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# THE INDIAN DILEMMA IN UKRAINE

EDITORIAL

## Racism, Politics and Career Fallout for Medical Students

**INDRANIL CHAKRAVORTY**

**Abstract**

The war in Ukraine has exposed the vulnerability of the Indian medical students who have little options but to study abroad due to the deficit of medical training infrastructure in India. The challenges of life in a foriegn country comes in many guieses even before the start of the invasion. India's abstention from the UN Security Council resolutions related to the conflict stems from a complicated political position and dependence on the Russian Federation for much of the military hardware.

Not that this complicated political relationship should not necessarily affect the life and fate of Indian students - but it does. Civilians including foreign students are always affected by conflict. This leads to displacement, loss of life or limb, destruction of civilian infrastructure and a huge setback to education, health and wellbeing.

The prevalence of bias, racism and discrimination faced by many during the mass evacuation is a double whammy and unfortunately a manifestation of the fractions that exist in such societal fabric. The Indian government's heroic efforts in evacuating over 18,000 students via Operation Ganga is commendable but a serious rethink is needed to provide the investment, infrastructure and opportunities that the India needs for it people and its future.

**Keywords:**

Ukraine, War, Indian, Medical Students, Bias, Racism

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# Indian dilemma in Ukraine | 2

There is new conflict in Europe again after the Bosnian war in 1995, which led to large scale displacement of people, estimated to be around 2 million.[1] The Russian annexation of Crimea in 2014 [2], was probably not felt to any great extent by people. In the current war in Ukraine, over a million people have been displaced within a week. A rate of displacement hardly ever seen before and estimated to end up affecting over 4-5 million people if the aggression continues.[3] The number of people displaced globally by conflict and persecution stood at 65.6 million at the end of 2016, the greatest number since World War II. [4]
In addition to loss of freedom and human rights, conflicts lead to destruction of life, property, infrastructure and lead to huge setbacks in education, health and wellbeing for those who manage to survive.[5]

There are over 200,000 Indian students reading medicine outside of India. As seen in Wuhan, at the onset of the COVID-19 pandemic in early 2020, events such as disease and conflict have devastating consequences for students who are caught ou tin such areas of disaster. India had to arrange evacuation of over 600 students from Hubei province at the epicentre of COVID-19 and over 18,000 from China before the lockdown.[6]

The challenge that Indian students face in Ukraine is not just of risk to life from incessant shelling but also one of discrimination, racism and a political scapegoating due to the Indian government's decision to abstain from the UN Security Council resolution condemning the Russian invasion of Ukraine.[7]

Many of the students have reported being harassed, assaulted and openly discriminated because of their foreign status (versus Ukrainian nationals competing for space on public transport in the exodus towards the border), in being denied or delayed access to Poland, Hungary and Romania at the checkpoints; and most worryingly being scapegoated for the Indian government's UN security council abstention.

*"The war will never be over, never, as long as somewhere a wound it had inflicted is still bleeding,"*

*Heinrich Böll*

The draft resolution was not adopted as Russia used its privilege as a permanent member to veto the text. While 11 Council members voted in favour, all three Asian members – India, China and the United Arab Emirates – abstained. India's decision to abstain from voting at the UN Security Council against Russia's war on Ukraine was explained as a way of keeping dialogue and diplomacy options open. India reiterated its call for immediate cessation of violence and an end to all hostilities.

However, India's position in the UN Security Council resolution perhaps stems from a deep-rooted grudge against the role Western players as well as the UN have played in safeguarding New Delhi's own national security interests — be it in relation to Jammu and Kashmir, Bangladesh, or for that matter, China.[8] During India's last stint on the United Nations Security Council in 2011-12, it was unable to pursue the originally charted strategy of demonstrating responsible diplomacy in the leagues of the great powers while also making the body a more legitimate and representative organisation. [9]

The fallout on the desperate Indian students either in Ukrainian cities under siege or amassing at the western border is palpable. There are media reports of Ukrainian authorities using uncalled for force in restraining and pushing back Indian students. There are also reports of residents turning against Indian students. The students via social media reports share their concerns and perception that this is either due to their foreign citizenship status or as a reaction to India's UN abstention. [10]

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There is another dark side to this issue- one of colour. Ukraine is not a novice in terms of racism. According to non-governmental organisations, there were 60 racist attacks in Ukraine in 2007 and six of these resulted in the death of the victims. In 2008, an Amnesty International report highlighted 30 racist incidents, of which four were murders. The majority of the victims have been African or Asian. More often than not the police have failed to react with the needed urgency to calls for help from victims of racist attacks or have refused to do so. In many cases victims do not report crimes because they have no confidence that they will get justice.[11]

Prejudice and violent attacks against Jews and Jewish properties also continue. Foreign-looking people are arbitrarily stopped for document checks. All members of certain Roma communities including women and children have been fingerprinted and photographed by the police apparently purely because of their ethnic identity. A kind of racial profiling which was in violation of Ukraine's international obligations.

The same degree of racism was reported to be on the rise and affected Black people with Ukrainian nationality. [12] and members of groups of ethnic minorities, lesbian, gay, bisexual, and transgender (LGBT) people and rights activists at risk, subjecting them to physical attacks and hate speech.[13] A BBC Panorama documentary, called "Euro 2012: Stadiums of Hate", was broadcast on 28 May and testified to the presence of racism and anti-Semitism in Polish and Ukrainian football stadia. The film featured several video clips of apparent Nazi saluting during football matches in Kiev and Kharkiv – both of which will host Championship matches – and violence by football fans. [14]

In Uzhgorod, the town's local aqua-park denied entrance to the black-skinned students of local university who happened to be from India and Nigeria.

*"A refugee is a refugee, whether European, African or Asian,"*

The pool's owner, former mayor of Uzhgorod and deputy to the Supreme Parliament, Serhei Ratushnyak, explained his pool's policy by mentioning concern about the public health of the town residents in the face of the danger caused by "syphilitic and tuberculosis Gypsyhood of the area and of the whole world."[15]

About 40 per cent of the students at the National Medical University were from African countries, and there were also some 2,000 Asians at the same school; there were reports about verbal discrimination against those students. In 2016, the Ukraine government had adopted the 2012 Human Rights Resolutions and had harmonised its anti-discrimination laws with the European Union provisions. Concrete measures to combat discrimination were contained in the National Strategy for Human Rights and its Action Plan to 2020. The National Point of Contact on Combatting Hate Crimes, and the Unit for combatting radical groups and criminal organizations were created within the police to counter intolerance and racial discrimination, and preventive police work was ongoing with the leaders and participants of radical youth organizations. [16]

The differential of treatment of refugees from the war in Ukraine at the borders of EU is also reported to be clearly discriminatory. When it comes to Ukraine, the change in tone of some of Europe's most extreme anti-migration leaders such as the Hungarian Prime Minister Viktor Orban was striking from advocating not to let anyone in when it came to refugees from Syria in 2015, to welcoming people with open arms in the current conflict. [17]

# Indian dilemma in Ukraine | 4

*The Ukrainian Ambassador at UNSC, without naming India, the UAE or China, said, "It is exactly the safety of your nationals in Ukraine that you should be the first to vote to stop the war to save your nationals in Ukraine, and not to think that you should vote or not vote."[18]*

There are reports of international students either forced to stay back in their university accommodation, against instructions issued by embassies to evacuate, threatened with suspension from their courses if they decided to leave which may have contributed to the last minute rush to evacuate. The Ukrainian University authorities will have to answer to these allegations once the current conflict is over and governments of countries whose citizens are in such universities do have a role in investigating these allegations.

**Where Next?**

The immediate priority of Ukrainian authorities, the diplomatic missions of countries with their citizens trapped in the conflict zone or at the borders, is to protect life, provide humanitarian aid and a safe passage out of the conflict zone. An example is the Indian government's Operation Ganga which is a coordinated effort to evacuate citizens through Hungary and Romania. This should also include providing speedy access to safe routes of evacuation from conflict besieged cities.

University authorities must remove any restrictions on students and remove any impediments which penalise them from evacuation. How and when university education can be resumed will depend on how the planned negotiations go between Ukraine and Russia and restoration of civic society.

Until that time, the governments in India have a responsibility to provide safety, support including humanitarian as well as mental health to all those who are affected.


Before, international students are returned to Ukrainian universities, there needs to be an acknowledgement at the highest level of the inherent racism and discrimination that exists in Ukrainian society (not uniquely though) and robust measures that prevent recurrence once civic society returns.

Whatever, the Indian stance in the UN Security Council has nothing to do with the safety, wellbeing and aspiration of Indian students in Ukraine and it will be against their human rights to be scapegoated for such actions.

Ultimately, India and other African nations will need to introspect the resources, innovation and investment needed to provide essential medical education and training for their own healthcare systems. This will include measures to mobilise private international investment in systems for regulating private training providers; and to prioritise research that includes evaluation of the social rate of return in economic analyses.

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# TACKLING WORKPLACE BULLYING FOR MINORITY ETHNIC DOCTORS

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Keywords
Bullying, Harassment, Undermining, Minority Ethnic, Healthcare Workers

## Abstract

Workplace bullying, undermining and microaggressions are a reality for many, and although the prevalence may vary, there is no environment that is free of such hostile interactions. The healthcare workforce is focussed on empathy, kindness and caring, yet the daily experiences of many are in stark contrast to this. Although awareness of these issues exist, incidents of bullying are still grossly under-reported.

Bullying and undermining behaviours stem from a gradient of power and lack of appreciation of the societal advantages of diversity. In keeping with this, the experience of particular sub-populations are disproportionately worse, such as for women, minority ethnic groups, those with disability, LGBTQ+ and those from deprived backgrounds. There have been campaigns and initiatives to change workplace behaviours, with mixed successes. A less explored role is that of organisations whose declared mission is to stand up for equality, represent the voice of the minorities and the under-represented, akin to self-help groups and advocacy.

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This article explores workplace bullying from the perspective of the minority ethnic doctors and proposes the potential benefit of their representative organisations in helping to balance the inherent workplace disadvantages.

## Background

Experiencing bullying, harassment and undermining in the workplace is not unique to healthcare, and is unfortunately only too common in many diverse workplaces and professions, including hospitality, arts as well as the uniformed forces.[1] Surprisingly white collar professions including medicine, legal and academic fields are not free of such toxic behaviours. Although healthcare self-selects people with an aptitude for caring and empathy, the evidence suggests that due to a multitude of factors, there is an environment that enables bullying and undermining (B&U).

Healthcare is a high stakes, hierarchical environment that depends heavily on teamwork and effective communication. Mistakes are usually catastrophic and often lives as well as careers are put at risk. Although many other professions (such as the air force or the army) also operate with a similar high pressure environment with life or death decision making, the healthcare profession is unique in the high rates of B&U reported, suggesting that there are other factors at play, aside from the nature of the job. These factors include the blame culture ingrained within the healthcare profession, isolation of minority groups (including ethnicity, gender and sexual orientation) and an ethos of underreporting due to fear of reprisals or being cast out. It is not surprising therefore, that the culture of extreme individual accountability within the healthcare profession may lead to negative behaviours.

In addition, gender as a social category is recognised as an important determinant of B&U. Importantly, gender interacts with other social categories such as race, creating unique experiences for different employee groups.[2] In the United Kingdom, there are established surveys conducted by higher education institutions, the National Health Service (NHS), Health Education England (HEE), Care Quality Commission (CQC) and the regulators, such as the General Medical Council (GMC). Many of these surveys measure the proportion and frequency of B&U either experienced by individuals or observed being perpetrated on colleagues.

Self-reported surveys also measure the power gradient by identifying the perpetrator or the origin of such behaviours. The results are made available to organisations and there is a voluntary expectation that appropriate corrective interventions are undertaken. Women, ethnic minority staff, migrants, nurses and healthcare assistants are most at risk of harassment.[3] This occurs within groups that are heavily dependent on the socialisation processes of acceptance, normalisation, indoctrination of professional standards and preservation of hierarchy such as the uniformed services and healthcare.[4]

*B&U not only impacts people themselves, but may also have a much wider impact, including patients, families and colleagues.*

Workplace bullying is indeed a potent social stressor with consequences similar to, or even more severe than, the effects of other stressors frequently encountered within organisations. [5] For the affected individual, B&U leads to distress, burnout, increased rates of absenteeism, lower productivity, and intention to leave the job. The wide implications of B&U include poor patient outcomes and impaired teamwork, which ultimately leads to economic and social fallout. Asymmetric intergroup bullying is a mechanism through which intergroup hierarchy in the broader society corrupts management practice, employee interactions, and in turn exacerbates economic inequality. [6]

However, there are many barriers which lead to the underreporting of B&U. These include the perception that nothing would change, not wanting to be seen as a trouble-maker, the seniority of the bully and uncertainty over how bullying cases are managed. Data from qualitative interviews support these findings and identify workload pressures and organisational culture as factors contributing to workplace bullying.[7] Avoidance and doing nothing exacerbates the negative impact of bullying on psychological well-being and self-esteem. [8]

## What constitutes B&U?

Bullying is defined as 'persistent behaviour against an individual that is intimidating, degrading, offensive or malicious and undermines the confidence and self-esteem of the recipient'.

