medical consultant in Bristol, first BAME paediatric gastroenterologist in UK, first female President of Commonwealth Association of Paediatric Gastroenterology , first female member of GAPIO executive council. More recently we have seen an impressive growth both in the numbers and in the range of medical specialities in which women have achieved high success and prominence, almost inconceivable 100 years ago. However many barriers remain for example in academic medicine, surgery and leadership roles.

The issue of work life balance is an issue for both genders. More men are sharing and wanting to share in childcare and household tasks but the majority of this still falls to women. We need to work with the men at home, in the workplace and within organisations including BAPIO to achieve true equality. The aim of BAPIO Women's Forum is to advance the personal and professional development of women in medicine, to change discriminatory attitudes and practices and to work on behalf of patients. We should also recognise the medical issues women face across the world. There are still many areas where women's health needs are not well met and we need to campaigns for change.

I have a long-standing commitment to equality issues. I have been a supporter of BAPIO since it conception and served as inaugural President of BAPIO South West. I was elected to BMA council and chaired BMA's Equality and Diversity Committee working with GMC, Department of Health and BAPIO to confront issues. I served as president of the Medical Women's Federation and worked on a number of issues including maternity pay, academic medicine and ACEA awards.

For example there was no data on the gender balance of academic medics so we asked the chair of the medical schools council to collect the data. This documented for the first time that only 11% of Professors were women 1 and despite various efforts this figure is still around 15%. With Dr Mehta's encouragement I progressed from BAPIO to GAPIO (Global Physicians of Indian Origin) executive Council and he, as President, and I were instrumental in setting up GAPIO Women's Forum and later BAPIO Women's Forum. As metaphoric parents we have nurtured both. I believe to achieve gender equality the work of women's forum is crucial. The task that we all need to face is identifying and breaking barriers and bridging the gap to ensure that the gender balance that we now see in the students is truly reflected across the profession and aspiring medical students are able to achieve their full potential and in turn improve health care globally irrespective of their race or ethnicity.

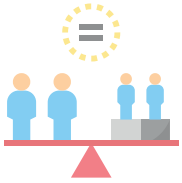
1 Sandhu et al Medical Education 2007; 41:909-914

LEVELLING THE PLAYING FIELD

BTG21

The British Association of Physicians of Indian Origin (BAPIO) is to be congratulated for its excellent "Bridging the Gap" report. It is the product of much thought and work and will serve as an important template for action in coming years.

EQUALITY & EQUITY



The General Medical Council are now committed to eliminate disproportionate complaints from employers about ethnic minority doctors and to eradicate disadvantage and discrimination in medical education and training. Anybody with any interest in equality - and equity – must support this.

Action Needed

What action is needed in the assessment community at this time? It is the responsibility of all who develop or deliver assessments of any sort, be they "high stakes" or "workplace based", to measure, monitor and publish rates of DA, and to dissect all elements of the assessment to ensure that no aspect of its content, context or conduct might contribute to or worsen DA.

DA IN ASSESSMENTS

Andrew Elder, President,
Royal College of Physicians of Edinburgh

My own specific interest is in assessments, particularly "high stakes" summative examinations. "Differential attainment" (DA) between groups of individuals with different protected characteristics, including ethnicity, has been widely identified in medical training in both machine-marked MCQ and "face to face" clinical examinations. MRCP(UK), one of the world's largest postgraduate medical examinations, and which I led, was amongst the first to publish evidence of such DA in 2007.

This basic finding provided the early focus for exploration of a phenomenon that is now known to extend far beyond the bounds of the content, structure or conduct of examinations in themselves. Examinations are a gauge, an explicit means by which disadvantage and discrimination in earlier education and training has been demonstrated. Research in the past 15 years has highlighted that although both high stakes examinations and workplace-based assessments can contribute to DA, they are not the sole or primary cause.

That simple point is a critical one. One response to the finding of DA in high stakes clinical examinations has been to suggest their abolition. Such abolition would not however eradicate disadvantage and discrimination in medical education and training, but would make it more difficult to monitor and detect. There may be sound pedagogic and psychometric arguments to move towards assessments that are based in the workplace, and focussed on what the trainee actually does, rather than how they perform in an examination setting, but these should be analysed separately. In "high stakes" settings, this should include, but not be limited to, clinical examiners' stringency and leniency ("hawk-dove") in relation to protected characteristics, and "differential item functioning" in written examinations.

Differential attainment damages individual doctors and the reputation of our profession. The GMC has asked the medical education and training community to eradicate it within the next ten years. It is the product of complex factors occurring at multiple stages in the training journey. Few other goals are of similarly high importance at this time and I look forward to working with BAPIO and other colleagues to define and implement the necessary solutions.

global learning benefits all

Robin Proctor

It is all too easy to look to international recruitment to fill a rota gap and tick some boxes on diversity, but what of the experience of those who will fill the posts, what about their department or hospital and what of the healthcare systems they work in? Fundamental to global learning initiatives must be an appreciation of these interlinked but different perspectives and experiences – individuals, their institutions and the systems in which they work. We know non-UK medical graduates have a worse regulatory experience than their UK qualified peers and we should be working to bridge that gap. This requires analysis and work on the part of the GMC, but it also requires appropriately structured programmes of employment to bring healthcare workers to the UK and appropriate behaviours from the institutions which participate whether on a large or a small scale.

The NHS may offer comprehensive care and this may be a huge draw for healthcare practitioners to experience such a system, but that is not to say it always has an easily comprehensible structure or working practice. Selection processes should not be pulling out the brightest and the best to bring to the UK and then leaving them unsupported.

Induction programmes and support structures to navigate a different culture and patients' different expectations are vital. Underlying technical skill and compassion may be transferrable, but there is inevitably a requirement to sensitively learn what is culturally appropriate in a new system. Such support is required before, during and after starting work and individual's needs will be just that – individual and needing bespoke support- proactively and before any issue develops. Even then, while induction will help it is simply unrealistic to expect someone who has never worked in the NHS to perform from day one as if they had worked there all their working life.

For an institution a series of new appointees may be long overdue and truly welcome. It's entirely reasonable to expect service work but there also needs to be an understanding that global learning is different. Colleagues will come with different expectations, different time horizons and requiring different input. Where institutions have been able to get beyond just 'we need more' and are enlightened enough to have recognisable workforce planning their modelling should be realistic rather than exploitative. We should encourage diversity and yet avoid creating systems which use difference as a lever for discriminatory behaviour – diversity should not become a diversity of opportunity. By this point I hope the readers who are still with me are thinking this is rather one sided. Just pause for a second. Did you consider this is very, "we need to teach them" and has he presumed 'they' might not have anything to teach 'us'?

I very much hope you did. Yes, acculturisation to the point of safe care is a requirement, but as we welcome colleagues from around the world there is a huge amount to learn from each other and we should remain open not just to the free consultancy of new eyes coming through our door but of the expertise they bring and how an issue has been tackled elsewhere, perhaps better than we do it already. I'm not advocating throwing everything that works up in the air and changing it for the sake of it but a considered turning of the message onto its head: looking not just at what the NHS can teach but at what we as individuals, as institutions and as an NHS can learn.

And what of the system? Well, the first question is which system? The NHS or the system which trained our new colleagues? The NHS should surely benefit from more, able colleagues and from garnering learning from them as they work, and contribute to improving the service they work in. The benefit for the other systems may be less clear and yet it is possible with programmes such as, "Earn, Learn, Return" to share the experience of comprehensive care, free at the point of use, and other elements where the NHS is leading the world. Individuals may wish to migrate permanently and that is their choice, but we can construct programmes which are designed to give an opportunity to upskill in relevant areas and take those skills to another healthcare system as our colleague moves on, whether that be back home or to somewhere else in the world. At their best Global learning initiates can have a massive positive effect within broader organisational development efforts to turn around, transform or sustain a unit but only when viewed through a two-way lens with benefits all round.

How to do that when there's a zeitgeist of how much more can we get for how much less?

That's tough and requires strong clinical leadership and to avoid exploitation, including at a senior level in organisations and the wider system.

BRIDGING THE GAP

Thanga KATIMADA

Despite the huge challenges facing the NHS, it is undoubtedly one of the best, when compared to other Public Sector Health Care systems the world over. None the less the NHS is facing unprecedented challenges and it is imperative that the cultural challenges within the NHS are resolved promptly to ensure that front line workers of all ethnicities are able to work collaboratively to uphold patient safety.

Statistically, non-UK NHS workers are overrepresented at the bottom rung of the hierarchy and grossly underrepresented at the top. Although this is a gross disparity which is due to differential attainment resulting from discrimination, we must also see it as a position of pride. We are the arms and the legs of the NHS and we deliver the very purpose of the NHS. It is high time we wore this honour with pride , own our position within the NHS and take the bull by the horns and strive to resolve this elephant in the room which at the least distracts us from caring for our patients and the most sees us leaving our jobs to escape the trauma resulting from this discriminatory culture.

The NHS is in the midst of a staffing crisis affecting the categories of NHS workers where ethnic minority workers form a sizable proportion. Of those who have braved to take on these jobs, 1/8 suffer discrimination and 1/5 leave in 3 years. For years now we have gathered data to evidence inequality, discrimination and differential attainment in the past. The big challenge was an acceptance by the NHS, the Deaneries and the Royal Colleges that the problem existed. The recent Judicial Ruling that the GMC has engaged in racially discriminatory behaviour is a big step in the acceptance of the existence of the problem at the highest level of government.

Whilst task forces, policies and guidance can form the frame work to address and bridge the gap in attainment, the culture which exists in the day to day working of the NHS will need our active participation.

As drivers of change, we as individuals must ensure that we show the utmost integrity and accountability and embrace equality and diversity ourselves. Replacing discrimination with marginalization of our British Colleagues will certainly be counter productive to our objectives. However we must find in ourselves the courage to stand up to unacceptable behaviour and state our objection to this. The years of meek acceptance of negative and discriminatory behaviour has in itself perpetuated this culture to the extent that it has become the norm.

We must also be conscious about the difference in our own behaviour towards our ethnic minority colleagues as compared to our British Colleagues. All level of ethnic minority workers, deserve the same respect that we have schooled ourselves to display when interacting with our British Colleagues. When we display disrespectful, insulting and undermining behaviour towards our ethnic minority colleagues, we set the standard for others who may perceive this as acceptable behaviour. When we seek change, it is important that we ensure that we have our own house in order.

GENERAL MEDICAL COUNCIL

IMPROVING FAIRNESS TO SUPPORT DOCTORS AND PATIENT CARE

Claire Light
Head of Equality, Diversity and Inclusion, Strategy and Policy Directorate, General Medical Council

The impacts of racial discrimination and disadvantage in the health service are longstanding. The medical education attainment gap mirrors the broader education attainment gap in society.

Postgraduate exam pass rates reflect a 12%-point difference between white trainees and black and minority ethnic (BME) UK graduated trainees, rising to over 30% for overseas graduates. BME doctors are referred to us by employers at twice the rate of white doctors. This is particularly concerning because a much higher proportion of employer referrals result in an investigation (77% versus 9% from the public). This is everyone's problem. The pace of addressing these issues hasn't matched the urgency and scale of the challenge. As BAPIO's Bridging the Gap report highlights - we must move from words to action. This is the right thing to do for those who face these challenges throughout their careers. But these aren't minority issues. In 2020, nearly 61% of doctors joining the register identified as being from an ethnic minority group, compared to 44% in 2017. Tackling these areas of inequality is vital to retain the doctors we have in our health services, and to support high quality patient care.

Accelerating our equality, diversity and inclusion work

Some doctors feel that fairness is not central to our work at the GMC. But we're determined to act and during 2021, we accelerated our equality, diversity and inclusion (ED&I) programme. We've committed to delivering this in our corporate strategy for 2021-25.

Our ED&I work has four key areas. Two involve us setting ourselves measurable targets - to eliminate disproportionate referrals from employers about ethnic minority doctors by 2026 and to eradicate disadvantage in medical education and training by 2031. We don't have all the levers of control over these issues. These targets hold us accountable for the ask we're making of others, which puts us in a new position. It's clear we all need to be pushed out of our comfort zones to deliver the progress that's long overdue.

Our third area focuses on how we'll build more assurance that our processes are fair and consistent. We regularly commission independent research on the fairness of our processes. The most recent independent audit of our fitness to practise decisions found no evidence of bias in the way decisions were reached. But we listen to feedback from doctors and some still view our processes with fear. In response, we'll regularly publish more information about how we consider fairness across everything we do. And we're developing a new approach to how we audit all our regulatory functions.

The fourth area involves us holding a mirror to ourselves and becoming more representative of the people we work with and for. We're increasing diversity at all levels of the GMC and improving career progression for ethnic minority colleagues. Addressing inequalities is one of the most critical priorities for UK health services. Doctors who work in supportive, inclusive environments deliver better patient care than when in closed, exclusionary ones. We'll do everything we can to deliver long-lasting changes that can't be undone.

HINA SHAHID

Continued>

The Hadiza-Bawa Garba case is emblematic of this; a female, ethnic minority, visibly Muslim junior doctor who had just returned from maternity leave was made a scapegoat for widespread systemic failings. Furthermore, ongoing work with ethnic minority Muslim doctors indicates that they experience discrimination and oppression that extends beyond the 9 legislated protected characteristics to include other aspects of identity such as international graduate status, accent, colourism, rank, geography, amongst others.

Using an intersectional lens to break barriers is vital to reveal invisible axes of discrimination and oppression and to appreciate that a one size fits all approach is insufficient- holistic and tailored personalised interventions are necessary to achieve equity and fairness that centre lived experience and address subgroup differential disadvantage. Furthermore, an asset-based approach to celebrate the strengths that diversity adds to the workplace and reconfiguring these identities as "productive resources" (Valander, 2012) can truly make doctors feel valued and empowered.

- **Trauma informed approach: early adverse experiences in medicine**

There is increasing awareness of the role of adverse childhood events (ACE) and life course approach that emphasise the critical and cumulative impact of trauma in early years and longitudinally across life. What if we apply this to trauma in the context of healthcare workers? For doctors like myself experience of discrimination and oppression start early on, even before entering medical school, for example at the medical school interview process.

At my medical school interview I was asked whether if I had to choose an effective bioterrorism weapon I would opt for anthrax or smallpox. As a young 17 year old recently returned from the Middle East having lived there for over a decade, I was stunned.

Subsequent experiences and encounters at medical school, postgraduate training and then post qualification lead to cumulative trauma. In addition to early intervention to eliminate discrimination, healing and wellbeing must also be core objectives that use a trauma-informed lens and to enable affected doctors to process their experiences and thrive.

EQUITY AND FAIRNESS: BREAKING BARRIERS IN MEDICINE

COVID and BLM have galvanised interest in eliminating racial inequity in health and medicine that. This was particularly brought into sharp focus with statistics revealing that over 90% of doctors who died from COVID-19 in 2020 were from ethnic minority communities (BMA, 2020). Current approaches to addressing racial inequities in the medical workforce are flawed, focusing on standalone training events, individualising system problems and reductive approaches targeting single issues. In this article I propose five principles necessary to inform and transform our approaches to equity and fairness and break down barriers.

- **Intersectional lens: protected characteristics and productive resources**

The Equality Act 2010 identifies 9 protected characteristics (Gov UK, 2010). We know that a gender pay and career progression gap exists in medicine and discrimination around flexible working for women and lack of adequate childcare support (DHSC, 2020), ethnic minority doctors are more likely to be referred for fitness to practice processes, face higher sanctions and fail postgraduate exams (GMC, 2019), NHS staff from all faith groups face discrimination but this is worse Muslims (West, 2015), doctors with disability are more likely to report lack of reasonable readjustments at work and face huge barriers to return to work if they suddenly become disabled (BMA, 2020), the vast majority of LGBTQ doctors report being abused and harassed at work (BMA, 2021).

However, individuals do not possess just one protected characteristic. Kimberley Crenshaw first conceptualised intersectional theory to provide an analytic framework for understanding how individuals with multiplied marginalised identities experience compounded and amplified discrimination and oppression due to the multiplicative and, in some cases, exponential interacting effects of protected characteristics (Crenshaw, 1989).

HINA SHAHID

EQUITY & FAIRNESS

Embodiment of experiences: weathering and allostatic load

These cumulative, traumatic intersectional experiences are embodied physically, mentally emotionally, socially and spiritually by doctors through pathways involving stress, weathering (Geronimus, 1992) and allostatic load (McEwen & Stellar, 1993). Doctors already have high stress and burnout rate (Patel et al, 2018), which may be higher for ethnic minority doctors, especially international medical gradates (Rich et a, 2016). A holistic approach which includes culturally and contextually sensitive psychospiritual counselling needs to be part of a tailored and personalised approach to support colleagues in addition to addressing discrimination, bullying and harassment faced by ethnic minority doctors.

Safe spaces and difficult conversations: focus on shared values

Standalone EDI training on unconscious bias does not work and it is about time we moved away from this. What we need are safe spaces with flattened hierarchies centering lived experiences and marginalised voices, where people feel comfortable being authentic and vulnerable to have the difficult conversations necessary to bring about root and branch sustainable reform in organisational culture. These spaces must enable deep listening and critical questioning and encourage continuous learning and reflection with a commitment to firmly embed shared values of respect, dignity, compassion, autonomy and flourishing; allowing everyone to feel they are celebrated and able to bring their whole selves to work without fear of judgement or exclusion.