Harassment is characterised as 'unwanted behaviour that may be related to age, sex, race, disability, religion, sexuality or any personal characteristic of the individual'.

Though these definitions are widely accepted, it can be challenging to define concepts such as bullying and undermining, as the experiences can be subjective and personal to the victim. However, within the workplace, there are several documented subtypes of bullying behaviours that pertain to specific aspects of working life.

Healthcare professionals from ethnic minority groups report a disproportionate amount of B&U. Several studies indicate that immigrants/migrants and ethnic minority members are more likely to report being exposed to bullying than the majority members, with some minority ethnic groups reporting more B&U than others. Experiences of bullying in the Medical Workforce Race Equality Standards (MWRES) indicate that whilst bullying from patients and relatives remain in equal proportions across all races (affecting a third of all doctors), minority ethnic doctors from all stages of training face significantly higher rates of bullying from colleagues, compared to their white peers (31% vs 22% for doctors in training and 33% vs 24% for other doctors). [11]

There is evidence demonstrating how line managers use different tactics when bullying minority ethnic employees compared to white employees. Furthermore, when colleagues bully fellow colleagues, there are subtly different patterns of bullying behaviour towards white and minority ethnic victims.[12] This ethnic difference in B&U may be due to inequalities in both personal and social vulnerabilities among employees of different ethnicities that are intrinsic in certain cultures [13], and lack of knowledge or empowerment to report due to inherent discrimination.

Types of bullying

- Threat to professional status (e.g., belittling opinion, public professional humiliation, and accusation regarding lack of effort);
- Threat to personal standing (e.g., name-calling, insults, intimidation, and devaluing with reference to age);
- Isolation (e.g., preventing access to opportunities, physical or social isolation, and withholding of information);
- Overwork (e.g., undue pressure, unrealistic deadlines, and unnecessary disruptions)
- Destabilisation (e.g., failure to give credit when due, meaningless tasks, removal of responsibility, repeated reminders of blunders, and setting up to fail);
- Indirect / reputational perpetrated by a third party (e.g., spreading rumors which lead to social manipulation); [9]
- Racially charged (minority ethnic employees report experiencing verbal abuse, being ignored, racist literature, name calling or mimicking, lack of access to training, arbitrary policies and unfair or excessive monitoring). [10]

The quality of interethnic relations among employees is an important determinant based on the social identity, the concept of similarity-attraction, the influence of cultural distance and the paucity of social interactions. [13] Groups who are most culturally distant from the majority group tend to suffer the most B&U behaviours, including social exclusion. [14]

One of the greatest challenges facing B&U in healthcare is the systematic underreporting of bullying incidents. Unfortunately, healthcare professionals from minority ethnic groups tend to underreport incidents more than their white colleagues, which means that the racial differences in bullying may be greater than current data suggests.[15] There are several proposed reasons for the hesitancy amongst victims to report B&U incidents, including fears of ongoing bullying, reputational damage, career implications in cases involving perpetration by seniors and a lack of confidence that the organisation would investigate the issues.

## BAPIO Survey on B&U?

A survey response from 348 doctors at a UK NHS hospital facilitated by the British Association of Physicians of Indian Origin (BAPIO), found that the majority of respondents (63%), had experienced harassment or bullying in the workplace. The survey showed that the commonest group to be victims of bullying and harassment were trainee doctors, followed by line managers and senior medical managers. Race, religion and gender accounted for the vast majority of reported reasons for bullying. A significant number report the mental and physical consequences of bullying and harassment. Overall the majority feel the organisation was poor in the way it investigated and managed bullies. [16,17]

**Other social characteristics impacting B&U**

Staff with certain protected characteristics are more vulnerable to workplace bullying or harassment. The results of the NHS England Staff Survey show that disabled staff are the most likely to report bullying or harassment (32%), followed by LGBT staff (27-30%).[18]

Similarly, in terms of gender, significantly more female junior doctors report bullying behaviours than male junior doctors [2], this is often postulated as either a different gendered perception or that women are permitted narrower bands of acceptable behaviour, and deviations from traditional roles may submit them to negative evaluations and increase the risk of experiencing bullying.[19]

**Hierarchy of B&U among doctors**

Among healthcare workers, many cases of bullying experienced by doctors are perpetrated by colleagues based on hierarchy. Data from the Medical Workforce Race Equality Standard (MWRES) report shows that junior doctors and doctors not in formal training programs face the most B&U.[11] Traditional hierarchical structures of hospitals and medical training produce a culture in which bullying is not only unchallenged, but expected. Furthermore, even when the dysfunctional nature of the hierarchical system is recognised, it may be seen as a "functional educational tool" and therefore allowed to continue.[20]

Clearly hierarchy, silence, incognisance, fear, denial and legacy of abuse are key thematic causes of the pervasiveness of bullying among junior doctors. [21] These are all issues that need to be tackled at the ground level. However, senior doctors are also the victims of B&U. For example, in a UK Trust, several consultants from minority ethnic backgrounds requested protection from the Chief Executive Officer following unrelenting discrimination, bullying and harassment.[22]

**Organisational factors**

There are significant differences in negative interactions experienced according to clinical specialty, with higher mistreatment indices reported for those in medical rotation compared to paediatric or surgical rotations and in obstetrics. This suggests that there are differences in terms of job demands and resources and subsequent job strain between the clinical subspecialties, as well as hierarchical differences by seniority or between staff groups (such as between midwifery staff and obstetric doctors). Certain subspecialties demand more time and provide less emotionally and socially supportive working environments. [23]

There are significant costs for organisations from bullying and harassment, mainly arising from higher turnover of staff and increased absence due to sickness [24]. Lower productivity, potential costs of litigation and compensation, and loss of public goodwill and reputational damage also need to be considered. Autocratic management, hierarchy and work intensification fuel bullying culture.

In recent years, there has been growing recognition of the role of organisational culture in encouraging and permitting bullying, which explains why some workplaces have higher levels than others. Among the factors identified as likely to lead to a bullying culture are: autocratic, target-driven management styles; poor job design; work intensification; and pressures arising from restructuring or organisational change, especially when radical and top-down.

## Solutions for tackling B&U?

Initiatives exist to tackle bullying and harassment in the NHS, but efforts to target racially charged B&U need to be embedded in these. [15] Formal anti-bullying policies and procedures may be insufficient. There have been very few formal evaluations of current interventions to stop bullying and harassment in the NHS or other healthcare settings. However, a recent evidence-based review of interventions to address workplace bullying and harassment for the Advisory, Conciliation and Arbitration Service (ACAS) identified the limited effectiveness of the traditional approach of relying solely on formal anti-bullying policies and procedures.

The barriers to this succeeding include;

- Placing the onus on the bullied individual to formally report the problem when surveys and research show an unwillingness to;
- A reliance on formal complaints mechanisms prevents early resolution – a reluctance to impose formal sanctions on 'high value' individuals;
- A desire to avoid litigation or protracted formal proceedings which can result in pressure to find against the complainant or force them out; [25]
- The archaically hierarchical nature of medicine (especially hospital medicine), surgery, nursing and midwifery, which makes it hard for juniors to speak back or speak out;
- An abiding sense, even among some clinicians, that blame is an appropriate response to error;
- The legal perils and adversarial implications of being truthful;
- The pressures on management to be judged as 'well led' in the face of chronic staff shortages and financial pressures
- Multiplicity of different professions and professional pathways, each with its own silo mentality;
- Covert or inherit racism among some patients and relatives and even among NHS colleagues
- Gender preconceptions;
- Cultural differences (especially among first-generation migrant clinicians) such as different training approaches and language issues which give rise to misunderstandings or prejudice;
- Poor training of middle management in encouraging and rewarding candour;
- Resistance to change among senior clinicians;
- Multiplicity of organisations such as HEE, HEIs, medical Royal Colleges and NHS with different priorities;
- Tendencies by trusts and national agencies to tick boxes rather than ensure underlying cultural change.
- Minority ethnic people who have weaker ethnic identity or assimilation acculturation tend to experience more direct victimisation. [26]

It is recognised that comprehensive organisational approaches that focus on ensuring a cohesive culture of multi professional, collaborative team working, improved work-life balance, manageable workload, clarity of roles as well as responsibilities, blame-free learning environment, a concerted focus on well-being and investment in diversity and inclusion is essential for tackling inherent B&U.

**Some good practice recommendations include:**

- Developing behavioural standards in collaboration with employees and role-modelling through change laboratory methodology' [27]
- Demonstrating good behaviours by senior managers and staff;
- Accountability of senior leadership to robustly tackle cultural issues and negative behaviours an when behaviour is reticent to remove bullies from leadership roles;
- Early identification of bullying behaviours (e.g. through staff surveys, exit interviews);
- Acting on risk factors like poor management practices and excessive workloads;
- Empowering people to talk more openly about what is acceptable and unacceptable behaviour;
- Strong support structures for employees and managers (e.g. union representatives, bullying or fair treatment officers, occupational health);
- Encouraging informal resolution where appropriate, backed up by clear and accessible formal procedures for when early resolution does not work. [25]

## How can minority ethnic organisations/ representation help?

Arguably, the best way to tackle a culture of B&U within the healthcare system is from within. This requires the safety and mindset to foster a change laboratory with expert facilitation and extensive consultation. Occasionally, the environment is so toxic and the lack of trust so deep, that change laboratory suffers due to a lack of engagement and overwhelming fear of reprisals. Therefore when negative behaviours and perceptions of organisational inaction or tolerance of B&U are embedded in the psyche of the workforce, external and holistic solutions are needed.

One of the first interventions is to ensure psychological and physical safety for the victims. The Freedom to Speak-Up (FTSU) Guardian approach in hospitals is designed to provide a conduit for reporting bullying, and in some NHS trusts is used to support victims and press for satisfactory resolution. However, the NHS has not designed the FTSU system to intervene proactively, and some Guardians believe their role ends once their report has been passed on. Similarly, human resources (HR) should get involved to support victims, but HR staff sometimes see their role as administrative and managerial rather than in support of individual staff; or take what they regard as a balanced and neutral response to complaints of bullying, which can leave the complainant feeling exposed. Thus, many instances require the intervention of a truly external agency. These can take many forms, including formal agencies including HEE, GMC, CQC and the NHS England and NHS Improvement (NHSE/I).

Most bullied individuals tend to voice their concerns through non-organisational support mechanisms, including trade unions, in preference to the systems created by employers to address bullying. Colleagues rarely offered overt support and union officials typically responded by providing indirect support to individual bullied members. Whilst unions may have limited power to alter managerially-derived solutions, there is some evidence that, where they engendered a collective response to allegations of bullying, perpetrators are more likely to be held accountable. [28]

The National Bullying Helpline is one such recognised advice centre, endorsed by several organisations founded in 2003 by employment law professionals to provide assistance to individuals struggling with bullying issues, whatever the nature of the abuse. It is essential that such organisations maintain the highest level of confidentiality while speaking out against systemic or individual abuse, including robust governance that ensures such standards. Third party interventions have a potential risk to individualise bullying allegations and may lead to a sense of impotence, injustice and lack of impartiality, serving to deflect bullying claims and exacerbate targets' suffering. [29]

However there is a role for independent organisations which represent specific groups of victims, such as women and ethnic minorities (Medical Women's Foundation, BAPIO and similar organisations). BAPIO has taken an active role previously in supporting its members in matters of employment dispute or victimisation through its arms length agency the Medical Defence Shield. More recently, it has taken on a proactive role in engaging with healthcare workforce in organisations struggling to improve their workplace behaviours. Such a collaborative intervention is likely to help those that are victimised to regain confidence and build trust. It is essential therefore that such employing organisations maintain a formal relationship with voluntary associations in addition to the trade union. This work needs to be collaborative and viewed as a tripartite alliance to tackle B&U, instead of being viewed as adversarial.

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ABSTRACT

Sexual harassment and gender discrimination overlap affecting people (including children) of all genders, however data shows an overwhelmingly high prevalence of violence or harassment experienced by women in areas of conflict, professional life and in their homes as well as in the healthcare workplace. It is pervasive, persistent and all too common.

Workplace sexual harassment and discrimination although illegal, is particularly is more common in women who are young, early in their careers, in temporary employment, from under-represented or marginalised groups based on ethnicity, immigrant status, gender non-conformity or disability.Majority of perpetrators are men, who are older and enjoy the privilege of disproportionate power and in certain toxic male-dominated healthcare environments.

Two recent stories of sexual harassment in healthcare prompted many women to follow suit and share similar stories referring to flashbacks, post-traumatic stress, damage to careers, pressure to leave their job, self-harm and suicidal thoughts, brought about by their experiences. Yet there are examples of women as role models breaking down historical barriers such as Hilary and Chandi in their polar adventures.

Tackling such structural inequality requires remedies that go beyond incremental approaches focussed on individuals and include transformation of the organisational and societal climate by interventions, affirmative policies and courageous, compassionate leadership. Workplace sexual harassment and discrimination is unacceptable, not inevitable and needs to be eradicated.

Keywords
Sexual harassment, gender discrimination, workplace dignity

# Structural Inequalities and Intersectionality are the Root Causes of Gender Discrimination & Sexual Harassment

## WHAT DOES THIS MEAN FOR THE HEALTHCARE WORKPLACE?

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Background

During the transition from 2021 to 2022, two very distinctive and disparate stories caught our attention. These stories found themselves circulating energetically on the social media platform Twitter. The first, was one of a colossal achievement by Captain Preet Chandi (Twitter @PreetChandi10) of the British Army, who walked unaccompanied, a gruelling 700 miles in 40 days, in temperatures as low as -50°C, to reach the South Pole. This made her the first woman of South Asian origin to accomplish this feat and an allied health professional (physiotherapist). It has been over 100 years since the first African-American, Matthew Henson, reached the North Pole in 1909 [1] and in 2007, Barbara Hillary, became the first African-American woman to set foot on the geographical North Pole. Four years later Hilary also became the first African-American to reach the South Pole.[2] Captain Preet Chandi has become an inspirational role model and demonstrated a great personal victory at a time when the healthcare workforce is particularly battered from the multiple surges of a global pandemic.

Concurrent to this story of great accomplishment, comes another of disillusion and disgust, one that like the former, diffused rapidly through social media. It is a letter written by Philippa Jackson in response to an article by Fleming and Fisher [3] discussing the painful truth of sexual assault in the surgical specialties. Philippa Jackson, now a Consultant Plastic Surgeon, responded to Fleming and Fisher with accounts of her harrowing personal story as a junior doctor that was filled with inappropriate sexual advances, poor leadership, immoral and cowardly behaviour from those who were aware and an inexcusable lack of support for someone who chose to speak up [4]. This story prompted many women to follow suit and share their experiences referring to flashbacks, post-traumatic stress, damage to careers, pressure to leave their job, self-harm and suicidal thoughts. Each individual story is yet another argument to strive for a culture that has a zero tolerance approach to sexual harassment and abuse. Although starkly different in their tones, there is a significant similarity in both stories; a high achieving woman bravely breaking down a barrier, overcoming a hurdle and positively changing the norm.

n this article, we will explore the emotional arena of workplace sexual harassment as experienced in the health service and seek solutions.

Prevalence

Sexual harassment or violence is widely prevalent. Although it may take a variety of forms and affect women, men, children and people of non-binary genders, and is often underreported - the prevalence of violence against women is the most frequent, affecting more than 1 in 3.[5] Sexual harassment is defined as a sexual advance, request for sexual favours, or other conduct of a sexual nature that is unwelcome, unsolicited, and makes the recipient feel harassed, upset, scared, offended or humiliated.

To understand and unravel sexual harassment, one has to tackle the overlapping issue of gender discrimination. Gender refers to the characteristics of women, men, girls and boys that are socially constructed norms, behaviours and roles, as well as relationships with each other. It is understood that gender interacts with but is different from sex, which refers to the different biological and physiological characteristics of females, males and intersex persons. Gender and sex are related to but different from gender identity. Gender identity usually refers to a person's deeply felt, internal and individual experience of gender, which may or may not correspond to the person's physiology or designated sex at birth.[6]

In a 2020 UK Government survey of sexual harassment in the workplace, approximately three-quarters (72%) of individuals reported having experienced at least one form of sexual harassment in their lifetime and 43%, at least one episode within the last 12 months. The three most commonly experienced sexual harassment behaviours, were unwelcome jokes or comments of a sexual nature, unwelcome staring, and unwelcome comments of a sexual nature about body and/or clothes. The demographic groups that were significantly more likely to have experienced sexual harassment were women, young people (aged 15-34), people from an ethnic minority, individuals that identified as lesbian, gay or bisexual, and those with disabilities.

# THE SEX DISCRIMINATION ACT 1975

The Sex Discrimination Act 1975 [7] makes sexual harassment unlawful in public life, including employment, while sexual assault is a criminal offence. Sexual harassment (as a form of discrimination) is conceptually distinguished into certain types of behaviour:
(1) gender harassment (verbal and nonverbal behaviours that convey hostility, objectification, exclusion, or second-class status about members of one gender),
(2) unwanted sexual attention (verbal or physical unwelcome sexual advances, which can include assault), and
(3) sexual coercion (when favourable professional or educational treatment is conditioned on sexual activity). Harassing behaviour can be either direct (targeted at an individual) or ambient (a general level of sexual harassment in an environment).[8]

The majority of individuals (75%), who had experienced sexual harassment, felt that at least one of the nine protected characteristics (as defined in the 2010 Equality Act) was a contributory factor. Even two thirds of female soldiers in the highly trained and regulated British Army have reported sexual harassment including assault. [9]

Sexual Harassment & Discrimination
Sexual harassment is a form of discrimination and stems from structural inequality, which comprises various forms of economic, social, religious, and political inequality ingrained in society. Gender-based discrimination intersects with ethnicity, socioeconomic status, disability, age, geographic location, gender identity and sexual orientation, among others. Structural inequality is often understood as an aggregate, cumulative product of historical wrongs, legal or policy decisions, and governmental inactions.[10]

A century after the suffragette movement, women continue to languish below their deserved status in every domain of society from pay gap [11,12] to domestic violence [13]. This divergence is exhibited even in the highest achieving global roles - such as in a study analysing the gender disparity of Nobel Laureates since 1901, found that only 6.2% of women have ever received this coveted prize, and only 23 women have received a prize in Medicine, Physics or Chemistry. [14] In the context of numerous examples of sexual discrimination, of persecution, denial of basic human rights of education, health and liberty, of rights of inheritance [15] - the achievements by women such as Hillary and Chandi are exceptional.

Often, the conversations about sexual harassment talks about women, as a single entity, whose experiences are all the same, yet women are not a homogenous group. The experience of women from diverse backgrounds or groups and with a range of protected characteristics is significantly different. To really understand the root causes of sexual harassment, we need to view the problem through an intersectional lens.[16]

High risk settings
The characteristic environments most associated with higher rates of sexual harassment are (a) male-dominated workplaces, a power imbalance in favour of men, male dominated work settings such as toxic masculine behaviours and (b) an organisational climate that fosters gender non-conformity, encourages normalisation or tolerance of sexual harassment, a culture of silence driven by fear or persecution and hierarchical, autocratic leadership lacking in compassion. [17]The 2018 Australian National Survey[18] found that the majority of individuals were sexually harassed by a single perpetrator, most (79%) were male, more than half (54%) were aged 40 or older and commonly a co-worker employed at the same level (27- 35%).
The healthcare workplace is typically hierarchical, carrying high stakes, consisting of toxic competitive professional aspirations often allowing an environment of harassment to be propagated. Within healthcare, female nurses report the highest levels of sexual harassment up to 87%, including 41% perpetrated by their physician colleagues.[20]

# SEXUAL HARASSMENT RISK

Some workplace settings with a higher risk of experiencing sexual harassment are;

- the information, media, telecommunication, arts and recreation industry,
- those which are primarily male-dominated (for example, the construction and mining industries),
- those which involve a high level of contact with third parties, including customers, clients or patients (for example, the retail and hospitality sectors, and the health care and social assistance industry);
- those that are organised in strict hierarchical structures (for example, in police organisations, the uniformed forces, and the medical as well as legal professions).
- settings with established gender inequality, therefore a symptom of social inequalities, sociocultural gender and power differentials.[19]
- healthcare, where this is most prevalent in male dominated specialties such as surgery, areas with increased personal contact such as when performing procedures together and areas of established historical role inequalities or differentials, such as in nursing and midwifery.

It is acknowledged that the interaction of different aspects of one's identities affects the ways that harassment is perpetrated and often occurs together with other forms of discrimination such as racism, homophobia, xenophobia or against those with disability. Younger workers (approximately aged 18-29 years), often at the beginning of their careers, in temporary work, in lower positions of power - are more prone to harassment, less confident to speak out and thus experience the highest levels of sexual harassment. In the context of healthcare, these are likely to be early career professionals who fear the impact on stressful and often arbitrary progression assessments such as their review of competency or career progression, the possibility of an increased length of training, the impairment of their reputation and confidence and diminished prospects of future employment.

Impact of Intersectionality

Crenshaw in 1989 [21] described that a person's social and political identities coalesce or 'intersect' with each other to determine their experiences of privilege or discrimination including harassment- perhaps the first description of intersectionality. It is a complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect thus determining the experiences of marginalised individuals or groups. [22] An individual's experience of harassment in the workplace is impacted by the intersections of their ethnic background, culture, religion, sexual and gender identity, disability and social status. [23]

Though there is still limited research on the impact of intersectionality, the US National Academies reported that Black, Asian and minority ethnic (BAME) women were more likely to feel unsafe to experience verbal racial harassment and much less likely to report this compared to white women.[24] [25] Relative to other social identities, religious identity can lead to higher levels of harassment. [26] The #MeToo movement (conceived in 2006 by Tarana Burke), brought visibility to sexual assault, harassment, and abuse of power. It illuminated how even those women with significant amounts of social, political, and economic power experience gender-based harassment that, until now, had gone unreported for fear of social and professional repercussions. The celebrity advocacy in 2017, drew attention to how sexual harassment was endemic in most societies, was differentiated by historical and material structures of race, gender, sexuality, citizenship, or class - highlighted the contribution to deepening gender inequality in workplaces, [27][28][29] occupational and psychological outcomes. [30]

Immigration

A large proportion of healthcare workforce have immigrated from their native countries or cultures to Western societies which encompass a different set of social and cultural norms. Immigrant status is an important determinant in perpetuating structural inequalities as well as sexual harassment. [31]

The power and privilege relationships between men and women are different across societies around the world where women may not be empowered to react to men including their sexual advances. Women from different ethnic backgrounds may be oblivious in unfamiliar social or cultural settings, different linguistic interpretations of cues, be isolated in their support systems and be unsure of how to react during uncomfortable situations.[32] They are often viewed differently or misunderstood by their colleagues and this compounds their vulnerability.

## Solutions

### Policies

Tackling structural inequality requires remedies that go beyond incremental approaches focussed on individuals and include transformation of the organisational and societal ethos by interventions supported by affirmative policies and courageous, compassionate leadership. [8] Most organisations believe in the power of developing relevant policies including gender mainstreaming. [33] Since 1997, the UN Economic and Social Council has incorporated this approach "assessing the implications for women and men of any planned action, including legislation, policies, or programmes". There is a need for society, governments and institutions to create policies and procedures to promote diverse, inclusive, and respectful environments. Institutions must encourage an organisational culture that fosters an open environment, minimises the negative consequences of frictions that are inevitable with culture change and recognise that progress from diversity is maximised when reflected in higher leadership positions. Policy and programmatic interventions to improve equity, diversity, culture, and workplace environment may lead to a decrease in gender pay disparity, a balanced workforce and a decrease in inappropriate behaviours between co-workers. [24] However, there is almost no real evidence yet to support the effectiveness of most major policy-based preventive measures, in fact the much of these interventions including research on sexual harassment is believed to lack theoretical, longitudinal, qualitative and intersectional approaches or perspectives.[23]

### Training

Education and training often focussed on the individual as a remedial measure or as team learning is a commonly employed intervention to tackle sexual harassment in workplaces. Ideally to understand the stages of sexual harassment from a victim's perspectives may help to design and target specific interventions. Yet there is little evidence of its longitudinal effectiveness or sustainability. Eatough et al., believe 'the burden to combat sexual harassment should not rest on training the victim but should involve preventative and educational training for both genders, as both genders are victims, bystanders, and perpetrators.'[34] Understanding the stages of sexual harassment from a victim's perspective helps to design and target specific interventions. These are: a perceived sexually harassing act, sensemaking and decision-making, resistance through voice/silence, and perceived organisational response. [35]

Contextual learning that embeds factors such as location, the prevalent culture, the work environment, the social norms, and the mental-emotional states of the individual are more likely to be successful. [34] However, a single training event is unlikely to change behaviour nor learning maintained over time.[36] Some training interventions achieve learning transfer [37] and that deep learning can affect the larger systems of belief and behaviour. [38] This can be completed by coaching or mentoring with the aim of generating a form of retrieval practice [39], reinforcement by use of local cases, role-play to practice acceptable behaviour norms, engagement in reflection and development of improvement strategies as well as an analysis of purpose. Discussion about sexual harassment can elicit a range of emotions, especially for those who have been victims, witnesses, confidants, or perpetrators and disagreements which can be both distracting and disruptive. Therefore, to be effective such training needs to ensure psychological safety and space for differing individual experiences within the learning environment to be heard and reflected on. Expert facilitation is essential for success.