Action, action and more action- multi-level and multi-professional

The time now is for action not more reports demonstrating what we already know. We have decades of data and lives ruined by discrimination and oppression. Any further data collection must focus on monitoring and accountability and evaluating the impact of interventions and in analysing intersectional experiences where data gaps exist. These efforts must not stall action which is urgently needed; research and action must not be dichotomised but occur in tandem, and in the age of lean and agile development, inform each other in real time to bring about responsive changes.

CHAIR, BMA UK COUNCIL

CHAAND NAGPAUL

BRITISH MEDICAL ASSOCIATION

This revealed ethnic minority doctors suffering bullying and harassment at twice the rate of their white colleagues and were twice as likely to be afraid to speak out regarding patient safety concerns, and more likely to feel blamed if they did so.
Throughout the Covid-19 pandemic, the BMA carried out large-scale tracker surveys, in which we publicised that ethnic minority doctors were up to 3 times more likely to feel pressured to see patients without adequate PPE, were less likely to have adequate risk assessments, and felt less able to challenge their managers because of fear of recrimination or it affecting their careers. We have used this irrefutable evidence of disadvantage to rebut the government's Commission On Race and Ethnic Disparities report that bizarrely failed to acknowledge structural racism in the NHS.
We produced our own report "A missed opportunity" with 22 recommendations for tackling racial injustices in the medical profession and society.

More recently, the BMA has challenged the GMC head-on, following the landmark judgment earlier this year that the GMC racially discriminated against Dr Omer Karim. We are supporting Dr Karim in his legal fight for justice. The BMA has also called for an independent, root-and-branch review of the GMC's processes, and a commitment that all referrals should be independently scrutinised to ensure they are free from bias.
I am also fully committed to support our international medical graduates (IMGs), who suffer so many additional hurdles, discrimination and an utterly inadequate induction to the NHS. The BMA has set up a dedicated IMG workstream which is campaigning to ensure that IMGs are provided with a fit-for-purpose induction, ongoing support and that their contribution is valued and respected.
Earlier this year I launched the BMA's first ever national BAME forum, which is underpinned with regional networks throughout the UK. This has already engaged several thousand grassroots ethnic minority doctors, giving them a voice and advocacy as well as a peer support.
I want to end with a personal thank you to BAPIO for the support it has given me. I recall vividly how Ramesh Mehta, gave me encouragement in my early days in medical politics, and indeed I received a BAPIO leadership award in 2012, that gave me so much motivation to continue to progress in the BMA.
I look forward to strengthening the links between the BMA and BAPIO, and I very much hope that doctors will see the value of being members of both organisations who together can do so much to represent the interests of ethnic minority doctors.

I wish BAPIO a successful silver jubilee conference, and I am both personally as well as on behalf the BMA, delighted to be able to play a part in this special event.

The BMA has a long history of supporting the annual BAPIO conference, but on this occasion I'm particularly pleased that we are platinum sponsors in the year of BAPIO's Silver Jubilee.

As a member of BAPIO myself, I've always felt that the BMA and BAPIO share so much in common, and that our roles are both complementary in fighting for a fair and just NHS for ethnic minority doctors, including those of Indian origin.
When I became chair of the BMA Council in 2017 – the first ethnic minority doctor to do so – I resolved to strengthen the links between the BMA and BAPIO, which has resulted in valuable joint work.

During my tenure, I've worked closely with BAPIO chairman Ramesh Mehta, President JS Bamrah -both longstanding friends. JS is a past BMA council member and current vice-chair of the BMA board of science – and I regularly work with other officers on a range of issues.

During the Covid pandemic, both the BMA and BAPIO were at the forefront of calling out the disproportionate impact of Covid on ethnic minorities including that 85% of all doctors who died were from ethnic minority backgrounds. Both organisations robustly spoke out with a common voice calling on the government to address these alarming disparities. We both successfully campaigned to end the absurd and unfair health surcharge, as well as ensuring visa extensions for doctors stranded during the pandemic waiting to sit their PLAB exam. I attended meetings of ministers, alongside BAPIO leaders, calling on the Government to ease visa restrictions for dependent relatives. Most recently, I was pleased to contribute to the excellent recent BAPIO publication 'Bridging the Gap' with a clear action plan to end differential attainment.

Our voice has been much louder, stronger and more effective, together.

Earlier this year, when the heart-wrenching Covid crisis hit India, the BMA was proud to provide a significant donation to BAPIO whose established links with India enabled exemplary and proactive support in providing much-needed oxygen supplies, medications and remote medical support.
I also want to take the opportunity to highlight the BMA's work to address race inequalities affecting our profession. In 2018, I organised the BMA's first ever race equality summit, bringing together a range of stakeholders and NHS leaders, including BAPIO, so that we could collectively commit to a trajectory of ending discrimination within our NHS. I followed this with a major BMA project, Caring Supportive Collaborative, which carried out the BMA's most comprehensive research of doctors' experiences.

WORKING TOGETHER TO MAKE A DIFFERENCE?

BACCH & BAPIO
DOUG SIMKISS

BACCH is the professional membership organisation for doctors and other professionals working in paediatrics & child health in the community.

The British Association of Community Child Health's (BACCH) purpose when it began in 1975, was 'to contribute to the improvement in the care of all children, to promote scientific study of clinical community paediatrics, to facilitate the exchange of knowledge, information and ideas among its members and to disseminate knowledge of clinical community paediatrics' Today BACCH's purpose is essentially unchanged - 'to promote and protect the good health of children and their families in their communities'. For me, this means community child health as both a clinical discipline and a philosophy of care. The clinical discipline includes care of children with disabilities, children with mental health issues and children with safeguarding concerns. This discipline puts the emphasis on 'community' meaning out of hospital care. Multidisciplinary and multiagency working (with social care and education in particular) is at its core. But more broadly, 'community' speaks to BACCH's roots in child public health and we should continue to work with other professional groups such as health visiting, school nursing and primary care in localities, encouraging system thinking and population health management skills alongside our safeguarding, disability and other clinical skills.

This is community child health as a philosophy of care and is the direction of travel for Integrated Care Systems. Some Community Paediatricians should develop expertise in this arena.

As I write this piece, I have been Chair of BACCH for two working days and so my insights on how BAPIO and BACCH can work together will continue to mature. But I am confident there is much that we can do together. BACCH has a strong interest in workforce and Ian Male is our Workforce Officer; Rebecca Gumm & Hannah Nicholson are his Deputies. I want to understand what Equality Diversity and Inclusion issues we have in Community Paediatrics. Related to EDI, historically many paediatricians of Indian origin took up posts as Staff, Specialty and Associate Specialist doctors and I want to understand if there are issues on career progression for these post holders. I am keen that BAPIO works with BACCH to address any issues we find as you will have expertise in resolving them in other medical disciplines.

Throughout my career I have been able to develop my cultural competence as colleagues have helped me to see health from the perspective of their communities. I am sure there is a role for Community Paediatricians from BAPIO to work with BACCH to develop cultural competence for all our members caring for children of families from India.

COMPASSIONATE LEADERSHIP

ANANTHAKRISHNAN RAGHURAMAN

Compassionate leadership should be linked with 'psychological safety' in health care teams.

The past few months have stretched the medical and nursing/ therapist workforce. Covid- 19 has exacerbated the underlying issues. Staff gaps are due to difficulties in recruitment is proving ever more difficult, absenteeism is high and staff are leaving or retiring early. Those that are left have performed well above the contracted hours which leads to high levels of staff stress and low morale.

The principles of compassionate leadership are;

- paying attention to the other and noticing their suffering – attending
- shared understanding what is causing the other's distress, by making an appraisal of the cause – understanding
- having an empathic response, a felt relation with the other's distress – empathising
- taking intelligent (thoughtful and appropriate) action to help relieve the other's suffering – helping.

What it is not;-

- A loss of commitment to purpose and high-quality performance
- Dilution of performance management processes
- Always seeking consensus rather than the "right approach" for patient and staff benefit

We need to enable a culture where staff members are able to challenge the status quo and enable radical changes. We need to enable strong team work and system working without undue influence from a few with "power".

A "command and control style" has the effect of silencing voices. We need to empower staff to make changes in their workplace. The endless remote top-down plans often fail because they ignore the reality of day to day care.

This helps staff to;

- feel safe to talk about their errors and near misses
- to address concerns about work overload,
- to talk about worries over lack of competence, and
- to call out bullying, harassment and discrimination.

Transformational change can only come through releasing staff from the rigidities of bureaucracies, command and control hierarchies, and relentless top-down scrutiny and control. And the evidence from research is clear that compassionate leadership is the vital cultural element for innovation in organisations.

Compassionate leadership requires courage. The courage to listen to tough messages from those we lead. The courage to explore their understanding of the challenges they face and to have our own interpretations challenged and rejected. Compassionate leadership requires huge courage, resilience and belief – it requires a commitment to be the best that you can be. It begins with self-compassion so that by attending to yourself, understanding the challenges you face in your own work (and life more generally), empathising or caring for yourself, and then taking wise action to help yourself, you are able to stay close to the core values that give our lives and work meaning – compassion, wisdom, courage, justice – we are able to have deeper, more authentic and more effective interactions with all those we work with and offer care for. Putting such leadership into action demonstrates not the myths, but the magic of compassionate leadership.

BAPIO HEALTH & WELLBEING

SARASWATI HOSDURGA

Is it a necessity?

Office of national statistics - Opinion and Lifestyle survey 2020 highlights low level of happiness and lesser satisfaction with life nowadays. Fancourt et al: Covid Social study 2021 further highlights inequalities due to gender where in lower happiness, increased stress and higher depression scores were seen in females. And inequalities due to ethnicity highlights higher score for depression amongst BAME compared to white.

Through the pandemic it has been acknowledged that the isolation, lack of interaction, increased workload, excess mortality and morbidity and losing loved ones has worsened psychological wellbeing of many healthcare professionals.

As per Fancourt, Scientific reports 2021, three key protective factors of wellbeing were identified : social support and cohesion, Art and creativity and nature and outdoors.

Health & Wellbeing Forum

Biological, psychological, spiritual, social and financial wellbeing are the key determinants to ensure good quality of life and happiness. A happy, resilient doctor can ensure patient safety by engaging well with patient care and reduce NHS expenses.

BAPIO Health and wellbeing Forum is committed to achieving excellent Health & Well-being for all its members: a unique service by extending activities and services to family and friends. The wellbeing of family unit is focussed as the stress factors within the family are interlinked. BAPIO health and wellbeing forum takes it personally and plan all supports and activities; Making it more fun, friendly, creating a sense of belonging, being valued and creating positive health through social support and networking.

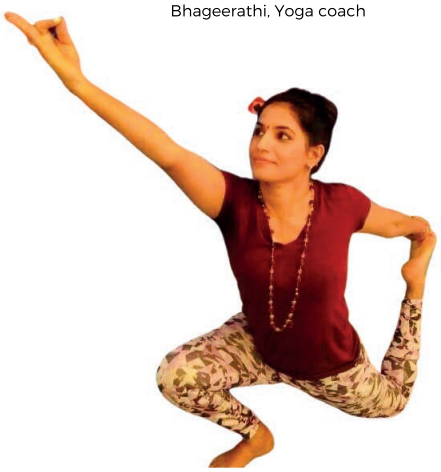
Our vision

- Health and Well being
- Quality of life
- Preserve positive energy
- Support peer support
- Reflect on lessons learnt

Our 3 Pillars

1. **PRESERVE**

Loneliness and Isolation is the biggest problem that drives off the energy. The Government Guidelines, although imposed to keep us safe during covid , have significantly restricted our contact with family and friends are understandably good measures but how can we overcome this? We initiated a social Whats app group dedicated to the members (Wellnet) and started many activities to preserve and maintain emotional wellbeing and to stay connected with friends and stay fit and healthy. With communal activities like yoga, dance fitness and walking tours are organised to benefit all members across the nation.



Bhageerathi, Yoga coach

Swapna Gambhir, Dance Trainer

2. SUPPORT

Levels of anxiety have sharply increased during the COVID-19 pandemic, particularly for those working on the frontline. How can we help those in need of support. I-peer support project provides this additional psychological wellbeing and signpost to appropriate resources. Monthly free sessions were organised focus sessions with particular cohort eg : Foundation doctors, Nurses, Covid affected group of doctors in UK, and for doctors in India

3. REFLECT and TRANSFORM

There are many health care professional going in to depression and there are many doctors in distress and committed suicide. We aim to gather the learning themes from confidential enquiries to incorporate and shape executive plans and activities to preserve, support strands of health and wellbeing forum.

BAPIO Silver Jubilee 2021

You will get an opportunity to join yoga session and walking tour followed by discussion session. Mounting evidence shows that creativity makes a significant difference to people's health and well-being in enabling us to access unknown parts of ourselves so that we can make deeper changes rather than putting sticking plasters over the wounds.

In summary, there is substantial evidence which spotlights on health and wellbeing and the real need to connect with the community cohesively. In the current climax wellbeing is a necessity not a luxury to ensure patient safety and better staff and patient outcomes.

SAPNA AGRAWAL

FOCUS ON WELLBEING IN GENERAL PRACTICE

Generational Indentity

To most Indians I am regarded as a first-generation British person but for my British peers I am a second-generation Indian, for Health Education England I am an international medical graduate who is regularly sent information to support IMGs and details of how to extend my visa.
I was born inear Sherwood Forrest known for the fable of Robin Hood and like him I have inherited my own moral code of justice. I credit my parents for giving me a truly global upbringing, having spent my childhood in England, I went on to experience Indian, Saudi Arabian and American schooling before returning to England for higher education.
Personally, I love both England and India and could not differentiate my love for either just as a child does not differentiate their love between their mother or father.

Heritage

My heritage and upbringing have made me who I am today. As far as my career like a lot of doctors of Indian origin I have had an interesting path to my training, but this helter-skelter of a journey has resulted in an experienced doctor who is now very suitable to be an versatile general practitioner.
I love my profession and I am fortunately surrounded with people who I enjoy working with. I was introduced to BAPIO and quickly found some superb mentors, who have been pillars of support in my training. During COVID-19,
I helped to produce an exercise dance video showcasing the various dance forms of the Indian subcontinent.

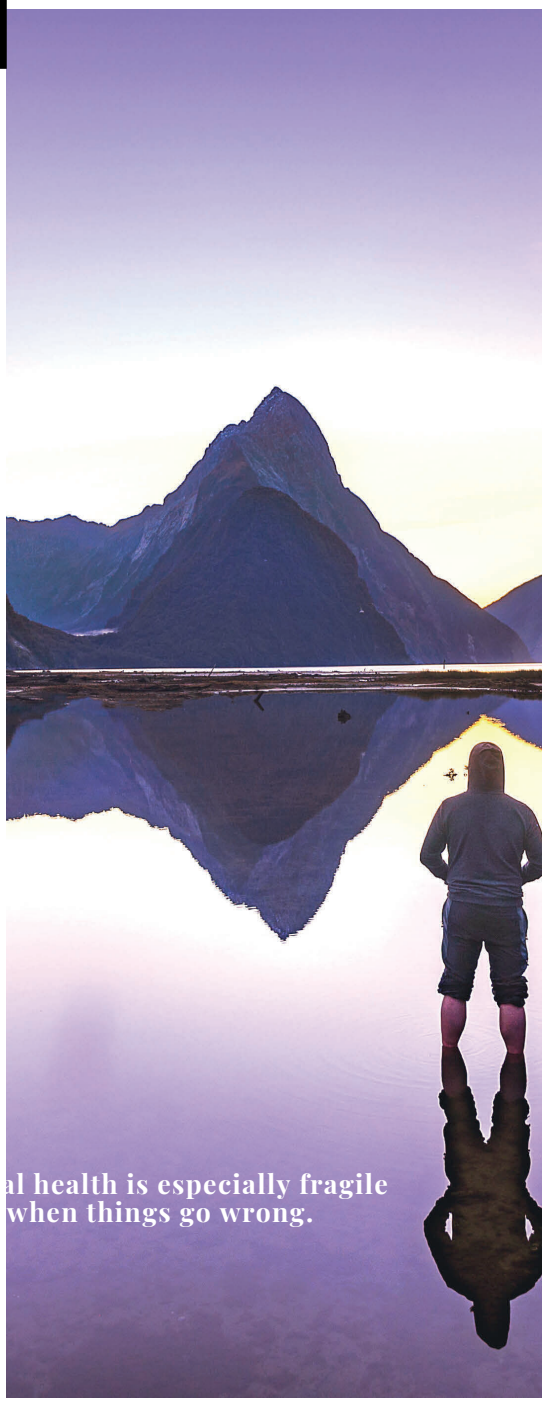
Focus on General Practice

General practice has undergone many hardships over recent years but most clinical general practitioners have worked hard and rapidly adapted to new ways of working and have also been the bedrock of the vaccination delivery programme. In recent times, however, there has been an onslaught against GPs in sections of the media and by some MPs. This unjust, unfair criticism which has damaged the doctor-patient relationship for some but worse still has resulted in cases of actual physical attacks and abuse and is seriously threatening to breakdown of an already broken system with a record number of general practitioners leaving the profession prematurely.
The talks include; health for self, which will be focusing on the delivery of health and wellbeing
for doctors, health for practice which will be looking into ways of making our practices greener which obviously will ultimately lead to cleaner air, improved patient health as well as tackling climate change; and finally we will be finishing with health for future, which will be focusing on how we can secure our future and finances as general practitioners.