Table. 1 Principles and approaches to primary prevention that may be relevant to future interventions.[40][24]

- Addressing intersecting forms of harassment and discrimination
  - For example, relating to a person's race, sexual orientation or disability), ensuring that minority ethnic women who are disproportionately targeted, are not virtually invisible. [26][27]
- Using a holistic community-based approach
  - to address different aspects of the problem across multiple settings, including workplaces, media, education, arts, and sports
- Encouraging bystanders to act
  - Engaging men and boys proactively in increasing awareness of the issues and acting to prevent such actions among their peers [28]
- Data Monitoring
  - survey data routinely and evaluating specific measures
- The #MeToo movement
  - demonstrated the power of grassroots individuals and their networks making a difference; Robustly dealing with backlash or resistance to prevention initiatives.[17]
- Networking can change things [29]
  - Supportive individuals, peers, senior leaders in management or organisations
- Advocacy and activism
  - Talking and sharing stories

Box. 1 Training intervention necessitate psychological safety measures: coaching alone or as supplement

- Trainer Psychological safety
  - Training of the trainer on psychological safety confidentiality provisions, small group size
- Coaching, either alone or as a supplement to workshop training In coaching,
  - the coach deliberately crafts a psychologically safe and
  - confidential relationship, similar to therapy,
  - where individual beliefs, attitudes, histories, and vulnerabilities can be realised.,
  - allowing individuals to adopt and explore different perspectives
  - using the individual's own pace and readiness.

- Coaching involves
  - partnering with the coached in a thought-provoking and
  - creative process with
  - the goal should be to maximise the coached individual's personal and professional potential. Coaches to maintain the strictest levels of confidentiality except under specific circumstances as required by law.
- Coaching also allows for
  - the exploration of emotionally driven decisions related to this issue, such as men's reluctance to mentor women due to fear of accusation
  - Allows for private discussion of one's experience as a victim,
  - a witness or bystander of an incident,
  - a confidant, or
  - a perpetrator (intentional or unintentional).

## Conclusions

There is a significant overlap in sexual harassment and gender-based discrimination- both being a manifestation of power imbalance, inherent structural inequalities and societal inaction or acceptance. This form of systematic discrimination, harassment and abuse is also widely prevalent in healthcare, as in the wider society. However change is possible and there are powerful role models like Hilary and Chandi who are breaking through. The #MeToo movement demonstrated the power of grassroots individuals and their networks making a difference; Their mantra included starting small, using every individual sphere of influence, the power of local activism, driven by compelling storytelling and using the power of social networks. [41]

At societal and organisational level, there is a need to implement the policies and laws that exist but to combine this with total commitment, compassionate leadership, accountability and holistic solutions which address the imbalance, social inequalities, the legacy power gradient and deep-rooted bias. This work must be led from both ends of the organisation; the grassroots and the top leadership and must include the intersectionality of multiple contributors to discrimination or harassment. The first step in tackling this issue is being honest, acknowledging the issue at hand and to apologise.

'Hope begins in the dark, the stubborn hope that if you just show up and try to do the right thing, the dawn will come' Anne Lamott

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Commentary

# The Legacy of Indenture

## Acknowledgement, Apology or Reparation

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### Introduction

In early 2022, there has been a shift in focus from the death and devastation being wrecked in Ukraine to the visit of Prince William and Kate to the West Indies. The press has been reporting on the one hand about the 'amazing' experience of the islanders interacting with the royal couple, the display of the rich Caribbean cultural heritage while on the other, there is coverage of the protests, the demand for a 'royal apology' for slavery and the process of removing the Queen from the position of head of state in Jamaica. Barbados has already completed this separation in 2021 with Dame Sandra Mason becoming the new President.These are important political matters and as responsible citizens of the world, we (even healthcare professionals) have a reason to be aware and care. For many healthcare workers in the UK, the legacy of the Empire and its many seemingly unresolved issues still affects their psyche and clouds their aspirations.

In 2017, the Harvard T.H. Chan School of Public Health held a symposium on the legacy of slavery on health and medicine which recognised that in the 18th through early 20th centuries, white physicians studied black slaves and their descendants in an attempt to identify characteristics that were distinctive of their race. They believed that all questions about health could be answered in the body; therefore, if black people had poorer health outcomes than those that were white, the differences must be due to inherent racial weaknesses (not the legacy of oppression, the deeply embedded disparities in economic circumstance stemming from a denial or exclusion from opportunity). It was their conclusion that medical research played a significant role in constructing a narrative of race in the United States, the repercussions of which are still being felt in the lives and health of African Americans.

***The story is no different to the indentured labourers brought from the Indian subcontinent by their Colonial masters to the plantations of the West Indies and Americas.***

***The UK National Archives describes, 'Many Indians agreed to become indentured labourers to escape the widespread poverty and famine in the 19th century. Some travelled alone; others brought their families to settle in the colonies they worked in.'***

The demand for Indian indentured labourers increased dramatically after the abolition of slavery in 1834. They were sent, sometimes in large numbers, to plantation colonies producing high value crops such as sugar in Africa and the Caribbean. The labourers were mostly young, active, able-bodied people used to demanding labour, but they were often ignorant of the places they 'agreed' to go to or the challenges they were going to face. These indentured servants 'chose' to work in the Caribbean mainly for socioeconomic reasons brought about by their own internal oppressive social system and the impact of Western colonialism and the promise of a better life - which was sadly never to be realised.

The main aspects of their labour contracts were basic "free" housing, fringe medical care, a right to return passage, a fixed daily wage, and continuous employment with one employer. When their five year contracts expired, Indian indentured labourers were given an option to re-indenture and receive small parcels of land in lieu of their return passage.

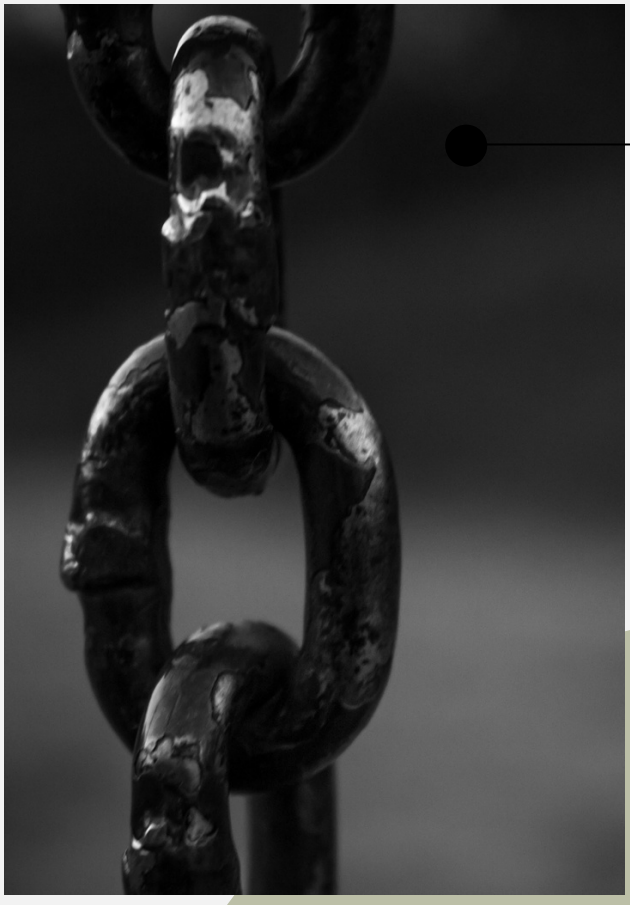
Before 1840 a large proportion of the labourers were so-called 'Hill coolies', aboriginal people from the foothills of the Himalayas and those from the plains of the Ganges. Later many others signed indentured labour contracts, including Hindus, Brahmins, high castes, agriculturists, artisans, Mussulmans, low castes (untouchables) and Christians. Over 41,000 Bengali labourers were sent to Mauritius in 1834.

The Indian government banned 'coolie' shipments in 1838 because there were reports of repression and abuse. In 1842 the British Prime Minister, Robert Peel directed the Indian government to re-open these lines of emigration under proper safeguards. A Protector of Emigrants was appointed to ensure that the labourers had adequate space, food, water and ventilation on the journey. Emigration was legalised from 1844 and the last indentured labourers went to the West Indies in 1916.

The state of the indentured labourers remained unaffected by these seemingly robust safeguards. There are numerous untold stories of repression and inhuman abuse while the plantation owners and the colonial masters gained incomprehensible wealth at the expense of basic human rights and dignity. There was also dissonance and ways in which dominance and oppression was contested in everyday life and the levels of organisation, which were visible in the plantation societies.

Hugh Tinker's book 'A New System of Slavery' (1974) established the paradigm that the system of Indian indentured labour witnessed the institutionalisation of a new labour system that incorporated most of the repressive features of slavery.

***Essentially, this indentured 'labour power' was owned by the 'employers', traded easily without the need for acceptance, or consent by the concerned labourers.***



***At all points of the indenture system—the Emigration Depot, on ships, the Immigration Depot, the estates—medical provisions for labourers were dismal and much below the standards of care for the time.***

Labourers endured extremely heavy workloads, long working days and poor housing, usually living in overcrowded former slave barracks, where food was scarce and medical attention was basic or lacking. Those under indenture were subjugated to the absolute authority of the Colonial upper class masters who used their power to starve, beat and cheat indentured labourers out of their wages. Many workers tried to escape their harsh life, were recaptured, and imprisoned. Sometimes their initial five year contract was doubled to ten years for attempted desertion.

**Health of Indentured Labourers**

In 1856-57, the average death rate for Indians travelling to the Caribbean was 17% due to diseases like dysentery, cholera and measles. After they disembarked, there were further deaths in the holding depot and during the process of acclimatisation in the colonies. Potential emigrants were carefully chosen to be of the right body type to demonstrate their ability to work hard and to be free of ailments. Although there were rules for the regular medical check up of the coolies, most of the accommodation was unfit for human occupation and none had any toilet facilities. Anyone found to have untreatable conditions including senility, syphilis, heart, liver disease or bronchitis were transported back to their villages in India.

Most people believed the indentured labourers to be from bad stock, from the wretched and lowly segments of Indian society, commonly from the lower castes, picked up like cattle and despatched to the colonies. The truth was different. Indentured labourers were from all castes and with a variety of skills. People who had become destitute due to the harsh British revenue policy or during the famine. They remained voiceless and mute and were blamed for most of the misfortune that fell on them. Women were blamed for the high infant mortality (estimated to be 25%) as they tended to lack the maternal instinct, promiscuity and poor hygiene.

This absolved the Plantation owners from the duty to provide appropriate living conditions, the compulsion of returning to back breaking work after childbirth and the prevalence of anaemia due to hookworm infestations. Sexual disparity of 40 women to 100 men in the indentured population led to sexual jealousy and a high rate of suicides. Suicides were also due to loss of family support, cultural domination of the minorities, despair, hopelessness and depression.

The ratio of doctors to patients, the amount of medicines and the numbers of beds for patients were insufficient. All of this was in the context of psychological stress as a result of homesickness, new experiences, the demanding life of plantation labour and the occupational hazards of the job. The quality of facilities provided for indentured Indians was influenced by British colonial perceptions of India, and what was 'adequate for Indians'. As a result, overcrowding and poor hygiene contributed to the substandard sanitation throughout the system.

The crew onboard these ships shifted the blame to uncontrollable circumstances and the Indians themselves. In the early phase of the system mortality was mainly the result of the lack of regulations governing the system.

Provisions for personal hygiene on emigrant ships were limited so it was a fertile situation for contagious diseases to spread. In the 20th century the chances of survival increased as mortality on voyages declined. The issues on ships included overcrowding, poor quality of food; and a lack of proper hygiene as there were only one or two toilets for all passengers; bad odours or miasma below deck and diseases. This resulted in the prevalence of diseases which reduced labourers' chances of survival, and their capacity to work.

***The liberated slaves were also required to provide 45 hours of unpaid labour a week to their former masters for the period of four years after the practice of slavery had been outlawed.***

**The Surgeon Superintendent**

There were some rules that stipulated guidelines on diet, clothing, medicines, ventilation, cleanliness, hospital records and more. Each ship was required to have a Surgeon Superintendent who was in charge of the welfare of the passengers. This position was filled by a man, usually recruited in England. He was paid according to how many immigrants landed in the West Indies alive. If neglect or misconduct could be proven on his account, a portion or all of his salary could be withheld. The Surgeon Superintendent was appointed by the Protector of Emigrants in India. His duties included medical inspection of the Indians, rejection of unfit persons; inspection of the ship and report on ventilation of the vessel. He was also responsible for the arrangements for cooking; setting up a hospital in the deckhouse and checking supplies to put on the ship for the Indians.

**Acknowledgement & Apology**

In 1807, British parliament passed the Abolition of the Slave Trade Act, which banned the practice of transporting enslaved African people to the Americas to be sold there. This brought to an end to Britain's involvement in the transatlantic slave trade, which began in 1562. It's estimated that British ships transported 3.4 million slaves across the Atlantic Ocean. Initially, British slave traders supplied Portuguese and Spanish colonies in the Americas. But later, with British colonial expansion, slave traders supplied British colonies in the Americas and the Caribbean. The use of slave labour was abolished throughout the British Empire when the Slavery Abolition Act was passed in 1833. At that time, there were 46,000 British slave owners, and the majority of their slaves were working on sugar plantations in British colonies in the Caribbean.

Under the provisions of the Act, the Slave Compensation Commission was established to oversee the distribution of £20 million in compensation to the slave owners for the loss of their "property."

They were first of 2 million Indian indentured labourers that were sent to work in 19 British colonies, including Fiji, Ceylon, Trinidad, Guyana, Uganda, Kenya and Natal. And to a lesser extent, indentured labourers were also recruited from China, Southeast Asia and the Pacific. Indentured labourers worked mainly on sugar plantations, tea and cotton industries as well as in rail construction in southeast Africa. While to the best of our knowledge, there has never been an official apology or acknowledgement of the fate of indentured labourers from India, there have been attempts to express deep regret.

In 2007, Prime Minister Tony Blair said sorry for Britain's role in the Transatlantic Slave Trade.
***"I have said we are sorry and I say it again … [It is important] to remember what happened in the past, to condemn it and say why it was entirely unacceptable,"***

In 2021, quite distinct from the legacy of predecessors, the the descendants of the South Sea Islanders forced or duped into a form of slavery on Australian plantations received a historic apology from the mayor of Bundaberg setting a national precedent and provide the catalyst for atonement at the highest reaches of government.

Jack Dempsey became Australia's first elected leader to formally say sorry to Pacific Islanders for the indentured labour trade – known as "blackbirding" – that from the second half of the 19th century until 1904 helped enrich the fledgling Queensland region and its sugarcane barons.

There are early voices of empowered descendents of slaves or indentured labourers being raised in the UK Parliament. Bell Ribeiro-Addy MP in her first speech in Parliament, reflecting the future of global Britain, demanded that old injustices and their links to current problems be acknowledged.

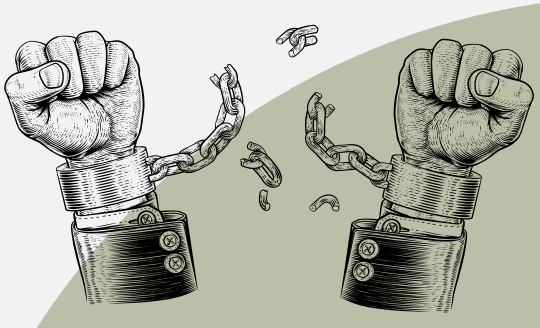
***"Not only will this country, my country, not apologise—by apologise I mean properly apologise; not 'expressing deep regret,'" she said, "It has not once offered a form of reparations."***

In 2018, the British government apologised after dozens of descendants of the Windrush generation —many born and raised in Britain—were wrongly detained, denied legal rights, and even deported from the UK over citizenship issues. Anti-Slavery International has been calling on the UK Government to make a formal apology for Britain's role in the Transatlantic Slave Trade and to take action to address its legacies, which continue to affect communities in Africa, the Americas and Caribbean.

**Moving to Reparations**

Following the campaign by the #BlackLivesMatter movement, since the unlawful killing of George Floyd in the USA, there have been increasing public protests against the ongoing legacy of slavery. The toppling of the statue of Coulson in Bristol and defacing of many of the other prominent individuals/ families who benefited from the exploitation of humans is a beginning. However, there is little or no acknowledgement of the exploitation of over 3 million indentured labourers from India.

A project by University College London has published the identities of 47,000 slave-owners who, at the abolition of slavery in 1833, claimed compensation of £20m for the loss of their "property". The sum, around £2.6bn in today's money, was 40 percent of Britain's national budget at the time and it took until 2015 to pay off the debt. There are calls for reparation monies to be paid to the countries whose generations were ripped apart by slavery. A similar call will need to be raised for the exploitation of indentured labourers and perhaps a day will come when imperialist countries will acknowledge and offer due compensation to the countries of origin, which continue to suffer the socio-economic consequences of centuries of oppression and exploitation.

# ABORTION RIGHTS IN THE USA

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## Abstract

The US Supreme Court overturned the 1973 Roe vs Wade ruling in July 2022. A highly controversial decision with wide ranging impact on the rights and health of women both in the USA and across the world.

There is no doubt that this judicial ruling will disproportionately affect those who are poor, with little access to healthcare; disabled, minors and those with physical or mental disabilities.[1] Rural women of colour from the Southern States are likely to be the worst affected.[2] This has far wider implications than only affecting the poor and marginalised.

Removing legal protection for abortions cannot be considered an isolated event. It sits squarely within the realm of human rights of the woman, her right to bodily autonomy, right to dignity and economic prosperity. In countries where women are safeguarded in their reproductive rights, civil society should be vigilant about ensuring these rights are equitable. The access to safe and affordable abortion is every human's right. It is up to us to safeguard it with everything we have.

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Abortion rights, Roe vs Wade, US Supreme court ruling, Women's health

# Abortion rights in the USA | 2

Background

Following a landmark ruling of the US Supreme Court this week, many women have lost their right to seek an abortion of an unwanted foetus, regardless of the circumstances that may have led to the pregnancy. This turns the clock back for reproductive rights for US women by nearly 50 years and has several consequences for women's futures. The historic Roe vs Wade verdict of 1973[3] the Court held that a set of Texas statutes criminalizing abortion in most instances violated a woman's constitutional right of privacy, which it found to be implicit in the liberty guarantee of the clause of the Fourteenth Amendment [4]("…nor shall any state deprive any person of life, liberty, or property, without due process of law"). This ruling gave a pregnant woman in the US the constitutional protection to decide, along with her physician, whether to proceed with or terminate any pregnancy during the first trimester. Since then, reproductive rights of US women have been gradually eroded during the decades of the country's move to more entrenched conservatism.[5] And if this week's US Supreme Court verdict is anything to go by, the erosion is absolute and soon to be codified in law in most conservative states.

Women have sought to take charge of their reproductive fate throughout history. Evidence exists in ancient Egypt of the use of birth control remedies, some 4000 years ago.[6] The Ebers Papyrus from 1550 BC and the Kahun Papyrus from 1850 BC have within them some of the earliest documented descriptions of birth control, the use of honey, acacia leaves and lint to be placed in the vagina to block sperm. In the modern era, access to contraception and abortion has played an immense role in allowing women to choose their own futures and pursue employment, plan families, and contribute to the economy. There is evidence that liberalising abortion laws can have positive spill over effects for women's educational attainment and labour supply, and that access to abortion services contributes to improvements in children's human capital.[7]

While, the political economy around abortion legislation is divisive and socio-emotionally controversial, this ruling threatens this very premise of choice. [8]

The repeal of Roe vs Wade has removed the constitutional safeguard for abortions, resulting in several States in the USA initiate 'trigger laws'- effectively bringing an immediate end to legal, State sanctioned abortions.[9] The health impact of this ruling on women is enormous. [10] Many women will now be forced to continue with their pregnancies regardless of whether the pregnancy was a result of incest or rape or whether the foetus has health issues that are not compatible with life. Women whose lives are threatened by pregnancies such as in the case of ectopic pregnancy will not be allowed to terminate. Women seeking abortions from States where they are banned will have very few options other than carrying the foetus through to birth, travelling at great expense to another State where the services are legal, attempting to self-abort the foetus or seeking help of illicit, and potentially life-threatening procedures closer to home or die due to pregnancy or childbirth. [11,12]

There is no doubt that the ruling will disproportionately affect those who are poor, with little access to healthcare; disabled, minors and those with physical or mental disabilities.[1] Rural women of colour from the Southern States are likely to be the worst affected.[2] Only women with the means to travel to other States to seek abortion will do so, forcing others to endure the trauma of bearing an unwanted pregnancy. This has far wider implications than only affecting the poor and marginalised. Women who oppose abortions may find themselves with reduced access to good quality women's healthcare if gynaecologists move out of States where abortions are not permitted. Abortion services may also be overwhelmed in States where they are available, affecting the lives of women in progressive States too.

The economic effect of this is also enormous. [13] Women forced to give birth will be less able to seek employment or further their careers and are likely to remain in poverty for longer. Their children are more likely to be brought up in poverty. Intimate partner violence is also likely to increase due to the economic and emotional toll of unwanted pregnancies. Those facilitating safe abortions for disadvantaged women may be prosecuted, medical school curricula may completely remove abortion training, medical careers may be destroyed due to vigilantism or prosecution. Inevitably, this will further widen the gap between men and women in their rights and liberties, as no burden of responsibility will be afforded to the biological father when a woman chooses to terminate her pregnancy, even when she is a victim of abuse.

As medical professionals, we dedicate our lives and careers in saving, prolonging, and dignifying life. This also means we save patients from the indignity of futile suffering when it is neither kind nor respectful to prolong life simply for the sake of it. While banning abortions is being presented as protecting the rights of an unborn child,[14,15] it must be recognised that terminations will spare babies with severe birth defects their terminal disease.[16] Babies born out of unwanted pregnancies may not bond with their mothers, may carry the psychological burden of rejection at birth, may be subjected to abuse due to the economic, social and emotional toll caused by the birth. Countless women will miss out on career opportunities, countless men might find themselves economically burdened while their partners are unable to work.

It is estimated that over 60,000 additional births will occur annually because of this ruling, based on official surveillance data from 2019 published by the US Centre for Disease Control.[17] There may be even further ramifications of this law, where some States may make it impossible for women to access 'morning after' pills, sex education may be removed from school curricula, access to contraception may be curtailed or even banned.

As is evident in many societies where draconian anti-abortion laws exist, lack of legal abortions will simply drive women to seek them illegally, putting their health at serious risk. [18]

As estimated by the World Health Organisation, [19]

- Six out of 10 of all unintended pregnancies end in an induced abortion.
- Around 45% of all abortions are unsafe, of which 97% take place in developing countries.
- Unsafe abortion is a leading – but preventable – cause of maternal deaths and morbidities. It can lead to physical and mental health complications and social and financial burdens for women, communities and health systems.
- Lack of access to safe, timely, affordable and respectful abortion care is a critical public health and human rights issue.

Many women will continue to suffer from sepsis, haemorrhage and even death following self-induced or shady back-alley abortions. The repeal of the Roe v Wade verdict has been a long and strategic road for those opposed to abortions. It needed years of political manoeuvring to change opinions within the conservative polity and appoint Supreme Court justices who have strong ideological opposition to abortions. Despite opinion polls indicating that up to 80% Americans favour abortions in certain circumstances[20], it is worthy of note that very soon women in at least 26 States of the USA are not going to be able to have access to them even in the most tragic circumstances. It is hard not to imagine however, that this is just a step towards further curtailment of civil liberties that have been fought and won over decades, such as separation of Church and State, banning segregation based on colour, tolerance towards religious and racial minorities.

The ramifications of the repeal may also have wider international effects. Many countries will use this as a precedence to reduce access to safe abortions, many programmes relying on US aid to provide safe abortions will no longer be able to provide these services to those in need.

However, there must be hope yet. Federal States with liberal laws will continue to provide abortions and many charities are already collecting funds to provide timely support to the poorest women in the Sates with no access to abortions. The economic and social effects of this will be felt by a generation of Americans who may decide to use their electoral franchise to bring about change. The former President and First Lady of the US, the Obamas urged people to get involved with groups that advocate for abortion rights.[21] The current President Joe Biden, stated that 'if the Court does overturn Roe, it will fall on our nation's elected officials at all levels of government to protect a woman's right to choose. And it will fall on voters to elect pro-choice officials this November.At the federal level, we will need more pro-choice Senators and a pro-choice majority in the House to adopt legislation that codifies Roe, which I will work to pass and sign into law.' [22]

In the UK, the Royal College of Obstetrics & Gynaecology, Royal College of Midwifery and the Royal College of Paediatrics & Child Health are among 150 institutions which have issued joint statements, "The United States Supreme Court decision to dismantle Roe v Wade and roll back 50 years of access to safe abortion care is a catastrophic blow to the lives of millions of women, girls and pregnant people who now face the prospect of being forced to continue pregnancies. It is a decision that will cost lives for years to come."[23]

For the last 50 years, abortion has been legal in India under various circumstances, following the enactment of the Medical Termination of Pregnancy (MTP) Act in 1971. In 2003, the Act was amended to allow women access to safe and legal abortion services.