A BRAVE NEW WORLD -

Reflections of a Final Year Medical Student

Triya A Chakravorty



I was not ready to be a doctor. That was how I felt six years ago, when I began my medical school journey. At times, it felt like an endless uphill battle. I have felt disheartened, unsupported and alone. Yet, thanks to my family, teachers and colleagues, I have also felt excited, nurtured and inspired. I have learnt an incredible amount: not just academic knowledge, but life lessons. In these few paragraphs, I would like to share the lessons I learnt from medical school. I hope that current and future medical students too, can learn from my experience.

Firstly, I have learnt how to adapt to face a challenge. The pandemic caused a seismic shift in medical education. In the World Health Organisation's pandemic response plan, the final stage is to "innovate and learn". As a medical student during the pandemic, this is something I had to do a lot. From taking swabs, performing blood tests and vaccinating individuals, to learning how to examine patients via Microsoft Teams, I have had to innovate in every part of my learning. I have seen people band together with great strength to solve new challenges. However, learning in isolation without my classmates was also desperately bleak.

That's why medical school has also taught me the importance of looking after your own mental health and wellbeing. In a profession with burnout levels at an all-time high, developing good habits is vital. Constant examinations and challenges have grown my resilience, but there were still times when I have felt my mental wellbeing was not an important factor for my medical school. So, my advice to future medical students is to make this your top priority. Take time to develop self-care rituals, and never be afraid to speak to others and seek help.

That brings me to the last lesson I learnt from medical school: how to fail. Failure is an essential part of medicine, academia, and life. Whether it's failing exams, missing diagnoses or getting papers rejected from journals, there is no escaping it. Instead, we should see it as an opportunity to learn and grow. Accepting failure and letting go of perfection are some of the hardest lessons to learn in medicine - but also the most important. In the words of Samuel Beckett: "I can't go on. I'll go on." When I started medical school, I did not feel ready to be a doctor. I do now. This is not because I know everything (it often feels like I know nothing), but because I feel emotionally, mentally and physically prepared for the realities of being a doctor. This brave new world fills me with nervous anticipation, but also with hope that I can learn even more.

GO WEST YOUNG ONE

M. Aamer Sarfraz

The title is a reincarnation in the subcontinent because this is what the people of my generation heard while growing up. We never understood, at that time, that when you leave your country, years blend into each other - one year becomes five, five years come to be fifteen, and fifteen years turn into thirty. Before you realise, you have become an immigrant. Since, you are in a country that does not speak your language, you do not complain. It is too much of a hassle. You learn to keep your head down.

We did not leave our homelands out of our heart's desire. Some came to achieve the locally unavailable training; others travelled as the last resort due to utter degradation of life where they were. We arrived here following the generation which had broken the glass ceiling. From hundreds of different places, we poured into the GP land and other subspecialties, blending into an enormous professional wave. In return for opportunity, we brought humanoid skills and enormous talent. We had tremendous potential to change the lives of others, and help the world around us become diverse and tolerant. We were bigger than our individual selves.

Cut off from our extended families and history, we made new places our homes. We were neither weighed down by the politics of emotionality nor feared policies shrouded in accents of bigotry. Even when hurt, we never let anyone notice because we had learned the art of breathing without gasping. There were times when our dignity was assailed or our ethnicity was caricatured, but we never surrendered our beliefs. In private thoughts, we took refuge in our traditions that were driven like guideposts into our subconscious. We knew where we came from and where we were heading. We were not a shadow, to simply watch the dominant culture; we were here to contribute. As health service workers and entrepreneurs, we were prepared to work hard and willing to take risks.

We were told an adage that citizenship without emotional attachment is the civic equivalent of a one-night stand. We accepted because, as health professionals, we appreciated that there was no such thing as a magic cure. There were baby steps to be taken when going up the hill - an unforeseen chuckle or a painless day was sufficient until the time when our reflection would not count anymore. With our truth, we stood our ground; without seeking attachment to the validation from others. We did not wait for some other person or another time; we are the change we had sought. Because it was nourished by so many cultures and peoples, national health service turned into an island where our thoughts, our journals and our narratives came together.

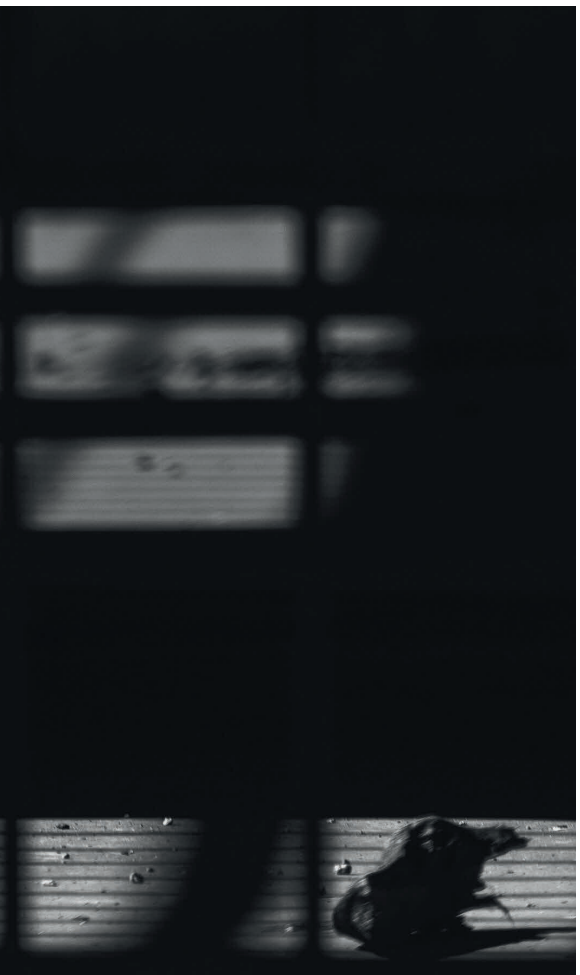
Our greatest contribution has been to define reality in health services – that the patient should be at the heart of the whole system. We have shown how it is possible to be kind, pleasant, approachable and competent at the same time. Our culture has taught us to be warm, connect with people and to make them feel valued.

Our leadership style is about delivering results, which can only be attained by looking after colleagues. Our management approach is not about telling people how to do their jobs or making life difficult for them; it is about simplifying things by cutting through red-tape and offering credible solutions. We are persuasive because we are plausible, we are believable because we are sincere, and we are credible because we are loyal. Before coming here, we were loved by our parents, treasured by our friends, respected in our milieu and were confident in our abilities. Therefore, despite negotiating hardships and new rulebooks, we never doubted ourselves. As a result, there is no end to our ambitions and the achievements that have followed. Meanwhile, Joshi Jogi is very hard to please. He tells me that whatever gains we have made are actually a story of loss – we left India, we lost our culture; we left Africa, we lost capital; we arrived here, we have lost our children. I tell him that we may have briefly turned our backs on our folks for leading the orchestra but our tradition is that children always come home by sunset. Picture abhi baqi hai meray dost....

We, as a cohort, are products of sovereign states.

ON BELONGING

Indranil CHAKRAVORTY
@indranilc



Author's personal reflections on the role of organisations such as BAPIO in one's professional life.

To be human is to belong. Humans are social animals and have a need to belong. This need to belong involves frequent or regular interactions and the safety, sustenance and comfort that come from belonging. According to Baumeister & Leary fulfilling the need to belong involves satisfying two criteria. First, individuals must have relatively frequent, positively valenced (or at least non-aversive) interactions with at least a few other people. Second, these interactions must take place within a framework of long-lasting affective concern for each other's welfare. Satisfying either of these criteria alone is not sufficient to fulfil the need: positive interactions outside of long-lasting relationships will not be completely satisfying and nor will long-term relationships that lack regular contact. It is well-known that a failure to satisfy this need to belong, ought to be marked by serious distress and long-term negative consequences.

In the process of growing up and assuming the challenges of adolescent or adult life, the need to belong remains a paramount influence in shaping our present and futures. As we go from the shelter of family units to schools, colleges and Universities- there remains the need to belong to different groups based on social, demographic or intellectual pursuits. The bonds formed deliberately or as a result of shared experiences - in early adulthood often are the most robust and last for several decades thereafter. An example are the alumni societies which tend to keep in touch even when the members are dispersed across the globe.

The ease of communication certainly has a role to play in bringing the world and its people closer. Some psychologists and philosophers often despair of the artificial distance that our dependence on digital communication may create within families or groups living in physical or geographical proximity. Yet, across continents and several thousands of miles it is the ease of digital social networking and the advent of smartphones that has transformed the world. The way that the global collaboration occurred during the COVID-19 pandemic induced moratorium on all types of travel is a testament to the advantages of being socially connected. When facebook, Whatsapp and Instagram servers were down in October, there was a huge outcry from people and this made it to the second most important news item after the Tory conference in the UK.

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ON BELONGING

The phenomenon of immigraton poses a different challenge to the immigrant who is often rapidly detached from their friends and family, the comfortable familiarity of their physical surroundings, the environment, the predictability (or otherwise) of their climate, the seasons, the flora and fauna and the sustenance drawn from their socio-cultural milieu. Any form of migration is definitely a stress inducing exercise, way beyond the physical.

Often the socio-cultural-economic conditions of the adopted country, even if the migration is temporary, can play a vital part in the wellbeing of the individual. For those whose decision to migrate was not voluntary (slavery or indentured workforce) or driven by extremes of conflict or persecution, the challenges are multiplied several fold.

Deprived of all that was known and familiar, the immigrant is left unbalanced, stressed and alone, even if they are in small micro-family units. There is a need to connect with the familiar or recreate an environment that brings peace and comforts of 'home'. This is where in any nation in the world, there is a profusion of food, music, literature, the arts, festivals (religious or cultural), apparel and artefacts that mirrors the 'home-land'. Many who embrace the language, socio-cultural practices of the adopted land, a process often described as 'acculturation' still find comfort, peace and sustenance from the recreation of the distant home.

There are a plethora of organisations which have been created by people needing to belong, to interact, to find safety in familiar settings and with people who share either a physical identity or socio-cultural norms. Some such as alumni organisations (a shared legacy), others such as 'Medical Women's Foundation' offer the safety of facing gender-based challenges; some are based on issues, some offer shared values of faith (British Indian Muslim Association, British Sikh Association), some the familiarity of home culture and traditions. Then there are those that bring people with a shared purpose.

In the case of BAPIO, it may have started with a view to support doctors from the Indian subcontinent all those 25 years ago, but it certainly comes of age as a different type of organisation. One that has moved from the fringes to the centre-stage.

As a bright eyed-bushy tailed young medical student in Kolkata, all those years ago, training in the UK was a dream.

Before the advent of the internet and personal computers, the printed word, descriptions of life and work in the UK and rare depiction of doctors on film was all one could go by. I had a personal connection. One of my Uncles was an Ophthalmic surgeon in NE Lincolnshire and every year, when he came over to visit in the warm Kolkata winter, I would wait on every word and create this technicolour dream of a job working in the UK healthcare system. As a son of Bengal, intellectual pursuit, to be able to work in an academic setting, to practice medicine as was depicted in the textbooks was all that I care about. Money was never a consideration.

The first five years were spent working hard, examinations and moving house and hospital every 6-12 months. In 1995, I remember applying for every Senior House Officer job advertised in London and not getting a single shortlisting. I put this down to my not having an additional intercalated degree, not having passed my MRCP like some of my peers. Aneez and Sam had already published their seminal work on how the name was a determinant for shortlisting between a European and a non-European one. Racial or ethnic bias did not cross my mind. Tucked away in Grimsby and having ice-cream on the beach in Cleethorpes, my friends and I were on top of the world. We were treated as equals, except on a rare Friday night when some inebriated, local hooligans refused to see a Black doctor in the emergency. Our colleagues and healthcare staff were quick to stand by us and not encourage such behaviour.

Like many of us, I was lucky to find some fantastic mentors while in Birmingham, Jon Ayres and Ruth Cayton gave me hope and encouragement. I had worked out that to get a job in London, I would have to offer more than my peers and competitors. I think the realisation, that in order to get a fair chance in life as an immigrant, one has to be better than the best- comes to all of us at some stage. When I managed to secure my first interview in London, I did not believe that I had even a 1 in a million chance to get in. I met Margaret Hodson. It was the only interview, where I went in my shirt sleeves (did not have time to get a suit), poured out my heart and spilled out all my dreams and aspirations. Margaret listened and offered me a job. I managed to get into a specialist registrar training rotation in London. This was at the time of Calmanisation and spelt misery for thousands of doctors from abroad. The hostile immigration policy was introduced, the permit free training was abolished.

ON BELONGING

Home Office restrictions meant that thousands of doctors from abroad had to leave their jobs and return to their home countries. A few years later BAPIO mounted a legal challenge to the Home Office rules in 2006, which went to judicial review. I was not aware of this. Reporting in the press was scant. We were not aware of the existence of such an organisation that was there to support doctors like me.

I know that many of my peers from the Indian subcontinent or those with a non-UK primary medical qualification were not so lucky. Many had to change their career aspirations, emigrate to Australia or I know that my mentor Ruth had hopes for me to follow in her footsteps and work in the Sleep Laboratory in Birmingham. But I was sad to disappoint her, when it came to accepting my first consultant job. My heart was set on London.

It is only when as a Consultant I was supervising and guiding immigrant doctors like me, as the college tutor giving career advice, did I start to realise that life was not fair, even in the UK medical system. I could see the skewed distribution of the faces in remote district hospitals compared to the tertiary ones. I noticed how at interviews, career progression assessments there appeared to be subtle but clearly demonstrable differences in how doctors were dealt with based on their ethnicity, race or primary medical qualifications.

I still believed that such bias was unconscious and continued to advise junior doctors and students to work harder, to choose less competitive specialties and be satisfied with less popular district hospital posts. Being a pacifist I chose the path of least resistance. Anger did not come naturally.

I knew I had to do more. Like many of my peers I offered to take on regional and national roles within the medical education and training system. I approached the college, discovering that there were rarely anyone with my colour, face or difficult to pronounce name that had made it to the top tier. Meeting Jane Dacre, I realised that she was only the 3rd woman to make it to the top, in 500 years of the Royal College of Physicians.

The glass ceilings were now clearly visible. Like any person of oriental or Asian philosophical roots, I followed my father's mantra, 'do your best but expect anything in return', one will be appreciated someday for one's contribution. Demanding what is due and fair was not in the DNA.

It took me years to realise that in spite of one's best efforts and having all the necessary talent or qualifications, the glass ceiling was not going to be shattered easily. Perhaps never. For many a choice of not reaching one's potential was inevitable. I had to discover the final step of making a mistake in one's professional life, and facing the NHS machinery of an MHPS investigation. I learnt how the 'fair to refer' process put me at risk of being formally investigated and censured while many of my White peers were dealt with a light touch approach.

I realised that it was time to have one's voice heard. It was time to stand up and ask for fairness and tackle bias. It was important that those of us who are in positions of some power or influence and able to stand up should do for all who can't or are not differently abled. We need to level the playing field for generations to come. Rome was not built in a day and neither will the world become a fair place for all for several thousand years. However, every step, every deed, every action one takes for fairness and equality is a step towards the goal of justice for all. Health for all is never going to be realised if we do not strive for justice for all.

I realised that one is more powerful if one has a shared destiny, a shared mission and this where belonging to a group of like-minded professionals is so critical.

Indranil Chakravorty qualified from Medical College Kolkata and moved to the UK in 1994

MY CSA JOURNEY

Sanjiv MASKARA | sanjeevmaskara@gmail.com

I was undergoing my General Practice (GP) training in Scotland. The Membership of the Royal College of General Practice (MRCGP) had three components in order to receive the Certificate of Completion of Training (CCT). I had passed my theory exam. My workplace-based assessments were good. I had excellent multi-source feedback from colleagues and patients. However, I was having difficulties with the Clinical Skill Assessment (CSA). The exam used to be conducted in Croydon by the RCGP, with professional actors. This exam comprised 13 stations, with day-to-day cases from primary care. I knew that it was more of a communication skills test. It was my last attempt at passing the CSA.

If I did not pass the exam, my potential career as a GP in the UK would be over. I was apprehensive, anxious and had nightmares. All my hard work and aspirations from my family and friends would disappear. I was anxious about what my GP trainer and practice staff would think of me. My GP trainers and training practice were looking forward to offering me a job and a partnership in the same surgery. I did not see any light at the end of the tunnel. There was a huge pressure on my shoulders. I could not think straight. My training scheme told me I was not alone and could practice exam cases and techniques with other candidates in the same predicament.

THERE WAS A STRONG FEELING THAT AN UNCONSCIOUS BIAS WITH THE CSA WAS PUTTING THEM AT A DISADVANTAGE.

We felt that there was something not right with this CSA. The exam pattern had changed three times during our training period. International Medical Graduates (IMG) performed poorly compared to our peers, despite all being given the same training. The chance of success was significantly lower. However, there was no objective evidence to prove our perception of bias. The CSA was a well established assessment system and had never been challenged. It was then that I heard of the BAPIO and the support to IMGs. I read their mission statement 'Awareness in diversity and inclusion that supports fairness & equality.' BAPIO was the only hope for us. I contacted the President who listenend to my predicament with great sympathy and compassion and promised to investigate our case. I prepared a list of 250 IMGs having similar problems with the CSA. Many had been thrown out of training programs and failed to pursue a career in GP. Many had been forced to return to their home countries or emigrate.