On the advice of doctors, all women can terminate their pregnancy up to 20 weeks. Since 2020, special categories such as survivors of sexual abuse, minors, rape victims, incest, and disabled women have been allowed to seek termination up to 24 weeks. There is real concern that the fall out of the US Supreme Court decision could embolden regressive ideas in society and also stigmatise reproductive health measures in India.[24]

**Conclusion**

Removing legal protection for abortions cannot be considered an isolated event. It sits squarely within the realm of human rights of the woman, her right to bodily autonomy, right to dignity and economic prosperity. In countries where women are safeguarded in their reproductive rights, civil society should be vigilant about ensuring these rights are equitable. The access to safe and affordable abortion is every human's right. It is up to us to safeguard it with everything we have.

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# RESPONDING TO GOOD MEDICAL PRACTICE CONSULTATION

SUMMARY

## WORKSHOP CONSENSUS 2022

**BAPIO- BIHR**

Between 2020-21, BAPIO through its arm's length Institute for Health Research (BIHR) and partners in the Alliance for Equality for Healthcare Professions, undertook a comprehensive, thematic synthesis of differential attainment as affecting the lifecycle of a health professional from entry to exit in the profession. This was followed by a series of consensus building workshops involving the triumvirate of grassroots professionals, their representative organisations, stakeholder agencies and academics. The consensus recommendations were published in 2021, as the Bridging the Gap 2021 report.

Chakravorty, I., Daga, S., Bamrah, J., Nageswaran, P., Dhelaria, A., George, C., Menon, G., Kataria, H., Bhala, N., Shrotri, N., Mattu, R., Jainer, R., Fida, R., Ramkisson, R., Agrawal, S., Hosdurga, S., Mathew, S., Sharma, S., Chakraborty, S., Chakravarty-Gannon, T., Jadav, V., Grover, J., Patel, M., Mathiekin, S., Dave, S., Dave, A., & Mehta, R. (2022). Responding to Good Medical Practice Consultation 2022: Consensus Workshop Report on the UK General Medical Council's Public Consultation, Coventry, UK 25 June 2022. Sushruta Journal of Health Policy & Opinion, 15(1), 1-24. https://doi.org/10.38192/15.1.10

# GMP Consultation | 2

One of the six domains in this report consisted of recommendations relating to professionalism and fitness to practise for the regulator and employing organisations. The report also provided a deep understanding of the onboarding, acculturation and differential treatment of international medical graduates, who make up approximately40% of doctors and 1 in 5 of the UK healthcare workforce. The report acknowledged the overwhelming inherent existence of ubiquitous institutional bias and incivility, its impact on the health and wellbeing of the workforce, hindrance of workforce development from the failure to recognise diversity and ultimate impact on patients that are at the centre of everything that healthcare professionals stand for.

The GMP guidance from the GMC UK aspires to describe and embody the letter and spirit of the values and behaviours that define the professionalism expected from doctors in the UK. The medical professionals (doctors and Physician associates) are required to provide evidence against domains of GMP during yearly appraisals and the five-year revalidation to continue to hold the licence to practise in the UK. The GMP thereby serves as a framework against which to determine if a regulated professional has deviated significantly from the expected high standards of professionalism. Therefore, GMP is routinely referenced by the public, employing organisations and by the GMC UK, when doctors are referred to the regulator for appropriate investigation and possible sanctions. Although the GMC UK is often at pains to point out that GMP is not a set of rules, however, as any practising doctor will be aware, especially those at the sharp end of the GMC's disciplining arm, the Medical Practitioners Tribunal Service, GMP is often the standard that determines whether or not a registered doctor has deviated away from what is expected of them.

However, there is growing evidence that the GMP, in its current format, fails to properly reflect diversity amongst the medical profession and patients nor demonstrate sensitivity to the interpretation of values or behaviours through the lens of culture or diversity intelligence. The GMP does not take into account the shared responsibility and collaborative healthcare in multi-professional teams. The GMP does not sufficiently reflect that doctors are working in and for large organisations, where those in leadership and management positions must have accountability. The leaders are responsible for developing and creating functioning teams, provide the optimum working environment, with the tools to perform their intended roles (education and training) and be held accountable for delivering on the requirements of equality, diversity, inclusion and fairness for all patients and professionals, as reinforced by the NHS Constitution and the Equality Act 2010.

The resulting unfairness in how healthcare organisations treat regulated professionals, in particular doctors and the differential referral to the regulator is in part due to the format and content of the current GMP, which embodies a set of standards conceived and crafted more than a decade ago, and therefore appears to be significantly outdated in transforming the modern, diverse healthcare landscape.

In this workshop, doctors from across the profession worked with psychologists and academics in reviewing the GMC UK's redraft of the GMP. In doing so, they suggested amendments and inclusions necessary, so that the proposed GMP 2022, demonstrates progress to a culture of fairness, social justice, diversity and inclusion.

The recommended amendments and inclusions to the GMP from this workshop are presented under three broad themes: 1) working with colleagues, 2) working with patients and for those 3) doctors in leadership or management positions.

- The workshop participants reflected the perception that the GMP appeared to overtly support people in authority, and is open to be interpreted pejoratively and utilised for punitive action, to thereby provide grounds for deviating from the aspiration of a 'blameless culture of learning' that is the hallmark of a modern organisation.
- That the proposed GMP did not reflect the diversity of the medical professionals nor their patients and therefore needed to be more explicit and unequivocal in every section in order to achieve dignity, respect and value to embed equality, diversity and inclusion in the profession and in healthcare.
- The workshop recommended that Responsible Officers and the regulator demonstrate robustly and transparently in their processes - fairness, diversity intelligence, accountability and an independent assessment of the impact of their referrals/decisions on the morale, wellbeing of the regulated professionals.

This paper summarises the extensive discussions and presents the amendments that will aid the architects of the new GMP to truly address the palpable shortcomings of the current GMP. The recommendations take into account modern societal transformation, the healthcare space that doctors function within, reflects the considerable diversity of our communities and professionals. This paper offers an opportunity to capture the wide-ranging views from the profession and academics to help right the many wrongs that have plagued the relationship of the regulator with the medical profession.

The workshop acknowledged the efforts of the GMC UK and its outreach ambassador in actively seeking out contributions from voluntary professional organisations and their vast membership in helping shape the new GMP, which we hope will be fit for a modern, post-pandemic just society in the UK and serve as an exemplar for the standards expected from the profession, across the globe.

Letter to the editor

# Intersectionality & Sexual harassment as a Minority Ethnic Female Surgeon

Anon

As a trainer, I have even taught women from certain cultures (who may find this level of contact difficult), that this is 'normal' in surgery. After reading the editorial and letter of response, in the Royal College of Surgeon's Bulletin, [1] I have to think again about what I teach. I have taken for granted that surgeons have some sort of moral standing. Maybe I should be explaining also what they should not be tolerating.

Even as a female surgeon, often at cultural gatherings, I feel I am perceived differently by women from my cultural or ethnic background, even if they are medical professionals themselves. I feel ostracised as being the woman who is playing with the men at their game. The younger generations however do applaud it, and I see more and more young women have a fervour for surgery. I feel now I want to protect them from this misogyny and sexual harassment more than ever.

A, A. (2022). Intersectionality & Sexual harassment as a Minority Ethnic Female Surgeon : A Personal Perspective. Sushruta Journal of Health Policy & Opinion, 15(1), 1-2. https://doi.org/10.38192/15.1.3

***Key words Sexual harassment, surgery, Female surgeons***

My only experience of sexual assault was at the age of 13 when I was on holiday abroad. I was touched inappropriately in a large crowd coming off a busy train. I couldn't tell who it was and my parents didn't even see it happen. I never told them about it as I felt I was in the wrong.

Nothing like this has ever happened to me in surgical training. I have never felt personally unsafe. Surgery is such a specialty that body contact with colleagues happens regularly, and is seen as part and parcel of working around an operating table. Indeed I hold sacred the bond one develops as an operating team during each operation. In no other specialty would it be common place to touch your boss' hand, or stand up close to them so you can hold a laparoscope for an operation. As a trainer, I have even taught women from certain cultures (who may find this level of contact difficult), that this is 'normal' in surgery. After reading the editorial and letter of response, in the Royal College of Surgeon's Bulletin, [1] I have to think again about what I teach. I have taken for granted that surgeons have a high moral standard. Maybe I should be explaining also what they should not be tolerating.

# Letter to the editor...

I have had comments made about my boots being 'kinky' or having nice legs when in high heels, but never really read much into it or felt this was a form of sexual harassment. Surely, then these comments are only harassment when the receiver feels it is so, and this happens repeatedly. As a woman in surgery, one sometimes has to become 'one of the lads'. It did not bother me as I love fast cars and motorbikes. This however meant I would be privy to lads chat. Often my male peers would gloat over which nurse they had taken to the roof, or how they flirted with the physiotherapist. I'd have feel the need to (awkwardly and hiding my discomfort) giggle at these stories, because I didn't want to rock the boat or be excluded. I didn't want anyone to tell the bosses that I wasn't a team player.

Even as a minority female surgeon, we are not homogenous as a group. Some are migrants, and first and second generation offspring of immigrants. We all have vastly different values, have been brought up with diverse cultural and social norms. All of these intersectional subtleties add different meaning to our perception and experiences. Some may find certain comments lurid, whereas others may brush these off as merely 'banter'. What is perhaps common is the experience of misogyny, even in surgery. [2]

The misogyny I have been subjected to in surgery, are by two groups of people. Firstly the 'old school' demigod-like surgeons who believe a woman cannot be a surgeon, wife and mother. I have had comments made to me, such as 'You need a wife at home', or 'You'll never be a consultant with children' and being made to work a 48-hr surgical on call when 34 weeks pregnant, despite having a sick note from Occupational Health.

The second group of men, I am sad to say, are those of the same minority cultural background as me. I have been asked what makes me 'so good' that I would get trained over a man? I have been asked, if I am sure even love my children cause I am a surgeon. One particular surgical colleague, mockingly laughed at me while I (dared to) operated.

As a senior female surgeon, I find that it is often hard for such men to take instruction from me and have had to on occasion, remove their hands from the operating table for not listening and potentially causing harm to patients. Fortunately, such instances are rare but I am sure will be recognised by senior female surgeons anywhere in the world. In my experience, majority of surgeons (including international medical graduates who may come from cultures with different social norms or experiences from women) are usually polite and considerate to women.

I once did make a formal complaint for being bullied. My consultant had an informal chat with the perpetrator (a manager) about his behaviour, while I was sent to formal counselling. Raising concerns is not without stress and inherent risk for young and female surgeons. In surgical specialities, reputation and word of mouth is a key factor in progress and the nepotism can be pervasive and deep-rooted. The repercussions for raising concerns or not accepting the misogyny as the norm - may result in having to extend training, being punished or torn apart at career progression reviews, and a battering to one's self-confidence or being excluded from future consultant jobs. Why would any young surgeon make a complaint when they know they risk being unpopular and the cost to career devastating? Unfortunately, such mistreatment or misperception of women professionals is not the exclusive preserve of surgeons or in the professional arena.

Even as a female surgeon, often at cultural gatherings, I feel I am perceived differently by women from my cultural or ethnic background, even if they are medical professionals themselves. I feel ostracised as being the woman who is playing with the men at their game. The younger generations however do applaud it, and I see more and more young women have a fervour for surgery. I feel now I want to protect them from this misogyny and sexual harassment more than ever.

Name and Address supplied

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SURVEY

# A SURVEY OF COVID-19 PANDEMIC-RELATED LOCKDOWN ON THE LIFESTYLE OF SECONDARY SCHOOL STUDENTS IN THE UK

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Background: We explored the impact of COVID-19 pandemic imposed lockdown on the lifestyle (physical, mental, dietary habits, development of new skills and behaviour) of secondary school students in an urban state all-girls school in Birmingham, United Kingdom.
Methods: An online survey using Google forms distributed online via the School Newsletter - comprising 40 questions on sleep, dietary habits, physical activity, mental health, new skills and COVID-19 symptoms. Responses were sought from pupils in school years 7-12, corresponding to age 11-18 years, (approximately 1099 students).

Results: There were 102 responses received, a response rate of 10%.

· Sleep - students slept for an additional two and half hours during lockdown, and 90 minutes extra during the period of attending school online.

· Physical activities – compared to 3-hours a day during regular school time, mean daily physical activity dropped to 1-3 hours per week for 60% of students during lockdown, which were mainly home workouts, walking and cycling.

· Skills – while 54% reported deterioration in academic performance, 33% learnt a new skill such as baking or a new language.

· Mood - one third of students felt negative and 45% felt more argumentative.

· Food & shopping - majority (60%) reported both increased snacking as well as fresh fruit consumption. 30% families had changed to online grocery shopping. 1 in 5 students reported the need to ration their food.

· Covid-19 symptoms – 1 in 4 students reported symptoms of COVID-19 infection

Conclusion: Our results exploring the impact of the pandemic on a girls secondary school pupils presents a mixed picture; On the one hand there is a positive impact on sleep, learning new skills and change in diet. However there is also the adverse impact on reduced physical activity, academic performance, mood, in social interactions and the economic necessity to ration food. More information is needed to explore the longer term impact of the pandemic on education, health and the interventions that may mitigate this.

Keywords: Coronavirus, COVID-19, Secondary school students, Lifestyle, physical, mental

Introduction:

COVID-19 has made a significant impact to our lifestyle since December 2019. The World Health Organisation (WHO) declared it as a pandemic in March 2020. It has since impacted around 22 million people of which around 4.5 million have succumbed as of September 2021 [1]. In the UK there were three lockdowns impacting the school life of children significantly. This was due to plethora of factors. It was ranging from lack of school meals, inadequate parental support at home, to complete cessation of physical activity and emotional interactions with peers due to imposed social isolation [2]. As a result the key stages of transition from primary to secondary schools were shortened. The school leaving examinations and University examinations were cancelled. Hence secondary school children felt lost due to variable guidance from different authorities, ambiguity over their progression and uncertainty about their future. Despite evidence that school children were not known to be affected to a great extent by COVID-19, schools were closed [3].

We felt that this was an opportunity to explore the impact of the pandemic on the younger generation, which would help schools and families to plan supportive interventions.

Methodology:

We designed an online survey comprising of 40 questions, using Google Forms. The questions were crafted to assess maintenance of a daily schedule, physical activities, mental wellbeing, and outlook on life, dietary habits, software and gadget use, development of new habits, hobby and motivation. The questionnaire was approved by the School administration in December 2020 and distributed via the newsletter to all the parents of secondary children in our school. Responses were collected between Jan and July 2021. Statistical analysis was done using Google spreadsheet.

Results:

Study population

We received 102 responses, a response rate of 10% (The all-girls school student population was = 1099). Data on ethnicity was not collected. King Edward VI Camp Hill School for Girls is a grammar school for girls aged 11-18 in Kings Heath, a suburb of South Birmingham. There are 1102 pupils currently on roll, most of whom live in the surrounding catchment area (figure 1). [4] The Kings Heath and Brandwood ward, in which the school is located, has a population of 18,948 (2011 census) of which 23.9% are under 18. [5] This ward has an average employment rate of 70.6% and 40.7% have NVQ4+ qualifications (equivalent to adequate undergraduate education/higher apprenticeship). [6] Kings Heath and Brandwood is a diverse ward in comparison to Birmingham and the UK, with 16.6% and 4.6% Asian and Black and minority groups respectively compared to 7.8% Asian and 3.5% black and ethnic minority groups representing the total UK population. The ward also has the 10th highest average income rate of all the Birmingham city wards. [5]

Sleep

Students reported a mean sleep period of 6h 30min during regular school days, which increased by two and half hours to 9 hours during the period of lockdown, but reduced down to around 7h 30min during periods of online lessons.

Outdoor Activities

Sixty six percent pupils felt their physical activity was reduced during lockdown. Students left house around once or twice a day during the lockdown, increasing to a mean 3-4 during the summer months. Compared to 54% of students spending more than 3-hours in physical activity during regular school-time, 63% of students spent only 1-3 hours per week, during the lockdown. The most popular activities were workout at home (40%), walking (27.5%) and cycling (11%).

Mental Health & Social Interactions

• Whilst 34% felt their mood became more negative, 31% felt positive, 26% of responders were unsure and 9% reported no change.
• 45% felt they became more argumentative.

Additional Skills

• 22% picked up baking/cooking as an additional skill, 11% learnt other languages.
• The remaining cohort learnt a wide array of activities ranging from mechanical skills, to gardening and online webinars.

Academic Performance

54% felt their academic performance was adversely affected. 81% felt that in-person teaching was better than online sessions.

Diet & Groceries

• Despite 60% feeling that their snacking increased during lockdown, 61% had increased consumption of fresh fruits.
• 20% reported having to ration food during the lockdown.
• 28% did online grocery shopping.

COVID-19

Almost a quarter of respondents experienced COVID-19 symptoms, whilst 14.5% of their family members also experienced symptoms.

Discussion:

Our survey explored the impact of the pandemic on lifestyle of secondary school students in an urban, all-girls state school in the midlands, hence our results are likely to allow extrapolation to a much larger cohort in the UK, but the results are unlikely to be applicable to male pupils.

Previous surveys have reported the impact on physical activity as well as mental health[3] but to the best of our knowledge, a holistic assessment of pupillary lifestyle has not been reported widely. Our results indicate a mixed picture for secondary school girls - particularly new starters to secondary school (year 7) and senior school students (years 11, 12 and 13). Academic performance had deteriorated and majority of pupils were not in favour of the online lessons.

Figure 1: Physical activity amongst respondents

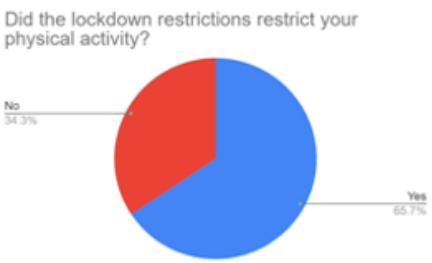



Figure 2: Forms of physical exercise

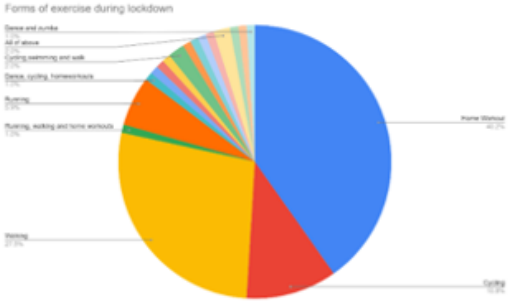



Figure 3a: Change in mood


Figure 3b: Outlook on life

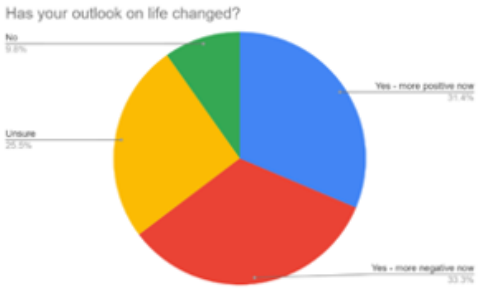
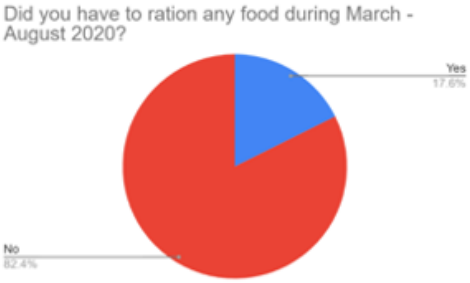



Figure 4: The need for rationing of food during the lockdown



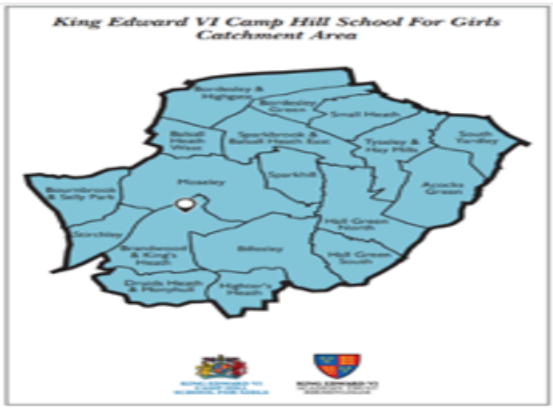




Figure 5 – Catchment Area

The average physical activity of pupils aged 11-17 is 60 minutes or more at least three times a week as per physical activity statistics from the British Heart Foundation survey (BHF 2015). Dunton et al[5] found that physical activity was reduced across the age group of 5-13 years during the first wave in the USA and were concerned that this could result in increase in secondary life style related illnesses like obesity and endocrine disorders. We found that secondary school pupils in our survey also had reduced time for physical activity, increased snacking but improved fresh fruit consumption in their diet.

The average pre-pandemic sleep is between 8-10 hours as recommended by NHS and National Sleep Foundation. Our survey demonstrated that pupils were able to benefit from increasing sleep period from an average 6h 30min to the recommended periods. Majority of pupils in our survey did not feel that their mood had changed despite facing a life changing pandemic, perhaps demonstrating a degree of resilience.

Despite multiple studies [6][7] demonstrating that there was lower risk to school children and transmission of virus, the UK administration imposed a total lockdown of schools even after the first wave. According to the UK Office of National Statistics (ONS), 0.42% of secondary school pupils tested positive for COVID-19 in June 2021 and 10.95% in November 2020. [8] These numbers differ from the 25% of our school sample population who tested positive for COVID-19. [9]

Our survey results have a ramification for students who missed taking the school leaving examinations in 2020 so their first ever competitive, externally administered assessment would be the A - levels. We believe that this may have deprived them of a learning experience. The continued disruption to regular assessments in the past 18 months will only augment the anxiety of facing a major external examination.

The limitations of our study are that it is a sample of an all-girls school and our response rates were low. We believe that we would have had more response if it was directly sent to the students.

## Conclusions

Our survey shows how the COVID-19 pandemic and the resulting lockdown impacted on the academic performance and lifestyle, both physically as well as emotionally. One in 4 students had to ration food. But also the ways by which the students found solutions by seeking new skills, compensating by home workouts and improving their sleep and diet. We believe that our results will help school administrations in planning strategies to support pupils with appropriate attention to academic performance, encourage managed physical activities and provide mental wellbeing resources. Attention should also be paid to pupils in families experiencing food poverty, where school meals are crucial.

Declaration: We have no conflict of interest

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# HOW PSYCHIATRY'S DISCONTENTS BECAME A SEA OF DISDAIN, CONTROVERSY & CONFUSION

BOOK REVIEW

## A review of DSM a History of Psychiatry's Bible

The issue of DSM-111 (the little blue book) in 1980 changed the face of psychiatry. It was intended to put the discipline on a scientific footing, ensure reliability of diagnoses and provided the basis to elucidate the scientific causes of such disorders.
It has however failed in almost every task set out, with succeeding iterations leading to even more controversy, culminating in DSM-5 in 2013.
DSM has had enormous success in terms of distribution and income for the APA but led to great controversy as evidenced by the growing number of critical articles and books.
This review of Allan Horwitz's book looks at the background to the controversy and the ongoing crisis for psychiatry.

Keywords
Allan Horwitz, DSM, Psychiatry Classification, Robert Spitzer, Pharmaceutical companies, Health Insurance

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Psychiatry, the medical discipline that treats disorders of the mind, has ever been a source of controversy. The mind, after all, is simply the modern term for what used to be considered the soul, usually the territory colonised by theologians or philosophers. Originally the province of the mad doctors, in the last two hundred years disturbances of the mind have crept and clawed their way into the ranks of mainstream medicine, providing the scientific and establishment status it needed.

If the vicissitudes of psychiatry over the following decades that came and went – and there were many –were the equivalent of perigean tides, this was nothing compared to the present state of desuetude which can be best compared to the debris left after a tsunami.

There are many causes of this state but a central issue, the veritable epicentre of the quake, can be attributed to a neat little blue pocket book – cerulean shades of Mao's Little Red Book – entitled the Diagnostic & Statistical Manual of the American Psychiatric Association (always known as DSM). Among the great books that have changed the course of history, its verbrente critics regard it as the Mein Kampf of the discipline. Perhaps the only equivalent is Psychopathia Sexualis by Richard von Krafft-Ebing, the first medical book to attain pornographic status.

The issue at stake goes to the beating heart of psychiatric epistemology: making sense of psychiatric illness – madness, if you will. Just as Carl Linnaeus classified all of nature, so was the intention to categorise the disorders of the mind which would render them accessible to scientific study from which treatment would hopefully emerge.

The process started with Philippe Pinel – the figure who largely defined the discipline as we know it – and his epigone Jean-Étienne Esquirol – whose lasting contribution was the diagnosis of monomania – passing on to the Germans where the giant figures of Kraepelin and Bleuler established a robust structure that was to last a century before it began creaking alarmingly at the edges.

World War 11 recast the issues of the earlier Great War. Psychiatric casualties were huge and the treatment was psychological, not physical.4 Leading figures in the US military were psychoanalysts Roy Grinker and William Menninger whose influence on American psychiatry continued in post-war years. When the conflict ended, psychoanalysis ruled supreme in America and this led to the first two DSMs (1952 and 1968): short, cheap and entirely based on the psychological basis of psychiatric disorders.