BAPIO, took on this challenge. I took the CSA the following year and passed, then spent some time working in Australia. However, many struggled to clear their exam in their last attempt and were thrown out of training. BAPIO kept its momentum and mounted a legal challenge against RCGP and GMC. Though BAPIO was not able to legally prove that there was discrimination, they had a moral victory.

Since then there is widespread acknowledgement of unconscious bias, resources have been invested to improve the outcome for IMGs in communication skills assessments. BAPIO stood by IMG and their emotions and supported them, and this support was vital to save my career from inevitable ruin. I am currently a GP partner, a trainer, an appraiser, a specialist advisor for CQC, and a CCG board member. I played an active role during covid-19 pandemics. And yes, I keep my head high and take pride in helping any IMG trainee in difficulty! There is much more work to be done as the differential attainment remains significant.

STRANDED DOCTORS

Savita BANSAL | savbansal@gmail.com

When the Covid 19 pandemic hit the UK, and the country went into lockdown in March 2020, it affected everyone's life one way or the other. No doubt, we are still learning to live with this virus. To some people, it hit very hard. People had plans for their lives, their futures, and suddenly nothing was within their control. Nobody knew what to do and how to deal with the uncertainties that the pandemic had created. New guidelines were put in place by governments daily to ensure people's safety, all flights were cancelled and travel came to a stop.

As a legal professional, I received queries every day from people stranded in the UK and overseas. I was aware that many International medical graduates (IMG) were in the UK on visitor visas for their PLAB 2 assessment. When I received a request from BAPIO to answer queries from over 250 stranded overseas doctors from around the world, I became aware of their real struggles.

Everyone had a unique scenario requiring a different approach to tackle their visa issues. Due to Covid-19 restrictions the PLAB II exam had been cancelled and visas were expiring. Due to flights cancellations and unable to work without passing the licensing examination, personal financial challenges were mounting. The option was either to go back to their home countries and make fresh visitor visa application or get an extension to stay in the UK. There were complex rules and restrictions preventing transfer to a work permit status. At the request of the BAPIO support team,

I conducted regular free zoom sessions to guide and support these distressed doctors. Many doctors benefited with this immigration advice and guidance, which was not easily available at the height of pandemic when most of the legal offices were closed and regulations were frequently updated by the Home Office. Some complex scenarios needed 1-1 sessions which were provided *pro bono*. Many HR departments, who were happy to provide them a job offer, were not clear on the ever - changing Home Office policies and needed legal guidance. Once the certificates were issued switching from Visitors visa to work visa was the next hurdle to cross. Through BAPIO and feedback from some doctors.

I am pleased to have assisted these doctors stranded overseas during their stressful time. The feeling that you make a positive difference in people's lives is indescribable. When I remember these meetings or teleconsultations, it brings a smile, confidence, and a sense of accomplishment that a paid consultation could never have done.

I am a London based Solicitor specialised in Immigration law with over 13 years of experience, and a director and trustee of the "Enfield Saheli" organisation which supports and empowers women suffering from domestic abuse. I am also a penal member/ Immigration solicitor for Medical defence shield & BAPIO.

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ADR VISA POLICY SPELLS WOES FOR THE NHS

Abhinav RAJ

Over the past four years, the Home Office has approved just 218 Adult Dependent Relative (ADR) visas for the elderly relatives of the NHS workers. This 'hostile' immigration policy has compelled many NHS staff to resign from their positions and return to their home countries to care for the elderly dependent. The NHS staff comprise 170,000 non-UK citizens (64,000 are of Asian origin) many have elderly relatives that require medical care. According to the ADR visa policy, medical practitioners, nursing staff among others in the UK must satisfy stringent criteria before their parents from their home countries are allowed entry into the UK—a legal system that's driving many immigrant NHS workers out of the UK.

Until July 2012, an elderly dependent of an NHS medic in the UK was only required to prove that they were subject to "the most exceptional compassionate circumstances"—however, the visa policy has since undergone changes such that medical practitioners who joined the NHS workforce several years ago now find it arduous, if not impossible, to bring their elderly parents to the UK. The elderly dependent of foreign-born nationals seeking an ADR visa are now required to provide evidence sourced from a local doctor or healthcare provider that they are unable to receive suitable care in their home countries.

Out of the thousand ADR visa applications made between 2017 and 2021, only 35 were granted in the first attempt. This occurrence has driven many foreign healthcare workers to resign from their positions and return to their home countries to care for their elderly parents, and left many others in a limbo. The British health service—since its genesis—is no stranger to migrant workers. With many doctors torn between caring for their elderly relatives back in their home countries and furthering their career in the NHS, the current ADR visa policy has introduced a sentimental dilemma in a major section of the workforce.

> 'The emotional dilemma that migrant doctors and nurses face from being unable to support elderly parents in their home countries, while serving the NHS is not to be underestimated. The Government needs to see this suffering, show humanity and compassion and change the ADR rules'
>
> *JS Bamrah, Chairman, BAPIO*

The visa policy has led to outcries for reform by the healthcare community. In March, hundreds of doctors including former presidents of the Royal College signed an open letter to the government calling for a review of the "inhumane" amendments to the visa policy ratified by the Home Office in 2012.

Currently, the British Medical Association, British Indian Nurses Association, British Association of Physicians of Indian Origin (BAPIO), Association of Pakistani Physicians of Northern Europe (APPNE) and the Royal College of GPs are spearheading a joint effort to call for a review and overhaul of the ADR visa rules. The bodies warn of an exodus of skilled medical professionals at a time of need if necessary changes to the policy are not introduced.

The House of Lords in May this year witnessed a debate on the existing ADR visa policy. Labour Party representative Lord Parekh called for the government to 'take a second look' at the modifications to the ADR policy proposed by BAPIO. "The rules must strike the right balance between ensuring those who need support can come here, without placing additional pressure on the health and welfare services which would need to be funded by taxpayers more widely."

The NHS staff are the backbone of the healthcare industry in the UK. In their altruistic pursuit to provide the country with their service, it's only reasonable to assume that the country must do its bit to help them look after their loved ones.

Abhinav Raj is a political correspondent for the Immigration Advice Service, a UK-based organization of immigration solicitors that provides Indefinite Leave to Remain (ILR) services, Visa assistance for prospective migrants and pro-bono legal counsel.

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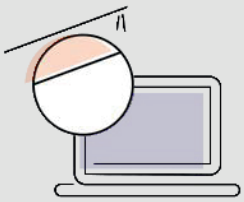

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Reducing Violence towards Health Professionals

The Role of Voluntary Sector Organisations

Indranil Chakravorty

ABSTRACT

There is a rising trend of violence against healthcare professionals across the world, especially after the COVID-19 pandemic. Many countries report between 43-75% of professionals experiencing at least one incident in any annual survey. The most recent incident of doctors and healthcare staff in a Manchester City General Practice raised alarms. As the healthcare infrastructure and services are severely stretched following the disruption of 2020, there are more reasons for disquiet and frustration from the public. The media and political portrayal of primary care physicians as not caring enough to provide face-to-face appointments in the UK is believed to increase the public angst. There are protests from professional organisations but this is not heard by the public.

In any violence prevention strategy, a multi-system approach is critical. While tackling misinformation is essential, so is the tackling the root causes, the waiting lists and a balanced information to the public. Political and organisational leaders need to be visible and vocal in explaining why the healthcare infrastructure is beyond breaking point. This will justify the additional resources needed and reduce the frustrations of the public, in need of care.

There is also a vital need to help new doctors and nurses as well as all frontline staff in violence dissipation techniques, self-preservation. The Voluntary community organisations including those that support professional groups have a vital role to play. The NHS People Plan has recommended that VSCEs should join robust and reliable partnerships with Integrated Care Organisations in developing strategies and interventions. There is more work to be done. This article is a call for action and invites all VSCEs interested in the reduction of violence against staff to join with employing organisations to set up collaborative working groups with specific actions to implement. This is essential to reduce harm and reduce the demoralisation of an already burnt-out healthcare workforce.

Key words

Violence against healthcare professionals, NHS Employers, Burn-out

There is more work to be done and VSCEs can help

Reducing Violence towards Health Professionals contd..

The Role of Voluntary Sector Organisations

The unfortunate incident of a General Practice in Manchester being attacked by an irate member of the public in Manchester this week, resulting in serious bodily harm to a doctor and healthcare staff has alarmed many within the profession and the public. Dr Manisha Kumar, a medical director at Manchester Health and Care Commissioning remarked, 'We are sadly used to aggression but this was life threatening. This is not okay.' [1] This simple observation does underline that aggression and violence towards healthcare staff is an uncanny reality of life.

When every country in the world recognises the rising incidence of physical violence and verbal aggression against healthcare workers (HCW), from patients or their relatives- it is certainly an issue that should concern the healthcare system leaders. A survey conducted by the Indian Medical Association in 2018, reported that 75% of doctors had experienced at least one instance of violence in the line of duty. [2] The United States, China [3] and the UK are no different in their experience. A survey in the UK in January 2020, before the COVID-19 pandemic found that 43% of 644 doctors saw physical violence or verbal abuse towards colleagues. [4] Although 32% of violent deaths of healthcare workers investigated in the USA from 2003-2016 (n=62) were due to homicide and perpetrated by a patient, relative or someone close to the patient - there was a larger proportion of deaths due to self-harm.[5] Emergency department staff, first responders, nursing or care home workers and psychiatric unit staff [6,7] are more at risk of physical violence.

Covid-19 pandemic

The risk of violence and reported incidents rose sharply after the pandemic, when health services were stretched to and often beyond breaking points in large swathes of countries across the world. [8] Most frequent reasons included mistrust in HCWs, belief in conspiracy theories, hospitals' refusal to admit COVID-19 patients due to limited space, COVID-19 hospital policies, and the death of the COVID-19 patients. Protests by doctors and other HCWs for provision of adequate PPE, better quarantine conditions for doctors with suspected COVID-19, and better compensation for doctors on COVID-19 patient duty resulted in police violence towards HCWs. [9] However, misinformation in respect of COVID-19 and adverse care outcomes led to an increase in violence against medical practitioners in low or middle income countries such as Bangladesh, India, Pakistan, Syria and Sudan [8]. In UK primary care settings, a perception of reduced face-to-face consultation availability has been cited as a reason for frustration and abusive behaviour.[10]

Experience of minority professionals

There is another angle to the violence experienced by healthcare professionals. This is the influence of gender, colour, religion and ethnicity.[11] The physical violence reported by minority ethnic and psychological abuse reported by female healthcare professionals is significantly worse than their peers. [12,13] A study of over 12,000 workers over the 6-year study period demonstrated the higher risk of violence towards professionals who were female (82%) and inpatient nurses. [14,15]

Determinants of Violence towards healthcare professionals

The likely drivers of violence are thought to be discontent with the service provided, health related or personal problems, and alcohol or substance abuse amongst the perpetrators. [16,17], poor administration, miscommunication, infrastructural issues especially differences in services between hospitals, and negative media portrayal of doctors.[18] Misinformation leading to a gap between expectation and reality (in relation to healthcare) is one of the key factors. Healthcare professionals in mental health services or emergency medicine departments received more violent threats and sexual harassment than physicians in other departments. [19] Midwives tend to suffer the highest risk of experiencing aggression. [20] The treatment room is the most common place where the violence is known to occur. Under-reporting is common and reported figures are likely to be gross underestimates. Only a minority of the professionals who experienced violence actually reported it. Being accustomed to workplace violence is the most stated reason for not reporting violence to the hospital administration or the authorities.[21] Among the HCW professions, nursing was the profession, in which HCWs were more prone to experience a violent episode, while male medical doctors were more prone to report violent episodes than female medical doctors. Moreover, female HCWs experienced more verbal violence (insults) than male HCWs did, while male HCWs experienced more physical violence (bodily contact) than female HCWs did. [22]

Consequences of Workplace violence

The studies identified seven categories of consequences of workplace violence:

- (1) physical,
- (2) psychological,
- (3) emotional,
- (4) work functioning, (
- 5) relationship with patients/quality of care,
- (6) social/general, and
- (7) financial. Psychological (e.g Post traumatic stress, depression) and emotional (e.g., anger, fear) consequences and impact on work functioning (e.g., sick leave, job satisfaction) were the most frequent and important effects of workplace violence. [23]

Solutions

WPV for healthcare professionals is a preventable public health problem that needs urgent and comprehensive attention. Those in healthcare leadership can: 1) obtain hospital commitment to reduce WPV; 2) obtain a work-site-specific analysis; 3) employ site-specific violence prevention interventions at the individual and institutional level; and 4) advocate for policies and programs that reduce risk for WPV. [24] In general, primary prevention is best conceptualized using systemic- and individual-specific approaches.

On a systemic level, the display of zero-tolerance policies such as the NHS zero-tolerance posters might have a deterrent effect, although the efficacy of this has not been established. As the health service outcomes depend on excellent communication and trusting relationships between the care-giver and patients, the use of segregation, restrictive spaces, and visible security presence usually undermines this relationship and in some circumstances is known to aggravate the risk of violence. Majority of healthcare settings, however, do not have these facilities which make primary prevention more challenging. Healthcare professionals also live in public spaces, therefore personal risk does extend beyond the workspace. Additionally, predicting violence is difficult, and formal violence risk assessment instruments have relatively poor positive predictive value in populations. Violence prevention in respect of the pandemic is more complex. Some countries such as India, have passed stringent laws against health care violence during the pandemic [8] and others such as Sudan, are developing a specific police response system.

Secondary prevention aims at escaping or de-escalating an evolving violent situation. In an acute situation where violence is imminent, it might be necessary for the professional to exit the consultation to seek help [25] or be within visibility of other staff members. In many secure psychiatric units dealing with patients with a history of violence, there are systems and protocols for such eventualities. In the consultation, a range of techniques such as allowing the patient space to vent, preventing an increase in arousal by using empathy, and maintaining a calm tone of voice are effective.[25] This requires specific training and role-playing to master. Healthcare workers, students and trainees would benefit from formal de-escalation and personal safety training as part of workplace inductions.

One of the first lessons I remember learning during my first on-call ever as a junior doctor in Kolkata Medical College Hospital, was the art of self-defence. While assisting my senior house officer in resuscitating a patient who (even to my inexperienced eye) was clearly dead, I noticed the strict adherence to the principles of an elaborate cardio-pulmonary resuscitation process being enacted. My quizzical look was answered by a slight nod of the head pointing me towards the 3 large, burly men who were crowding round the bed and pointing menacingly at the hapless trio of doctors and nurses undertaking the resuscitation. Although by that time, the patient was beyond our help, the enthusiasm with which we 'tried our very best' was rewarded with gratitude. The slippery slope from gratitude for trying your best to being blamed for the inevitable demise and then having to pay for it with physical harm- is all too familiar to many. That early lesson has helped me several times in my career to date.

A qualitative study from London reported that receptionists in GP practices were found to be most at risk, due to exclusion from team meetings and lack of peer support and advice. [26] The authors found that 'negative management tactics, such as patient appeasement or exclusion, were the norm'. A real commitment from leaders is needed and be understood by frontline staff in order to encourage reporting and implementation of the 'zero tolerance' policies which exist on paper.

Tertiary prevention (after the incident) includes accurate recording of the incident in the patient's clinical notes and clinical alerts. Having an incident debrief with practice staff, including, sometimes an independent experienced colleague, can help establish learning points in respect of how an incident was managed. Decisions about the ongoing care of the patient by a different practitioner within the same clinic or at a different clinic might need to be taken based on the seriousness of the violent episode.

In the UK, there have also been calls for a systematic response from Clinical Commissioning Groups to respond to the increased reports of pandemic-related violence with a consistent approach and for increasing the availability of occupational health measures for the doctors involved.[10] Therefore most recommendations on the management of workplace violence include the development of participative, gender-based, culture-based, non-discriminatory, and systematic strategies to deal with issues related to violence.

Trade Unions & Voluntary sector partnerships

Partnership working between the voluntary sector, local government and the NHS is crucial to improving care for people and communities. The British Medical Association and Royal College of Nursing as the largest trade union organisations in the UK, play an important role in supporting their members, encouraging specific policies and protocols to be developed and monitoring when such incidents of violence against professionals is on the rise. [4] There is more to be done and we see a need for collaborative working with the voluntary sector.

The NHS People's Plan [27] highlights the need for closer working across public and voluntary sectors to address the wider determinants of health, which in turn could impact on the demand on primary and acute services. Voluntary, Community and Social Enterprise (VCSE) involvement and leadership has been key to developing rich partnerships within local health and care systems. We know that it is through the support of the VCSE sector that Integrated Care Systems (ICS) have been able to make progress towards addressing health inequalities and improving public health.

COVID-19 has acted as a catalyst for even greater integration of VCSE services and time and resources are progressively being directed towards facilitating access to educational resources, reducing social isolation and delivering preventative interventions for crime reduction. One such example of a community voluntary organisation supporting Filipino nurses in the UK was expanded during the pandemic to help families too. [28]

VCSE organisations are often embedded in neighbourhoods and have a unique advantage when it comes to engaging the most at-risk and rarely heard communities. They play a key role in facilitating dialogue between the system and its residents, making sure that services are co-produced with purpose, with residents at the heart of service provision. The voluntary sector works in three main ways. The first, and by far the largest area of work, is service delivery to support individuals in the criminal justice system and their families. The second – often in combination with the first - is campaigning and advocating in order to reform the criminal justice system. Finally, there are self help organisations, set up to share experiences and support amongst peers, which are usually local and volunteer run.[29] This type of resource is largely missing for women and minority ethnic professionals in the UK NHS.

For the VCSE to achieve its full potential in the delivery of integrated care, it needs to be recognised fully as a part of the system.[30] In April 2018 the UK Government published its Serious Violence Strategy which represents a step change in how to think and respond to serious violence, establishing a new balance between prevention and law enforcement. It declared a call to action to partners from across different sectors to come together and adopt a whole-system multi-agency approach to tackling and preventing serious violence at a local level, often referred to as a 'public health approach'. The Government introduced a range of initiatives including: a new statutory duty on public sector agencies and bodies to prevent and tackle serious violence, which will help create the conditions for collaboration and regular communication to share data and intelligence to understand and tackle the root causes of serious violence. [31] This strategy and the public duty applies equally to instances of violence against healthcare professionals and rests with NHS Employers.

We are aware of the initiatives that the women's forum of the British Association of Physicians of Indian Origin are initiating to reduce personal violence towards women specially around commuting to and from work, which is also on the rise. Although the intention remains from policy makers to engage 'a whole system approach' to tackling violence, there needs to be more engagement from both sectors. We propose setting up a reducing violence working group and a roundtable for developing consensus between NHS Employers, Clinical Commissioning Groups and Social care providers including local authorities. This is a call for action before more lives are lost and a weather-beaten workforce is further demoralised.

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Impact of COVID-19 on Mental Health of Adults with Autism in India- A case series

"Increasing performance while decreasing value"

Ritwika Roy & Amaan Javed
DOI https://doi.org/10.38192/14.3.4

Background:
This study focuses on the direct and indirect implications of the COVID-19 pandemic on adults with Autism in India. This study took into account the social isolation during the global pandemic in 2020 and its effect on the emotional well-being of the community.
Methods:
We designed a survey involving Indian residents. Part I involved questionnaires for different cohorts: 1) educated, 2) employed and 3) unemployed. The questions were based on proposed life models to maintain the heterogeneity according to the preferences of the target group. Part II of involved online interviews conducted in English. Qualitative and quantitative analyses were performed.

Findings:
The analyses of participants' responses (N=10) stipulated that the impact of the COVID-19 pandemic on autistic people's mental health has been variable. Participants encountered both positive and negative emotions. Factors such as disrupted schedules, fear of job loss, poor domestic support system and inconsistency in transition were important. These were associated with development of new or worsening of pre-existing psychological as well as behavioural conditions including depression, anxiety, panic attacks and high-stress levels. At the same time, reduced interactions with decreased social insistence led to an improvement for some participants.
Interpretation:
Our results illustrate the deterioration of mental health and well-being for Autistic adults due to the impact of the COVID-19 pandemic. These findings emphasise the need for the development of innovative approaches and investment in the creation of support systems to address mental distress in this population.

Keywords: Coronavirus, COVID-19, Autism spectrum disorder, Neuropsychiatric presentations, Mental Health

Autism in India - Introduction

In the last two decades, several viral epidemics such as the severe acute respiratory syndrome coronavirus (SARS-CoV-1) from 2002 to 2003, and H1N1 influenza in 2009, have been recorded (1). Since December 2019 the entire world has been affected by the SARS-CoV-2 infection that emerged in Wuhan, China, leading to huge afflictions on health and lives. To date (May 22nd, 2021), the total number of confirmed cases is more than 166 million, and the number of deaths ascribed to the disease is more than 3 million (2).

Various studies have reported an increase in psychological distress and most relevant psychological presentations as uncertainties and fears (3), pervasive anxiety (4), and disabling loneliness (5). Long-term isolation/quarantine, with mass lockdowns and economic recession, is predicted to lead to increases in suicide as well as mental health conditions (6). Studies have also correlated the positive rate of incidence of restrictions on movement, inconvenient routine screening, and medical treatments with high rates of depression and anxiety (7). Not just the general population but also healthcare professionals and front-line workers have been displaying a higher risk of mental health problems due to work under extreme pressure to diagnose, treat, and care for COVID-19 patients (8).

While this pandemic has affected all groups of people in society, little has been done to highlight the disproportionate vulnerabilities of certain groups especially people with neurodevelopmental conditions like autism spectrum disorder (ASD) (9). The term includes Autism, Pervasive Developmental Disorder (PDD), and Asperger's syndrome which have been characterised as displaying social and communication awkwardness with barriers and/or repetitive sensory-motor behaviours (10).

For individuals with Autism, the published data suggests amplification of mental health changes like depression, personality change (11), abnormal behaviour (12), symptoms of post-traumatic stress disorder (13), post-intensive care syndrome (PICS) (14). These changes are attributed to the classic characteristics of the syndrome i.e., inflexibility, insistence on sameness, and loathe change (15). Despite a large Indian population being affected by Autism, little data is available on mental health exacerbations due to COVID-19 in the population having autism.

Additionally, India is one of the largest exceptions to the list of countries that lacks an estimate of autism prevalence and there exists a massive underreporting of this disorder among both adults and children (16). Only small-scale studies involving local hospital settings have been reported which estimate the prevalence of autism spectrum disorders, varying widely from 2.9% to 62.5% (17).

This study aims to analyse the correlation between the development and exacerbation of mental health disorders and COVID-19 in individuals with Autism. These correlations are speculated and associated with COVID-19 due to multifarious factors like limitations in understanding, personal relationships involving resilience and social support, employment/education status, long term isolation/quarantine.

We hypothesize that COVID-19 exacerbated the pre-existing mental health conditions or resulted in the development of other neuropsychiatric presentations in individuals with Autism. We hope to create awareness amongst the healthcare professionals and policymakers to manage and encompass the needs of individuals with Autism to prevent misdiagnosis, adopt behavioural strategies to reduce the burden, and limit long-term sequelae.

2. Methodology

2.1. Sample
We designed a pan India survey involving only Indian residents. An invitation describing expression of interest with a description of the study was shared on various platforms including universities, organizations, and NGOs requesting to share the description with their contacts. This study was directed towards adults (18+) with ASD living in India during the COVID-19 pandemic. The respondents were from the cities of Mumbai, Kolkata, Bangalore, Delhi, Amritsar, and Ooty. In accordance with the principles of the Declaration of Helsinki, consent was included in the survey and was accompanied by a description of the study describing the aims, methods and other relevant aspects of this study.

2.3. Data collection
The consent for participation in questionnaires, interviews, and recordings was obtained along with assuring them confidentiality. To ensure anonymity the participants were coded as P1-P10. The data collection for the study consisted of two parts. Part I involved independent questionnaires, which were prepared for different cohorts:
1) educated, 2) employed and 3) unemployed.

The questions were based on various proposed life models that can be to maintain the heterogeneity according to the preferences of the target group. Once the questionnaire was deemed appropriate to be used for examination of the quality of life, the final set of questions was finalised (18–21). These questionnaires apart from the participants' journey since diagnosis, included sections on the impact of the COVID-19 on daily routines, variations between present and pre-COVID mental health with exacerbations if any, social relationships, and the transition to online classes/work-from-home hybrid model. Part II of this study involved extensive online interviews which were conducted in English.

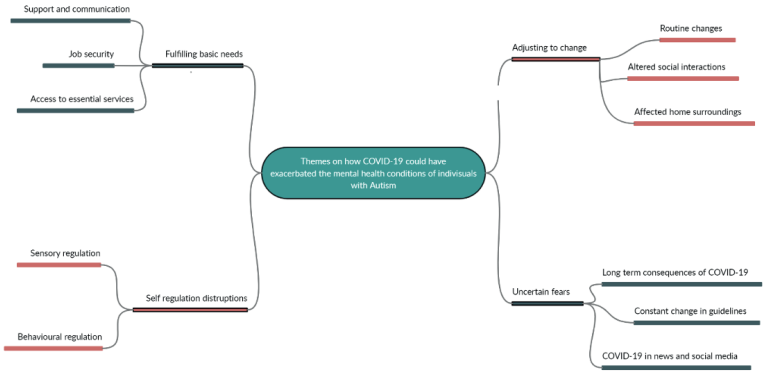

Figure 1: Major factors deduced to exacerbated the mental health condition in our target group.

Autism in India - Results

Additionally, the audio-recorded interviews were transcribed into electronic format. Qualitative and quantitative analyses were performed for the assessed variables and divided into profuse segments following the precedence of the study.

Statistical Analysis

The analyses were conducted using Microsoft Excel 2019 where the quantitative data was presented by frequencies and percentages while qualitative data was presented using inter-rater reliability. We used the critical realism thematic approach to analyse the responses (22). We analysed the content and identified themes across the participants' responses to broadly organize the causes of exacerbation of mental health presentations. Figure 1 consists of broad themes on how COVID-19 could have exacerbated mental health.

To minimize the risk of bias and expand the extent of the accurate representation of data we calculated interrater reliability using Cohen's Kappa Coefficient. The quality of agreement was defined as follows: values ≤ 0 as indicating no agreement and 0.01–0.20 as none to slight, 0.21–0.40 as fair, 0.41– 0.60 as moderate, 0.61–0.80 as substantial, and 0.81–1.00 as almost perfect agreement. Perfect agreement (0.81–1.00) was reached for 96.5% of the variables (23). Table 1 consists of categories and percentages of response in addition to interrater reliability.

All participants reported having received information about the coronavirus, where the sources of information were COVID-19 websites (50%), social media (50%), News Channels (40%), Newspapers (20%), and family and friends (1%). One participant reported refraining from all the news.

A significant number of participants reported a sufficient level of comfort in adhering to lockdown rules (80%) and staying indoors (60%) during the pandemic.

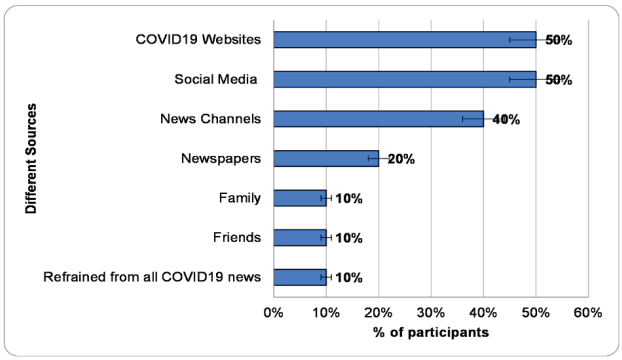

Figure 2: Major sources of information concerning COVID-19 pandemic

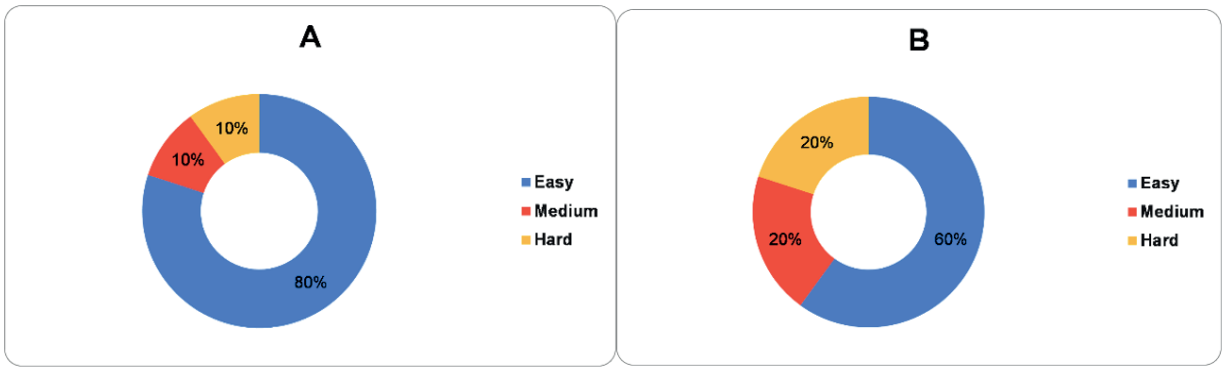

Figure 3: A: Comfort level adhering to lockdown rules, B: Comfort levels staying indoors

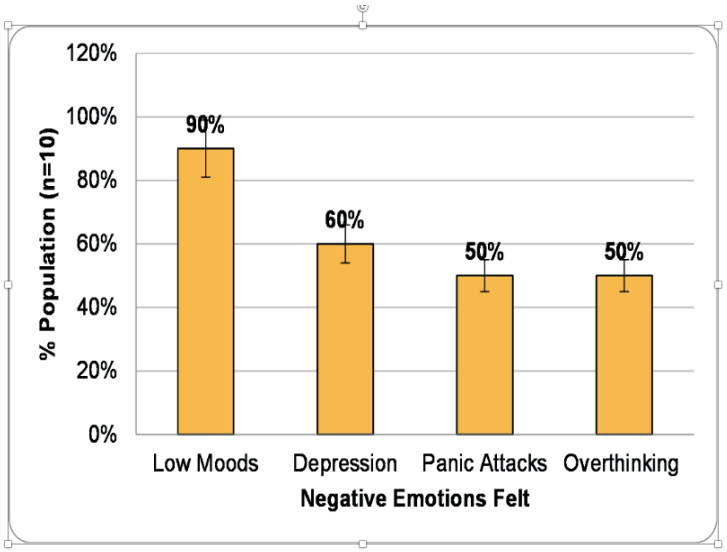

Figure 4: Percentage of participants experiencing negative emotions

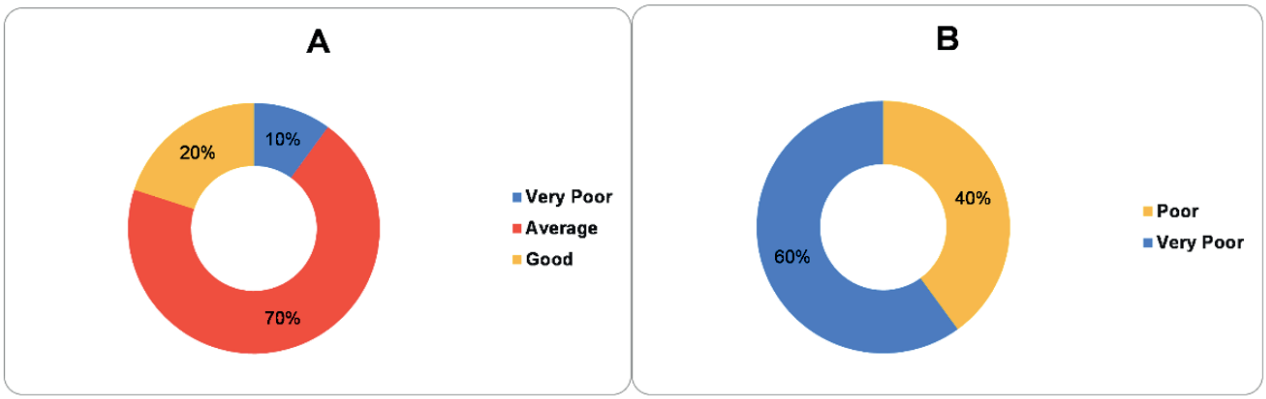

Figure 5: Comparison of mental health. A: Before lockdown, B: After lockdown

Autism in India – Results contd

The participants reported experiencing negative emotions: low moods (90%), depression (60%), panic attacks (50%), and overthinking (50%) during the nationwide COVID lockdown.
All candidates reported worsening of mental health in comparison with pre-lockdown states with higher frequency (60% high and 40% medium) and higher intensity (70% high and 30% medium) of negative emotions.
The reported levels of anxiety at home were: Non-Existent (10%), Low (20%), High (30%), and Unbearable (40%).

From the analyses of the responses, the most common factors that were found to affect mental health were: affected social relationships, sensory overload, loud home surroundings. The reported factors to have supported mental health were: discovering their strategies to help them during meltdowns (50%), staying at home with minimal interaction with new people (60%). Participants described how the initial preference to avoid social interactions became difficult after a few months.

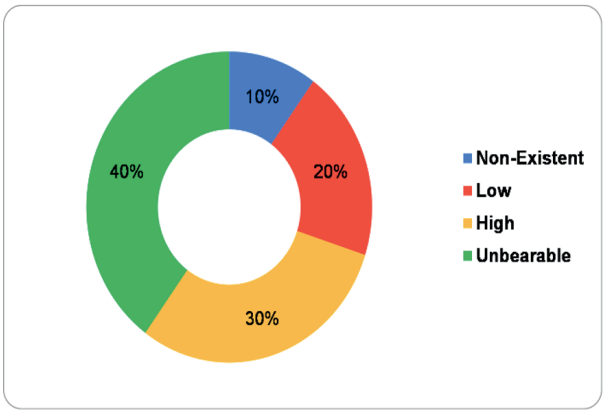

Figure 6: Anxiety levels at home

Autism in India – Results contd

P1 reported:
"Initially, I was happy - I didn't have to talk to new people, so stress decreased. Initially, my mental health was good. Became worse with progressive months. By the third month, I craved human contact. That impacted my mental health negatively."
50% of the participants were perturbed about loved ones becoming infected with SARS-CoV 2, and how they now had more burden and responsibilities.
P5 reported about supplementary competence:
"Day-care for my son was gone, so added responsibilities, husband is very social so he was losing his mind, we started fighting."
However, at the same time, more time spent with family was followed by misunderstandings and disagreements: increased time spent together resulted in disagreements and misunderstandings.
For example, P9 reported:
"Misunderstanding with parents, parents' relationship is fragile, they are not going for divorce, they used to fight a lot, this impacted me, and each other's anger was put on me."

Another contributor to the soaring stress levels was unreliability and uncertainty over job security and access to healthcare facilities. Those who were employed (n=7) reported difficulty in transition to work from a home-based setup.
Additionally, participants devised strategies and ways to help them during meltdowns.
For example, P2 reported about managing the multifaceted stressors of the pandemic: "Set personal boundaries, changed philosophies, morality on certain behaviours, all that shifted in the lockdown, I don't want to set unrealistic expectations of myself, realistic expectations from myself, Learnt more about different things".

Among all interviewed adults, regardless of age or gender, the living circumstances appear to be appreciably associated with specific support sources. Those who were employed and living an independent life had a lack of a natural support system, while those who were students lived with their families and particularly depended on the support provided by the family. Since all services and activities were moved online teletherapy became the new normal and the counsellors/therapists/ practitioners spoke to their clients over tele sessions. 56% preferred in-person therapy, 33% preferred teletherapy while 11% found therapy ineffective.

4.0 Discussion
Adults belonging to the range of autism spectrum disorders are one of the clinical groups at the highest risk of being affected by COVID-19. This study analysed the impact that COVID-19 had on autistic adults living in India. The escalated risk of exposure in this population can be elucidated by a variety of factors including necessary daily care requiring regular contact, shared transportation, etc.

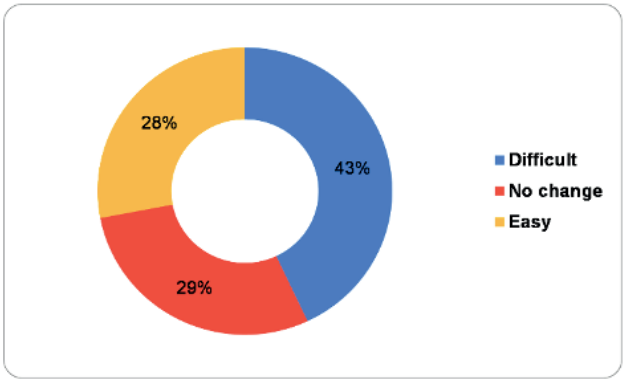

Figure 7: Difficulty in transition to work from home-based setup

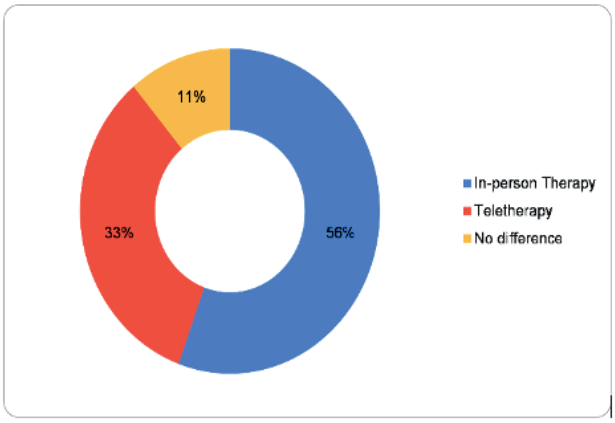

Figure 8: Therapy preference during the pandemic & lockdown

It's worth highlighting the importance of the internet and the effect it has on minds in providing easy-to-understand information.

Overall, the analyses of the participants' responses stipulated that the reverberation of the COVID-19 pandemic on autistic people's mental health has been variable. Participants encountered both positive and negative emotions, not, particularly at the extremes.

Factors like disrupted routine schedules, fear of job loss, poor domestic support system and inconsistency in transition were associated with development and worsening of pre-existing psychological and behavioural conditions like depression, anxiety, panic attacks and high-stress levels. At the same time, reduced interactions with decreased social insistence led to an improvement for some participants.

Unfortunately, the magnified risk of negatives outweighs this benefit. Irrespective of age, gender, and financial stability, fortification by family and friends played an important role to reduce anxiety. The other encouraging factor to be accentuated was recreational and leisure activities, in addition to discovering new ways to adapt to the new routine. Auxiliary efforts were required especially by the employed individuals to make their family and work-life compatible.

There is a critical requirement of studies to highlight how the pandemic has affected the employment of people with Autism as they are frequently only recognized as the recipient of services. Hardly any importance is given to the role that the individuals with Autism play for the support of surrounding members. Other needs expressed by autistic adults were related to access to appropriate and affordable healthcare services. Before the pandemic, accessibility was a huge problem for autistic people and this appears to have been amplified over this period. There was variability in participants' experiences of therapy. While a small proportion found it ineffective, a significant number of participants found in-person and teletherapy effective.

Based on our above findings it is amiable to deduce the direct and indirect implications of the COVID-19 pandemic on adults with autism spectrum disorders in India. The analyses of the participants' responses and perspectives exemplify the significant decline of mental well-being. The findings of this study emphasize the need for the development of innovative approaches and the creation of multifaceted support systems to address mental distress in this population.

A set of recommendations have been curated to ensure better support and therapy resources are available to the neurodiverse community:

1) Enhanced availability and accessibility of therapists, counsellors and practitioners.
2) Virtual helplines to cater to the emotional well-being and mental health concerns.
3) Multidisciplinary centres with therapists, doctors and support staff could actively provide real-time support and toolkits for safe mental well-being. Further studies can investigate the real-world application of early interventions, provision of full-time support via support groups and neurodiverse specific helplines; to address the mental health concerns and mitigate the effects of prolonged quarantine as a result of the COVID-19 lockdown in this population.

6.0 Limitations of the study

The selection of the participants was randomised with variations in their demography. Due to time and financial constraints the sample size was relatively small to draw any conclusive judgments, lacking geographical and socioeconomic diversity. Sampling biases could have led to a skewed understanding of the issues examined, for example, participants varied in their verbal expressions of feelings, either being extremely verbose or too laconic (being a part of the spectrum).

Therefore, findings may only be characteristic of the segments of the population represented. The questionnaires used were created by the authors working on this project and no standard tools were used to assess the mental well-being of the participants. To enable more consistency in the future, we would recommend the use standard questionnaires, look into a larger sample size of the participants and document their strategies for verifying diagnoses and eligibility.

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WHY IS THERE A PANDEMIC OF HEART DISEASE AND TYPE 2 DIABETES IN SOUTH ASIANS?

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Raj Bhopal reflects on the gargantuan, long-term pandemic facing South Asians and its causes and consequences in his latest book, Epidemic of cardiovascular disease and diabetes. Explaining the Phenomenon in South Asians Worldwide. (Oxford University Press, 2019). In using the term South Asian Bhopal is referring mainly to people with origins in India, Pakistan and Sri Lanka wherever they are settled, whether on the Indian subcontinent or overseas.

I was raised from 1955 in Glasgow, Scotland, an epicentre for coronary heart disease (CHD) and as a teenager was aware of people dying suddenly from heart attacks. As a clinical medical student in A & E I remember, still with shock, the frantic, unsuccessful attempt to resuscitate a 29-year old woman after a myocardial infarction. As a junior doctor I looked after mostly men with heart attacks, some in their late 30s and early 40s. Seeing at post-mortem the dissected, glistening coronary artery with discrete yellow plaques and a snakelike thrombus is a sight never forgotten. By the time I entered public health in 1983 I knew the six big risk factors from both clinical and epidemiologic perspectives: smoking, high cholesterol, high blood pressure, diabetes, physical inactivity and poor quality diet.

In 1984, however, I was thrown this googly by Professor William Littler, a Cardiologist, at a conference:Raj, What do you make of the risk of coronary heart disease in South Asians? I had never thought about it and applied first principles, suggesting they would have less risk because of lower smoking and more vegetarianism. The immensely high risk of type 2 diabetes in South Asians was yet to be demonstrated in 1985 by the Southall, London Diabetes Survey. Just after my conversation with Prof Littler, Professor Michael Marmot presented data showing that men living in England and Wales who were born in the Indian Subcontinent had an age standardised mortality ratio 15% higher than in those predominantly White European origin men born in England and Wales. Oops, I was wrong! I learned a lesson about the limitations of first-principles-based thinking. It needs to be tested through library research and empirically. In my subsequent studies, to my surprise, I found that the high risk of heart disease in South Asians had already been demonstrated in a number of countries including South Africa, and many papers had discussed the dangers of type 2 diabetes, although without empirical research data.

The book has 10 chapters:

- the size of the problem in the UK, the Indian subcontinent and some other countries and an overview of causes;
- genetic explanations including the thrifty genotype;
- genetic explanations including body composition;
- genetic explanations to do with behaviour and the brain;
- the thrifty phenotype and developmental hypotheses;
- social and economic development, lifestyles and psychosocial circumstances;
- the established major risk factors in the context of South Asian health;
- about 22 other risk factors e.g. vitamin D, microbiota and infections;
- explanations with the jigsaw puzzle metaphor and causal models; and,
- implications for policy, public health, healthcare and research.

I introduced the metaphor of the jigsaw puzzle with pieces scattered and some missing at the beginning of the book and put the jigsaw together at the end. I hope Sushruta readers will try and complete the jigsaw better than I did. I then discussed the key question of causality with 22 internationally recognised researchers/scholars. Their observations are provided in the book and weaved into explanations. Let me summarise the main findings.

The known and traditional risk factors are incredibly important in explaining both cardiovascular diseases and type 2 diabetes in South Asians. However, these traditional explanations are necessary but insufficient. Important ideas such as insulin resistance, genetic variants and the foetal and developmental origins of disease are very interesting but not gaining strong support from research. Body composition, with relatively high fat mass and reduced muscle mass, is of potential importance in South Asians.

I developed four major new ideas to stimulate new work.

- Firstly, I considered whether contaminants in the diet are causing problems and focused on neoformed contaminants e.g. advanced glycation end products and transfatty acids, both created through high-heat cooking.
- Secondly, I considered whether arterial stiffness is leading to increased blood pressure in the central and major arteries e.g. the aorta, with adverse consequences.
- Thirdly, I discussed the possibility that both atherosclerosis and type 2 diabetes are diseases of the microcirculation, the vasa vasorum -the vessels conveying the blood supply to the artery itself -in the case of the coronary heart disease, and the arterioles supplying the Islets of Langerhans in the case of type 2 diabetes.
- Finally, I reflected on whether there is insufficient capacity, given the rapidity of change in lifestyles, to maintain homeostasis, thereby leading to allostasis (changing setpoints, e.g. the normal blood pressure resets to a higher level).

These newer hypotheses are interweaved with the existing ones, and are not to be seen as alternatives but as part of a complex picture. While researchers and scholars continue to delve into these complexities what are practitioners and policymakers to do? We could apply with extra vigour the internationally agreed CVD and type 2 diabetes prevention and treatment strategies, with actions at lower than usual thresholds of risk factors. Our challenge is to produce low cost, effective actions that professionals and the public can understand and health services can implement.

One important message for professionals and public is that the high risk of CVD and type 2 diabetes in urbanising South Asians is real but not inevitable. It does not seem to be innate or genetic and there is no strong evidence that these diseases are acquired in-utero, in early infancy and programmed in a fixed way. Insulin resistance and high natural insulin, topics that have been the centre of attention, are likely to be markers and not direct causes. Rather, exposure to the causal risk factors in childhood, adolescence and adulthood is the key.

In my view more focus is needed on the content of the diet and the preparation of food, on muscle bulk, and on the amount and nature of physical activity.

I am persuaded by my colleagues that South Asians need one hour, not 30 minutes, of exercise every day and some of that needs to be anaerobic i.e. resistance exercise, increasing strength.

Public health strategy targeted at individuals and families needs to continue but to be successful this needs legislation and policy that alters environments allowing people to follow guidance easily. Obviously, as repeatedly said, preventative healthcare needs to be targeted to reduce tobacco use, tackle overweight/obesity, control and prevent hypertension, diminish both exposure to glycating agents including glucose and LDL-cholesterol levels. Actions are required to increase physical activity, muscle strength, fitness and to promote diets with complex carbohydrates and uncooked or lightly cooked vegetables and fruits. Unfortunately, these things are easier said than done.

I retired in May 2018 and handed over the baton to the new generations of scholars and researchers. I am confident that many mysteries will be uncovered and the pandemic will be controlled but this task will be harder and take longer than bringing Covid-19 to heel.

Raj and his wife Roma complete 192 miles coast to coast walk from St Abbs to Robin Hoods bay.

Acknowledgements

A full list of acknowledgements is in the book. Many colleagues helped me but 22 of them shared their innermost thoughts on the topic.They are listed in the book together with a digest of their ideas. My wife Roma was, as ever, the rock upon which my waves crashed. I thank Mr Vipin Zamvar for inviting me to write this. It is an honour to do so on the 25th anniversary of BAPIO, particularly as a recipient of the 2008 national BAPIO award, of which I am very proud.

GEOPOLITICAL CONFLICTS AND IMPACT ON HEALTHCARE

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The right to life in all circumstances including during conflicts is universally protected by international laws and regional treaties, however, right to healthcare is less well defined and does not find as much support and devotion in these declarations. Leading to this, the United Nations (UN) with Sustainable Development Goals (SDG) by 2030(1) recently stipulated a clear question:
How can we achieve universal accessibility to healthcare for populations affected by conflicts?

Right to healthcare during conflicts should be a basic human right, especially in areas where long-standing geopolitical issues have protracted over a long period for various reasons.The well-being of society is generally ignored and not even a part of The original Geneva declaration, an oath made to prevent medical crimes against humanity (2). The Conventions stipulate and expect parties of the conflict to respect and provide emergency care to the wounded and sick including the health workers that offer them care. In geopolitical conflicts, there is completely silence on the potential to offer the right to available, accessible and acceptable quality of health services to the civilian population (3)

The scale of this challenge is huge. Twenty people every minute are displaced due to conflicts or fear of persecution by the governments of the world. There are more than 22.2 million refugees in various countries and this figure does not include internally displaced people. More than 10 million people are stateless and are denied basic healthcare. Protracted conflicts cause food insecurity and malnutrition, especially in children and young adults. The crises of workforce in particular doctors are a real challenge. More than half the doctors in Syria have fled the conflicted country (4). The destruction of infrastructure weakens the ability to fight outbreaks of pandemics. The displaced population, due to the conflict within their own country, live in poor conditions of overcrowding and spread of life-threatening infections: cholera, respiratory diseases, viral illness etc. (1). Mental and maternal health is particularly vulnerable.

It is strange and completely in contrast to beliefs and principles of modern society that such an important issue of right to health has not been focus of intense discussion or debate in international fora.

Acts of charity, protection and standing up for co-human beings are known to be common acts to societies all over the world but state-run machineries conveniently turn a blind eye.(3). States and governments go further in some parts of world and formulate laws and policies contradictory to basic access healthcare rights against groups in society, in particular for migrants and women exercising their reproduction right, denying them to have the ability to protect and care for their body because of popular opinions opposed on them.

These laws have been opposed, however in some states medical workers and doctors are continually persecuted for providing healthcare in an impartial way to parties involved in conflict (5). This discourages medical help reaching the people in need at a time most critical for them. In the United Kingdom, the risk of prosecution for legitimate humanitarian effort is low but not zero and ambiguous interpretation may leave space for criminal charges to be brought against workers especially in areas where terrorism is rife.

Many governments have become more risk-averse and banned funding from banks, charities, and humanitarian organisations denying good work done on healthcare. This has detrimental impact of the health of people in poor countries (6). Bureaucratic or administrative hurdles and procrastination of processes of health related work by the states, dissuade humanitarian organisations to fund local projects (7). This constant neglect for the war or conflict affected populace demonstrates societal immorality towards the innocent people. The immigrant population at borders or within the country suffer dearly from healthcare neglect: Physical and mental wellbeing of those who have chosen to move out of their country of birth due to conflict, becomes nobody's issue. External support through charities is often limited or not possible in the current environment with legal hurdles (2, 8).

Most healthcare delivery in conflict areas is funded by the governments and is dependant heavily on the prevailing political agenda. Very few international organisations such as the International Red Cross provide short-term aid in areas and help in recovery. However they are not mandated to provide a sustainable healthcare and most conflicts are infact chronic and protracted or have a 40% risk of reverting back to acute state after an initial temporarily resolution.

The collection of data as source to plan healthcare in countries where conflicts are happening is often poor. The 4W matrix (who does what, where and when) is collected only in two out of 13 conflicts studied (1). Needs assessments are patchy and quality of data collected is often not reliable. 'Beneficiaries' of aid are not consulted and lack representation in decision-making and have no trust in the system. Combined with the risk of aid being perceived as politically motivated, the humanitarian health related aid interventions become less effective resulting in the population being stranded to fend for themselves. The question remains:

Can we make healthcare a universal service in conflicts-torn areas of the globe?
The world has resources, manpower and capacity to deliver this. To answer this question, the status quo needs to be challenged. A planned reorganisation of effort combined with political willingness can make this possible.

Deliver Accelerated Results Effectively and Sustainably (DARES) is a collaborative effort between WHO, World Food Programme (WFP), UNICEF, UNFPA and World Bank to preserve and improve healthcare in conflict settings(9, 10).

We reproduce some of the principles of this initiative here:

- **Support national systems. Strengthen local national systems and prepare and respond to deteriorating healthcare scenario in conflicted zones.**
- **Implement, multi-layered, flexible long-term planning**
- **Evidence base programming. The efforts need to match needs based on data, joint analyses and focus on most vulnerable.**
- **Maximize partnership. There should be a collective assessment, decision-making and risk sharing.**

A universal healthcare package should be based on local needs and empowerment with no compromise in equity of access and quality of care(11). In conclusions, world needs robust collaborative efforts to place a healthcare system for the conflicts affected populations with agreed basic work packages and quality assessment systems. This should be backed by a sound legal system transcending the geographical boundaries of the world map. Till this shape up, the suffering of fellow human being due to lack of basic healthcare will continue to be there in some part of the world.

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Impact of COVID-19 Pandemic on Global Healthcare Systems

The role of a new era of global collaborations

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ABSTRACT

The Covid-19 pandemic has changed the world, socially, economically and politically. There have been many positives in global scientific information flow, collaboration, speed of translation of research, technological innovation and its diffusion has been phenomenal. However the cost to human lives and livelihood has also been catastrophic.

In the post-pandemic world, the ambition to provide a well-resourced and universal health infrastructure to populations has become a challenge even for wealthy nation-states. The access to routine and elective healthcare has become severely compromised. In poorer nations, this has affected basic healthcare needs particularly for children, women and those on or below the poverty line.

Yet health is a fundamental human right, one that is guaranteed by the treatise on 'Declaration of Health for All' to which most countries are signatories. However, could the impact of this pandemic be mitigated by global health initiatives and collaboration? In this context, it is pertinent to analyse the existing global health framework and conventions to identify how we may prepare for future challenges.

Keywords

Covid-19, pandemic, global health, public health

Global Health Systems - Introduction

Due to globalisation, the mobility of the human population and urbanisation is likely to make the next emerging virus spread rapidly. It will be impossible to predict the nature of such a virus or its source and to what extent it shall spread. However, there will likely be delays in recognising and acting on such a future health threat/virus. Unusually, both developed and developing countries remain critically vulnerable. This is not the first time a health emergency has been declared by the World Health Organisation (WHO), and it will certainly not be the last.

Right To Health- A Fundamental Right

The right to health is a fundamental human right. [1] The preamble of the 1946 Constitution of the WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The preamble further states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of each person without distinction of race, religion, political belief, economic or social condition." Since its first declaration, various international treaties and laws recognised the right to health or its sublets like the right to medical care. Every nation-state has adopted health as a fundamental right and ratified its internal treaties and policies recognising health.

Right to health is an inclusive term. It includes the basics of survival, namely air, clean drinking water or healthy food, and freedom from non-consensual medical experiments and treatments posing a risk to human life. Further, it also highlights equality when it comes to health. Non-discrimination is a key to equality and crucial for enjoying the right to the highest attainable standard of health.

Right to Health and Right to be Healthy Discriminated:

A common misconception is that the state guarantees good health. However, one fails to consider factors beyond the state's control, such as an individual's hygiene or economy. The state may provide adequate means to improve the standard of living and maintain that standard is an individual's choice. The right to remain healthy is unconditional, whereas the right to health is the enjoyment of conditions required to attain a healthy life. Moreover, no nation-state may offer a defence under the blanket of financial breakdown or a lack of resources for not recognising this right.

Role of the WHO

WHO is the directing and coordinating authority for health within the United Nations.[2] It is responsible for providing leadership on global health matters and collaboration across the many health systems across the globe. In the 21st century, health is a shared international responsibility, allowing equitable access to essential care and collective defence against transnational threats.The WHO was established during World War -II [3] and had been striving to establish conventions, agreements and recommendations concerning international health matters.[4] It also actively participates in the research of various epidemic diseases and props humanity in fighting against them.[5] The WHO is also responsible for framing various policies and agreements to set out international health standards and define a healthy life. The most historic responsibility that WHO takes up is the international control of the spread of disease.[6]

International Health Regulation

The International Health Regulations (IHR 2005) adopted by the World Health Assembly came into force in June 2007. These regulations are binding on 194 state parties and all the members of the WHO.[7] This regulation is the successor of the International Sanitary Regulations 1951 that was renamed and reframed to International Health Regulations 1969, further revised to International Health Regulations 2005. This instrument protects the states from the outbreak of disease, public health risks and public health emergencies.[8] The reason for IHR, as per article 2, is 'to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade'.

Evolution Of Global Health Laws [9]

Public health is among the earliest domains of international cooperation for which an intergovernmental organisation was created. However, the scope of international legal cooperation of public health until recently was minimal. Diseases have been the unwelcomed travelling companion of international commerce throughout history, and international public health cooperation is concerned with protecting public health. The functions of the first international health organisations of the nineteenth and twentieth centuries centred on combating infectious and communicable diseases and preventing their spread across international boundaries.

For instance, the Conseil supérieur de santé (Superior Council of Health) of Constantinople, composed of delegates of the Ottoman Empire and the chief maritime states, was established in 1838 to supervise sanitary regulation of the Turkish ports to stop the spread of cholera. International disease control remained the predominant area of international legal cooperation throughout the mid-nineteenth century and most of the twentieth century. With attention limited to international disease control, public health law remained a comparatively neglected field—the WHO traditionally neglected the utilisation of international legislative strategies to publicise its global public health policies. Member states also paid little attention to the potential contribution of the law of nations in advancing global health during most of the last century.

Global health law is defined as a 'field that encompasses the legal norms, processes, and institutions needed to make the conditions for people throughout the planet to achieve the very best possible level of physical and mental health'. Within the last few decades, the global health law has expanded due to globalisation, public health diplomacy, and concerns with economic and social rights.

Healthcare in the European Union & Asia

Every country in the European Union (EU) has its healthcare system, which has many similarities to the National Health Service in the UK and automatically includes all its citizens. In most countries, healthcare is free except for some paid services.[10] The introduction of internal markets has increased healthcare efficiency and simplified resource allocation. However, the resource pressures on the nation-states are likely to go up with increasing expectations, medical advancement and ageing populations. Many EU countries have failed to curb the inequalities in health status and rising health resource demands. As far as Asian countries are concerned, healthcare is a melange of public and privately managed programmes.[11]

Covid-19 Impact on the EU [12]

While many countries implemented an effective command and control mechanism to control and contain the emerging pandemic, the EU was largely unprepared. The stockpiles of equipment to tackle such a pandemic with infection control, personal protection, medicines, and life-support ventilators were considered inadequate. Inordinate delays were encountered in sourcing these as global trade came to a standstill. Crisis management plans fell at the altar of logistics, forcing healthcare staff to improvise and compromise, often their safety. There was a realisation that practical global cooperation in the redistribution of essential equipment was a necessity.

Thus, logistics, crisis preparedness, coordination, and continuing with routine healthcare are areas that require future improvement on a global scale. There is no "ideal healthcare system", but there is a need for long-term investment in human resources and infrastructure. Public funding to provide universal access to essential healthcare is a dream of many welfare orientated nation-states such as the UK and many EU countries. However, there is a challenge to reconcile public expectations from their health service and their willingness to pay. The ideological barrier is that the healthy, younger working populace are usually reluctant to pay for the health care costs of the elderly, those that are unable to work productively and with chronic ailments. Paying for healthcare for children is an exception.

Real-time data-driven digital innovations, including continued investment in health promotion and genomics, are crucial to breaking the disease cycles, creating affordable healthcare systems, and offering universal coverage, thus improving long-term outcomes.

The impact of Covid-19 in Asia [13]

The strategy to contain the SARS-CoV-2 virus in East Asia was by using conventional containment measures, often viewed by many as 'draconian' such as in Singapore and Hong Kong. In some developing parts of the world like India and Africa, with inadequate public health infrastructure and burgeoning populace, the pandemic was tackled by public health education and non-pharmaceutical approaches such as social distancing, lockdowns, wearing masks at all times and community-led sanitising. In India, an early imposition of lockdown was a pivotal weapon to curb the spread of SARS-CoV-2 virus in the first surge. The experience in the second surge in India was fuelled by a combination of religious and political decisions and a national leadership focussed on the machinations of democracy.Poverty, an under resource healthcare system and a high population remain a barrier for India to control its cases with similar conditions prevailing in Africa.

Failure of the WHO

During SARS in 2002-03 the WHO was quick enough to impose travel restrictions and criticise China for not disclosing material facts and vitals necessary to curb the effect globally. [14] After successfully eradicating SARS, the WHO warned member states about viruses and epidemics in the future and implored the international community to investigate every possible animal reservoir that could be a source for future outbreaks and also the movement of such viruses in humans. China was warned about its wet markets and restrictions were imposed.

The mutable nature of viruses, coupled with China's growing urbanisation and apparent refusal to tackle the illegal trade in exotic animals, was termed a ticking 'time bomb'.[15] In 2019 when a pneumonia-like virus was detected in Wuhan [16], China, despite previous experience during SARS, the WHO failed to take prompt action. [17] The WHO's lack of responsiveness and leadership during the early days of the COVID-19 pandemic has compromised the faith that member-states have previously placed in it.

Need For International Pandemic Treaty

Covid-19, to date, continues to have a devastating impact on the world, with countries developing their policies and interventions, often at odds with their neighbours.[18] There are bipartite agreements implemented on sourcing life-saving equipment, and vaccine diplomacy gives way to vaccine protectionism. There is a need for a new international order in public health. Perhaps in the form of an international health treaty.

The treaty should bring nations together, dispel the temptations for protectionism and nationalism, address the challenges that could only be resolved through collaboration and rebuild trust. The French President Emmanuel Macron, German Chancellor Angela Markel and other leaders are urging all countries to be better prepared to predict, prevent, detect, assess and efficiently respond to future pandemics in an organised and professional fashion.[19]

A new treaty should mandate collaboration and sharing of research and development expertise, data and resources. The Vaccine collaborative is one area of collaboration. Many countries led by South Africa and India seek a temporary pandemic waiver to global rules protecting the technology for Covid vaccines, which wealthier countries including the United Kingdom and the USA have rejected, fearing a negative impact on the financial interests of the pharmaceutical industry. [20] Such a waiver of intellectual rights will be detrimental to future innovation. However, an international treaty on public health will be able to provide guarantees so that investment in innovations are shared equitably, and outcomes are people-oriented. While competition and incentives are essential for driving innovation, the price to humankind is too high to reject a well-designed international treaty. Perhaps the WHO will need to be reincarnated with transparency and responsiveness, which is critical for the survival of humankind. We owe it to the five million who have lost their lives in the current pandemic.

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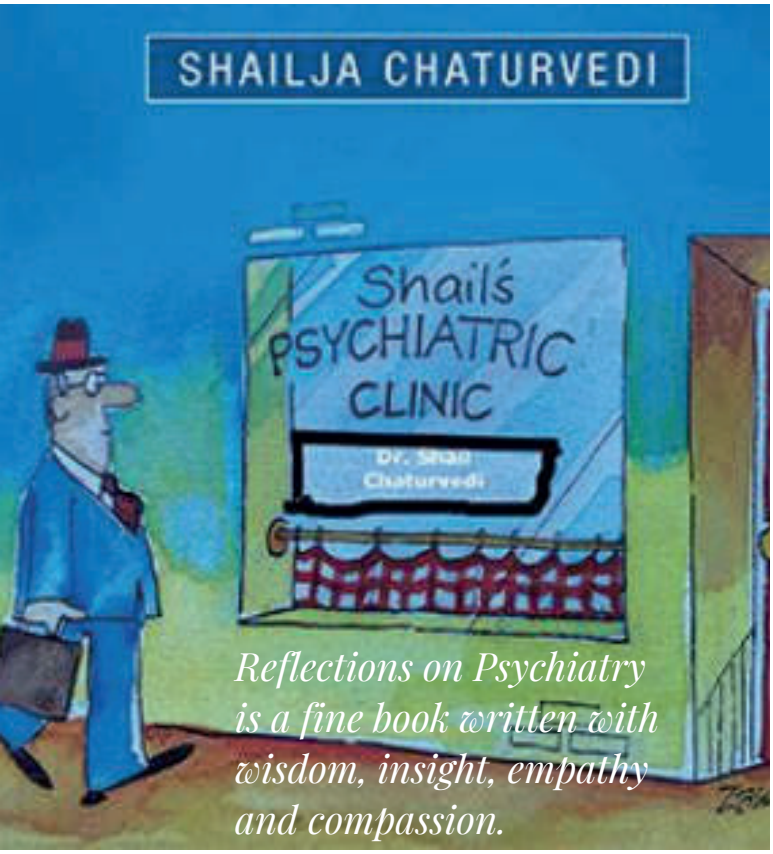
Reflections of a Psychiatrist



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More than other medical disciplines, psychiatrists have a creative side that can be expressed in writing (not referring to academic works). This can come out in novels (occasionally, such as Irving Yalom), autobiographies (mostly a mixed bag) and books for the general reader. There is a fine line to follow. The public is always interested in psychiatry, but ever ready to misinterpret or criticise information that is not to its taste or does not meet the prevailing populist prejudices.

Shailja Chaturverdi, the author of Reflections on Psychiatry, has devoted her career to patients in Western Sydney, a region of widely varying incomes, employment, education and ethnic backgrounds. In short, exactly the kind of area where psychiatrists are most needed, rather than clustering in comfortable inner suburbs. Her dedication is of the highest, her practice impeccable and this is reflected in the cases described in her book.

Reflections on Psychiatry is for general readers but contains much for the profession. It is a book not only for and about patients, but psychiatrists, looking at issues like research, journals, ethics and spirituality.

Reflections describes psychiatric disorders with comments on treatment and presentation supplemented by case vignettes. In addition useful sections are added, such as violence in schizophrenia, NDIS, refugee settlement, euthanasia and climate change. There is good insight on resilience and domestic violence, issues always relevant to psychiatric practice.

To this writer's relief, the author does not wedge her case descriptions into the tight-fitting corset of the egregious DSM (as so prevalent now psychiatric textbooks), but follows a clinically sensible and user-friendly pattern. As some past efforts show, this is harder do than it seems, but this author reaches her goal in an admirable fashion.

Two issues raised in the book should be of special interest to psychiatric readers. Dr Chaturverdi is scathingly honest in her chilling account of the new world of medical regulation by complaints units run by bureaucrats and, as often becomes evident, non-medical people with a vested antagonism towards doctors. The two cases she describes are far from exceptional and she rightly points out how vexatious complaints are given the benefit of the doubt with far lower standards of proof than are required in criminal courts. Another suspicion is that some doctors who sit on tribunals have a pharisaical sanctimony that ignores any consideration of collegial support. The casualties of the medical witch hunt are not insubstantial and there have been a few suicides. The role of our official body in supporting those who have fallen in this way is not encouraging. If we don't look after our own, then who else is there to do that?

The author provides a case study of the tragic murder of a colleague by a patient, echoing the 2006 murder of Wayne Fenton, an authority on schizophrenia, punched to death by a 19-year-old schizophrenic patient in his rooms, and the murder of Dr Margaret Tobin, not by a patient but a deregistered psychiatrist. Murder of health care personnel is a growing problem and one likely to increase in future. To add to this is the growing phenomenon of illness terrorism. Groups who reject medical explanations and treatment for their conditions (real or otherwise) often make death threats to doctors. Two notable offenders are the anti-vaxxers and the chronic fatigue lobby. Leading researchers have withdrawn from the field because of the sheer vehemence of the threats they have been subjected to. It can only be a question of time before another tragedy occurs.

The vagaries of publishers being what they are, this is a user-friendly book with a clear and readable print with no typos – no mean achievement in this era of computer-formatted printing and rather indifferent editing.

It is recommended for the public, trainees and mental health workers. It should be in every hospital library and there is much for practicing psychiatrists to learn.

VOYAGE TO RECOVERY

Nandini Chakraborty

DOI

ABSTRACT
The Voyage to Recovery was a UK wide project born out of a networking initiative of early intervention in psychosis (EIP) teams in liaison with Cirdan Sailing Trust, a non-profit charity organisation. Cirdan specialises in enabling groups of young people, particularly those who are disadvantaged in some way, to experience the challenge and adventure of life at sea on large sailing vessels.

Yet health is a fundamental human right, one that is guaranteed by the treatise on 'Declaration of Health for All' to which most countries are signatories. However, could the impact of this pandemic be mitigated by global health initiatives and collaboration? In this context, it is pertinent to analyse the existing global health framework and conventions to identify how we may prepare for future challenges.

Keywords
Covid-19, pandemic, global health, public health

It was in December 2020 that I was contacted by a fellow consultant psychiatrist working in EIP, Dr Wolfgang Kuster, from Tees, Esk And Wear Valleys NHS Foundation Trust. The project at that point was well underway. Dr Mike Jackson, Consultant Clinical Psychologist, Betsi Cadwaladr University, held the central organisation.

The plan was to have an 8-week project, involving 8 legs which would each include 5-6 days of sailing around the British Isles. Each leg would have involvement from one or two EIP teams- around 10 patients and 5 staff supported by 3 professional crew from Cirdan. In an initial meeting with Mike and Wolfgang, to discuss how I could help the project, the direction was obvious- to get the Leicester EIP team involved. We were slotted in with Norfolk and Suffolk EIP who were looking for partners for their leg from Ipswich to London.

Our boat would be the hardy Faramir. Faramir, a Ketch with a length of 22.35m and a breadth of 5.26m, was designed by Marine Architect David Cannell in 1982, specifically for use as a sail training vessel for an organisation called Shaftsbury Homes & Arethusa, from where she gained her name, 'Arethusa'.

In 2002, after many years of service, during which she developed a following of loyal sailors, Arethusa was sold on to another sail training organisation who changed her name to 'Bulldog'. Not being able to fulfil her potential, her owners sold her to The Cirdan Sailing Trust in January 2006.

Being absolutely ideal for the work undertaken by The Cirdan Sailing Trust, she was purchased to replace the vessel Hartlepool Renaissance which had to be retired from service at the end of the 2005 season. Finding it necessary to change her name again, the vessel was renamed Faramir after Cirdan's sister charity with which it joined forces in 2002.

The project was due to start in June 2021 but was pushed back by COVID restrictions. Ultimately when it started in late July 2021, it was only down to the perseverance and hard work of the Cirdan staff- Pippa and Leonie who set down to re-booking marinas and re-organizing the trip. By sheer determination they pulled it off. Unfortunately, it would not be a 'round the UK' sail anymore but a 'there and back' along the east coast. Leicester and the Norfolk-Suffolk team still got Ipswich to London, dated for 12th to 17th September.

Sadly, there were team members on both sides who could no longer make the new dates. They stuck with us till the end, helping with food shopping, emails, paperwork. Our hearts were with them throughout the trip.

12 SEPTEMBER

12th September 2021, Leicester to Ipswich, then somewhere into the River Orwell

So, at last we set off. An early meet up at base, Merlyn Vaz centre to do a last set of current lateral flow tests and register them on Gov.UK, we set off in taxi at 7:30 AM. Along with Gen, my CPN colleague, I was responsible for the four patients who were accompanying us on this trip. They were all in their early twenties, had been through psychotic episodes, doing well currently but still fighting anxieties as they readied themselves for new jobs, universities, and volunteering. All of them were keen for the trip. A little nervous, uncertain what to expect but certainly enthusiastic. Catherine Bayley, our clinical psychologist who had been instrumental in helping plan the trip was unable to join us but waved us off.

We reached Haven Marina in Ipswich where we met our Norfolk/Suffolk colleagues for the first time (outside MS teams). Craig was a peer volunteer, Felicity a social worker and Laura a mental health nurse. Also waiting for us was Justin, our photographer arranged by the Royal College of Psychiatrists to take our 'set-off photographs'. Some of our staff set off with our patients for a McDonald's snack. Craig from the Norfolk & Suffolk team and I stayed back to guard our stuff.

We discovered on ringing Mark Oliver our skipper that Faramir was right at the opposite end of where we had offloaded our luggage and considerable food supplies (whatever else happened, we were not going hungry). Whilst we were trying to figure out how to get there with all our bags, Mark sent over our bosun Jake with a dinghy to gather our luggage so that we could walk the mile needed, with just our day packs.

So now it happened- our foray into the world of posh boats, yachts, and marinas. Armed with the code which let us through the gate, admitting us to the towpaths, we had a view of several cheekily named vessels, lined up on a watery version of car park. Several poshly dressed couples passed us on the way to their private yachts as we stood surrounded by Tesco bags full of carefully budgeted food and toilet supplies.

It was a brilliantly sunny day, blue sky, and blue water. We had arrived at the marina. We had established contact with our crew. Nothing was going to dampen our spirits.

We reached the Faramir in a procession after sending over the heavy bags. The first sight of Faramir, with her name painted over deep blue, tall masts with her sails neatly tucked away, rich, and heavy wood stretching out in an oblong 22.35 metres.

Voyage to Recovery -2

The next three hours passed in a whir of getting everyone and everything on board, selecting bunks, putting away food in the fridges (tucked into the table in a genius of space saving), learning to put on our life jackets and the basic rules of sailing. We got to know our skipper Mark Oliver, first mate Sam and bosun Jake. Justin in the meantime busied himself clicking photographs and gave us a wonderful see-off.
We ultimately sailed 3 hours later, around 4:30 pm. Tides had to be right, the gates had to be opened and we had to absorb the enormous amount of basics to be of any use. It was all beginning to sink in, the combination of an understanding of physics and blessing of nature which can help a boat stream through the water, the bow cutting through the waves like a knife. We had managed a round of hot drinks and finished one of the rich chocolate cakes baked for us by a member of the Norfolk Suffolk EIP team. It would sustain us through to dinner.
We docked at around 7 pm. we stopped at a point in the River Orwell where an orange buoy was our point of anchor. Mark pointed it out to say that the 'orangey balloon like thing' would be our home for the night. We had sailed through a gentle river, rolling fields on both sides spotted with cottages. Felixstowe docks with its large cranes stood at a distance.
After a dinner of chicken fajitas we turned in early. We had been told to sleep tight, it would be a long day tomorrow.

13 SEPTEMBER

13 September 2021, River Orwell, the Thames estuary and on to Dover
(This would be turn out to be one of the best days of the trip. A steady breeze, strong enough for the sails to pick up and the engine to take a rest for the day. 50-60 miles on the sea with a gentle sun and rocking waves. Ending with a view of the cliffs of Dover. Teamwork, beautiful scenery and feeling the rhythm of the Faramir under our feet. By the end of the day, we felt like true sailors.)
We were to sail at 7 am. I put on the alarm at 6 am, had coffee on the deck, watching the sky lightening and the birds getting to work. A chat with fellow shipmates in the cockpit is great way to start the day.
We were divided into two groups, to take 'watch' in turns. One group to be led by Sam and the other by Jake. We had a rota of 4 hours at a time to be on deck. The system worked like this: when we started sail for the day and when we docked, it was a case of all hands on deck to help. In between it would be a case of changing watch between groups every four hours. The early part of the sail would need sails putting up, the later end putting them down, getting ropes and fenders ready. In between it would be making sure the sails were in the right direction, sometimes needing tautening, sometimes slackening.

Around 9-10 am we crossed Felixstowe docks with its huge container ships and cranes. I was downstairs doing dishes when I felt a sudden surge of nausea. Being downstairs in the heart of the vessel with its kitchen, dining area, bunks and two tiny toilets is overwhelming when feeling seasick. I rushed upstairs to feel the breeze on my face. The scenery had changed, we had crossed the Thames estuary and were on the sea.
We crossed Harwick, Margate, Ramsgate and turned to the chalk cliffs of Dover. As the groups changed, we all took turns at steering under the watchful eyes of our professional crew.
I watched our patients grow in confidence through the day. From being isolated and nervous in their own worlds, they were reaching out to each other, helping together as a team as instructions needed to be followed on deck and in the kitchen in making meals. Initially hesitant, they all ultimately took a go at steering.
As we got ready for bed after a dinner of spaghetti Bolognese, I reflected (and I truly would at different points during the voyage) on what I had learnt this day. I learnt about my own anxieties, the feeling of responsibility for our patients during the trip. And I realised that I was feeling more relaxed now. Our patients were finding their own journeys, own spaces. I did not need to watch them every moment. Watching one of them help me when I struggled with a can of tomatoes and a not too efficient can opener; watching the patients of the two teams talk to each other openly sharing their feelings were tiny moments where no description is enough. Perhaps the greatest revealing moment was when I realised our skipper was an NHS consultant anaesthetist who used his annual leave to volunteer for Cirdan sailing trust, volunteering without charge.
I struggled to keep my eyes open for my video diary and my mobile does not have a blow by blow record of each sailing moment. We were realising something else, living a moment is precious. Every moment does not need capturing on lens. The most exciting points on the deck were also the busiest. We gave it our all. I do not need pics to remind me of that sun kissed sea we rocked through, sitting on the deck near the bow- chalk cliffs on one end, France on the other, a seal which jumped out with a tiny gymnastic roll to entertain us. Amid all that beauty, rubber boats in a distance which might be carrying illegal immigrants escaping desperate circumstances. There almost seemed too much going through me as sleep came over. This was certainly not a holiday and not a sporting event. It was not meant to be.

14 SEPTEMBER

14 September 2021, Dover to Ramsgate

Breakfast at 8 am was followed by our first round of thorough boat cleaning. The entire team was given specific duties- sleeping quarters, kitchen and salon, the deck, chart house and most importantly- the toilets. We all did our bit, without question. Done by 11 am we were given until 2 pm to explore Dover. Gen and I walked with three of our patients to explore some history in Dover Castle. One more was still feeling too anxious to come off the boat to land, we did not press too much.
Walking up to Dover castle took twenty minutes. We spent an hour or so going through ruins which held stories of Anglo-Saxon times, Henry II and World War II. Our group stuck together, with a bit of guidance to show respect for each other, given importance to all tastes and views. We finished with the gift shop and it was a very satisfied team which returned to the boat.
We were all feeling better today and lunch went down well. 3 pm, we sailed off in the direction of Ramsgate. We would retrace some of our route from the day before and dock at Ramsgate. It was still a lot at sea but only around 15 miles.
Dinner was casserole and cheesecake. One thing was for sure. We were eating very well. The crew were speaking from the heart when they said that we were making a very good job of the food.

15 SEPTEMBER

15 September 2021, Ramsgate to Queenborough, Isle of Sheppey

It was breakfast duty for me today. Had porridge ready at 8 am so that we could eat and start off at 9 am. It would be a long sail, around 50 miles. But at the end we would re-enter the Thames estuary, sail up the river Medway and dock at Queenborough harbour on the Isle of Sheppey.
It was a sunny day again but with hardly any breeze. So, engines had to go on and there was less to do on the sails. Not very exciting but we made most of the time to sit on the deck and find time to talk. Over the week we got time for a number of 1:1 chats, between professionals and with our patients.
The sea this day had a number of interesting World War relics. We learnt about the 'Principality of Sealand' located on an abandoned sea fortress which due to its location in international waters is outside the jurisdiction of the UK. Claimed by Roy Bates, a major in the British army, Sealand has its own website where you are invited to apply for not only for merchandise but apply for knighthood and several other titles. https://sealandgov.org/about/.

We passed a cluster of WWII gunning platforms which looked like huge barrels supported by several legs, something out of a Star Wars movie. An old ship sunk at sea lay just with its mast sticking out- the SS Richard Montgomery. Explosives still lay at its heart and apparently it had stopped air routes from passing too near it, in the apprehension that vibrations might set up a giant explosion.
Reaching Queenborough we were in time to see a brilliant sunset. We managed to grill our food and have a 'barbecue' in the cockpit followed by fruit salad.
My handwritten notes were getting shorter and shorter. Physical exertion feels good, satisfying but very tiring.

16 SEPTEMBER

16 September 2021, Queenborough to London

Woke up early to watch sunset over coffee in the cockpit with a heart-to-heart chat with Gen. Both of us were feeling deeply grateful for this opportunity- for our patients and for ourselves, really emotional about it. The priority of course was to finish the trip successfully but then go back home and talk about it further. It would be important to continue such activities in future. A one off was not good enough. We needed sustained change, an embedding of a culture which looked at outdoor team building activities both for patients and staff. The trip had been rewarding not only for our patients but for ourselves as well.
I found one of our patients in the kitchen attempting banana pancakes for sixteen people, to use the bananas which were beginning to get bruised. I asked her if I could help, she confidently pushed me a bowl of bananas to mash. For once, I was following instructions. The pancakes were a huge success and good fuel for our next round of 'deep cleaning'.
This time I got the chart room- the space used by the skipper to navigate, communicate, and keep a log of observations. I expected to sweep the floor and wipe out the desks, but Mark had other things in mind. He got the floorboards off to expose a criss-cross of aluminium bars overhanging a deep chamber which held the machinery which ran the boat while on engine. He assured me that it looked more frightening than it was, and I would come to no harm even if I happened to fall in, which was reassuring. To be honest, the aluminium bars were strong and broad. I was not unsteady on them. The floorboards went off to the deck to be hosed and I cleaned the aluminium bars of dirt and grime worth possibly a couple of decades. A round of hoovering followed by a fine tuning of all purpose liquid and a scouring pad did a fine job. I was rather proud to see the look on Sam, Jake, and Mark's faces.
We had two hours to explore Queenborough. Everyone came off board today. Most of our colleagues and patients went to enjoy themselves on a beach, with swimming, paddle boating or simply sitting on the beach.

Voyage to Recovery -4

I went to two patients to walk around and find Queenborough castle which turned out to be a plaque on the ground in memory of a castle that once stood there. So we spent the time in a park, entertaining ourselves with the swings instead.
We set sail at midday with no wind. So, it was a quiet engine driven sail from Medway into Thames, entering London.
The colour of the water turns from greenish blue to deep cornflower as the rivers change. Somewhere as we entered the Thames, three dolphins made a quick jump for us, delighting us for a few quick seconds. We crossed the Thames barrier, Greenwich, Cutty Sark, and the Queen Anne Naval School, finally docking with a gorgeous view of Tower Bridge and the Shard.
Dinner was curry tonight. With help from our patients and Gen, we did what Leicester does best- a curry dinner which was hugely anticipated, (no pressure). By 8:15 we had turned out chickpeas, mixed vegetables and pilau rice.
When we came out to deck after dinner, Tower Bridge and the Shard were lit up. We sat in the cockpit for a last chat. Tomorrow we would be busy packing and finishing final paperwork.

Afterword
The greatest gift from the trip was our feeling of teamwork and camaraderie. Laura, Felicity and Craig felt like long time known colleagues. But then you volunteered for a trip like this only if you felt and thought alike. I was extremely proud of our patients who put in so much effort, conquered their anxieties and got to know each other. Goodbye was painful. As I reached out to shake hands with one of the Norfolk and Suffolk patients, his face crumpled. 'I want a hug', he said. Human relationships transcend everything we do.

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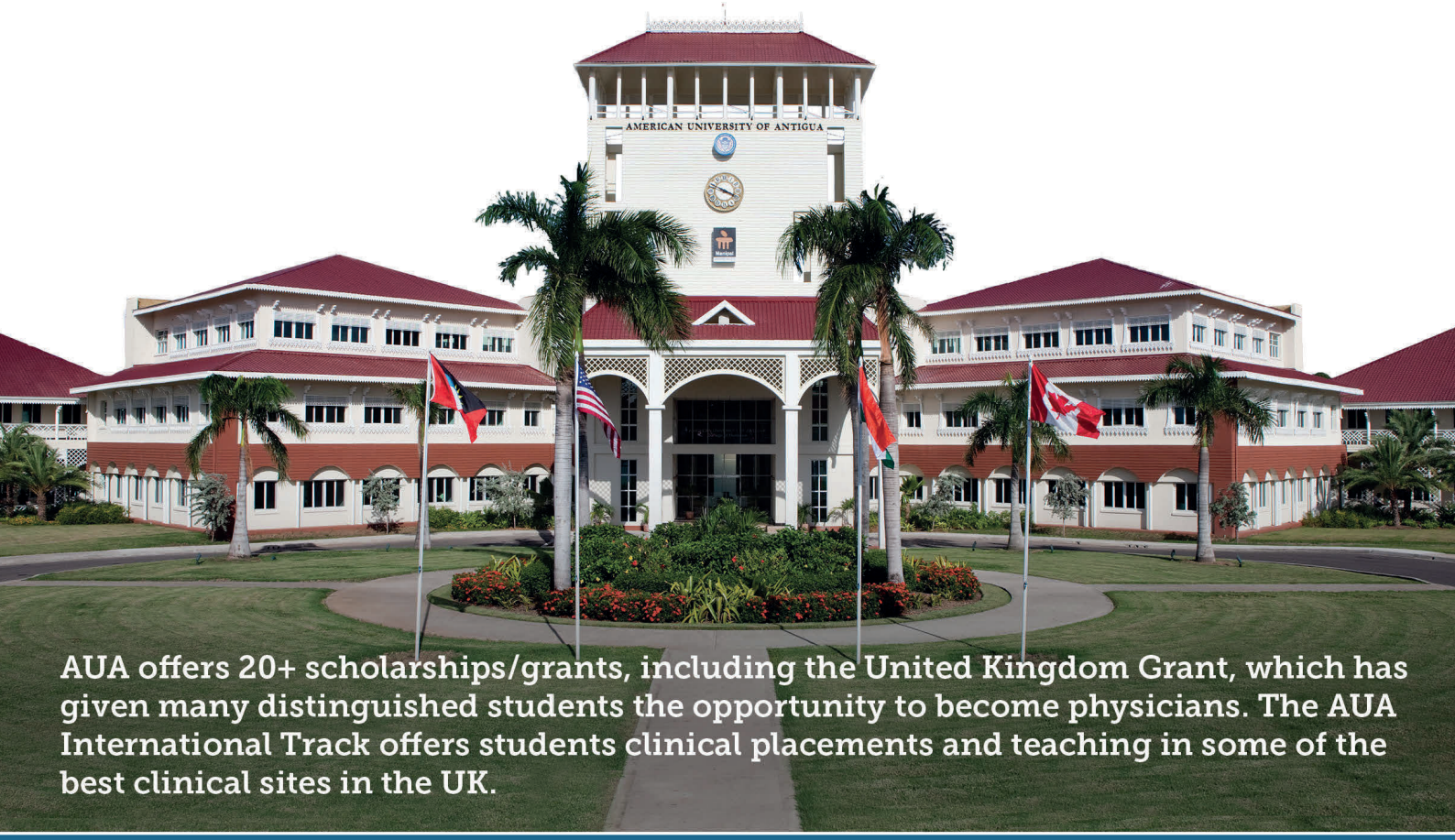

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