No one paid attention; for pscychoanalytic psychiatry, a productive future lay ahead. This illusion was not to last. It was started by the counter-culture environment of the Sixties. The anti-psychiatry movement started by Szasz, Laing, Goffman and others kicked into high gear. 5 The movie One Flew Over the Cuckoo's Nest played its part in persuading the public to see psychiatry as inherently oppressive. Michael Foucault, the French intellectual superstar, based on his rather dubious historical research, said that asylums represented the punitive arm of society. If that weren't enough, then along came David Rosenhan. In 1973 the psychiatric profession was deeply shaken by a paper published in Science, purporting to show that psychiatric diagnosis was effectively useless.6

"On Being Sane in Insane Places" by Stanford psychologist David Rosenhan described a unique experiment: Eight volunteer "pseudo patients" presented themselves at mental hospitals under fake names, complaining that they heard voices and were duly admitted.7The question asked was psychiatric diagnosis scientifically valid or merely a random, subjective and erratic process? Arguably the most influential psychological paper published in the last half-century, Rosenhan became a star and it is still one of the most cited social science papers, as well as prescribed reading in psychology and social work courses.

Rosenhan's findings, taken at face value, were very difficult to refute.8 One motivation for the experiment not considered was one of the oldest: turf war. Psychologists, especially then, were excluded from many activities on which psychiatrists had a monopoly. Discrediting their practice would expand the opportunities for all mental health workers. Rosenhan, however, did not get away unchallenged. Most of the criticism he could dismiss, but Robert Spitzer, a professor of psychiatry at Columbia–destined to be the leading figure behind DSM-111–was of a different calibre.9

Writing that "Some foods taste delicious but leave a bad aftertaste," he described the paper as pseudoscience presented as science and its conclusion a diagnosis of 'logic in remission. 'The Rosenhan paper led to a typhoon of discussion about the practice of psychiatry. It fed into the deinstitutionalisation movement, an agenda driven by governments, radicals, the counter-culture and others. Although not intended, the results of closing the hospital wards to discharge the patients were catastrophic. Community services never came close to meeting the needs of the discharged patients and the vacuum was filled by the streets and prisons, creating the depressing inner-city scenes so familiar today.

The American Psychiatric Association(APA), all too aware of the problems, decided that something had to be done: the result was the epochal DSM-111in 1980. Its midwife was Robert Spitzer who had gone into psychiatric life with a Reichian analysis.10 To what extent we can blame this for what followed is an interesting but unanswered question. Spitzer had a clear mandate: a disease classification that eschewed aetiology (or, more correctly, etiological speculation), but instead open a path finding the scientific basis for the illnesses.11

The intentions of the DSM committee could not be faulted. Operational diagnoses provided a list of required symptoms, as well those that had to be excluded. For the first time diagnoses were categorised with listed symptoms, free of etiological presumptions, notably psychoanalytic. Disorders were established by a "tick-the-boxes" approach.

The little blue book, as it became known, was regarded as the most important psychiatric book of all time, making Spitzer one of the most influential psychiatrists of the twentieth century. The response to its publication was huge. Such a nodal point was it in the development of psychiatry that it is possible to consider events as anti-or post-DSM-111. And all this over a book that could fit in any pocket. It was a Kuhnian paradigm shifter and the profession could now go on to a scientific footing that would hold its own in the academy, the clinic and the court. It took off like wildfire and was soon used in every country round the world with a few hold-offs like the French (to no surprise).

It was eagerly adopted by government health departments, psychiatric hospitals, insurance companies and courts. For the flailing psychoanalytic community, DSM-111was the final nail in the coffin. Neurosis, the condition the analysts treated in their offices, was officially gone. Its death throes had taken a while, but it was now dead. As a consolation (or, rather, pay-off) they were left with dysthymia, a synonym for chronic depression, and several types of personality disorder: borderline, narcissistic and masochistic.

This was very thin gruel indeed and a grim future lay ahead in dealing with health insurance companies that wanted everything neatly boxed and defined with evidence-based quantifiable treatment. For companies required to pay for psychiatric illness that can have a prolonged and difficult course, massive savings can be made by insisting on quantifiable sessions that can be judged against the far shorter number required for CBT treatments.

The old saw that personal analysis was something restricted to the rich in cities like New York –think Woody Allen –was now a reality. In all the hoopla, there were a few dissident voices but they were lost in the excitement. DSM rules OK! was the mantra and things could only get better in future. It had certainly brought an unprecedented benefit. In a triumph of medical marketing, the APA had created a brand that may be as well known as Apple or Coca Cola.

The APA made many millions of dollars and the rivers of gold will keep flowing with future editions. But megabucks alone was not the solution. Had DSM solved the problems, not least epistemological, that beset psychiatric diagnoses? If only.

The DSM-111 revolution actually reversed its intended goals. By providing a tick-box list for every disorder, it made instant diagnosis a reality for anyone who wanted to get in to the mental health business. So much for the lengthy and careful psychiatric examination that had been refined over the years. If the APA had intended to use DSM to protect their domain, it in fact raised the portcullis for psychologists, social workers and therapists of multiple persuasions to get in on the act. The squabbling over methodology and classification in succeeding years steadily escalated with parties becoming more antagonistic, akin to those theological disputes about angels dancing on the head of a pin. The result has not been pretty.

By the time of the next iterations, DSM–III–R(1987) and DSM–IV(1994), concerns were rising and knowledge of how the classifications were decided was not a good look. The resignation of Spitzer did not help either, another case of the revolution consuming its own. Allan Francis, his successor, left on equally disillusioned terms.12 The DSM-5 version, released in 2013, dragged credibility to its lowest point. Conditions that were determined by 150 years of careful psychiatric observation were put through a political and bureaucratic grinder that killed off well-established and understood conditions like paraphrenia and Asperger's syndrome, seriously messed up depression13 and inflicted such etymological gallimaufries as Late Luteal Phase Dysphoria Disorder(aka premenstrual syndrome).14

Critics of the system made two points. Pathologizing normal experience stigmatized those so diagnosed, resulting in unnecessary and often harmful treatment. Furthermore, treating non-disordered conditions took resources away from those in genuine need.

The most profound failure of the DSM enterprise was the way it played into the hands of the pharmaceutical and insurance industry. By providing a diagnosis unmoored from clinical reality but defined by operational criteria, a specific drug could be manufactured and marketed –the index example is Prozac for Major Depressive Disorder, followed by Paxil (Aropax or paroxetine) for Social Anxiety Disorder and then many others.

A new product, it seems, is launched on the market every day, judging by the journal ads, the glossy flyers in the mail and the bevvies of pert and perky sales reps who come calling with their latest brochures. The problem is that the new drugs are all variations on a theme.

Antidepressants, antipsychotics and sedatives have not changed for decades; the only real difference is in the side effects. A particularly egregious practice is the use of the so-called "atypical antipsychotics" as a kind of psychiatric penicillin. They are prescribed now for just about any disorder, regardless what other drugs are used. Their effect is to produce an emotional flattening. If this is considered an improvement, it is hardly a cure. Add to this the most spectacular side effect is weight gain, turning skeletal figures into Michelin men and women in a few weeks. Journals are now full of articles about the metabolic syndrome produced by these drugs.

More egregious however, is the medicalising of normal distress by making normal grief segue into Complex Prolonged Bereavement Disorder, effectively a clone of Major Depressive Disorder. This arises from the widespread misconception that "normal grief" just lasts a year. This is a ludicrous assumption. The process of grief varies with circumstances (for example, sudden or unexpected death) and individuals, so it can last from several years without necessarily assuming pathological features.

Allan Horwitz, who writes excellent books on the history of psychiatry, has provided what will turn out to be the definitive account of the DSM, one that will set the guidelines for future studies, although the extent to which it will quell the acrimonious debate is another matter. The DSM story, in all its perturbations, is carefully unveiled in a highly readable account that accomplishes its task in a lucid fashion without being too wordy or overloaded with footnotes. The first point Horwitz makes is that DSM was an entirely American endeavour, shaped by the local approach to mental illness and deeply shaped by the local culture. That it would play such a significant role in other psychiatric domains was not considered but, in view of its huge influence, must make it the refulgent arm of US psychiatric imperialism.

Horwitz starts in the post-war fifties, the high days of psychoanalysis in the US. The focus was on neurosis, which arose from unconscious conflicts in early development. Even psychosis, which Freud thought to be untreatable, according to Freda Fromm-Reichman and John Rosen, was accessible to the couch.15 Nit picking about different categories therefore meant little and nothing changed with the first two DSM versions. In order to get the project going, Spitzer had to deal with a major obstruction: the classification of homosexuality as an illness. This he accomplished in the face of much squealing by the conservative rear-guard, not least the analysts, but the issue was firmly consigned to history. Paradoxically, the LGTB community was later to lobby to retain the gender dysphoria category in order to have reassignment surgery funded. He reveals the astonishing amount of money the little book16brought to the APA: DSM-111 earned $9.3 million; DSM-IV was still producing $5 million a year more than a decade and a half after its publication; and DSM-5 sold $20 million worth of copies in its first year.17 While previously revealed by Edward Shorter and Hannah Decker inter alia18, Horwitz aptly shows how decisions were reached by the DSM committees. Clinical opinions and political deal-making between vested interests was the modus operandi with Spitzer tapping away at his typewriter while astutely juggling the committee factions.

Once haggling was completed, the final wording was determined by the unscientific means of a vote, reminding some of the old saw that a camel is a horse constructed by a committee. Added to this was the elephant in the room. Some committee members (Horwitz lists 70%) were shown to be tucked into the purses of pharmaceutical companies while others had well-known political agendas. Horwitz describes the enormous damage done to paediatric psychiatry. The most rebarbative example is the diagnosis of bipolar disorder in children as young as infants who are put on powerful drugs with heavy side effects.

Another storm arose from the decision to eliminate Asperger's syndrome and collapse autism, Rett syndrome and childhood disintegrative disorders into Autism Spectrum Disorder. Asperger parents did not wish to have their children classified with the lower functioning autistics and families panicked because some would not be eligible for benefits. This was followed by the massive increase in cases of Attention-Deficit Hyperactive Disorder(aka ADHD, another user-friendly acronym that says as much as its hides), a problem with huge clinical, financial, social and even political ramifications, which has led to the widespread use of stimulant drugs to control behaviour in children. Add to that all the adult ADHD cases that have since emerged and you get some idea of the mess.

Personality disorder classification was driven by researchers, rather than clinicians. There was a widespread belief that dimensions rather than categories would be the best approach, but this was overturned because it would prevent patients from being eligible for insurance payments. Nothing sums up the problem more than the epidemic(or should that be pseudo-epidemic?)of post-traumatic stress disorder (aka PTSD, the most enticing acronym of them all).19In 1980 the US Vietnam Veterans Association, through intense lobbying, persuaded DSM to give it the slick moniker

and, in the process, a user-friendly acronym. After heavy lobbying by the vested interests, Spitzer only adopted the definition after modifying the original proposal for a "post-Vietnam syndrome". A condition previously found in survivors of battle, concentration camps or life-threatening accidents has become the gold standard for the victim culture, rapidly becoming the commonest injury in compensation claims.

In subsequent DSM revisions, Horwitz writes, the criteria for traumatic exposure were so expansive that they encompassed virtually everyone. PTSD is now said to be found in someone having an argument at work, watching footage of terrorist attacks20or, vicariously, from treating patients with PTSD!21PTSD is worn as a badge of pride. As Nancy Andreassen, former President of the APA, says, "It is rare to find a psychiatric diagnosis that anyone likes to have, but PTSD seems to be one of them."22 Demonstrating the principles of free market economics, bracket creep (a concept of Richard McNally) is on the rise. Horwitz concludes that the replacement of analytic concepts with theory neutrality, the recognition that intense social stressors can produce lasting mental disorders, the removal of homosexuality and the acknowledgment of autistic disorders—improved the manual in ways which few psychiatrists would object to.

The profound failure of the DSM enterprise, however, is the focus on treating the disease and not the patient, in the process ignoring the role of social and cultural factors. As Horwitz pointedly states, the manual results from the dynamics and organization of the psychiatric profession and wider cultural, political, and economic currents. Fluctuations in the psychiatric politics, reimbursement for treatment, drug company marketing and the benefits patients, families, clinicians, and researchers receive from diagnoses shape the manual's uses. And on it goes.

DSM has given the world an American-based classification of psychiatric 'disorders' (no one is allowed to have a disease or illness now) derived from in-house committees subject to intense political, social and personality processes.

Add to this the appetite of a voracious legal profession for new "conditions" that could provide opportunities to litigate and, with one thing and another, we are where we are today. Despite all the subsequent versions, the endeavour has utterly failed to provide reliable diagnoses from which biological tests could be derived. As third parties increasingly required DSM diagnoses to pay for treatment, patients and families saw them as valuable commodities, making it even more difficult to change problematic categories, of which there were many. Parent groups drove the huge expansion of mental disorders among children and adolescents. If there was a knife that came close to the heart of the enterprise, it was the decision of the National Institute of Mental Health to cast aside DSM-5, recommending instead the Research Diagnostic Criteria.

The hecatombs of criticism notwithstanding, can any thing good be said about the DSM enterprise? Many of the categories are well defined and adjusted for recent developments. These include Organic and Neurocognitive Disorders and the Anxiety Disorders. Substance Use Disorders, having started off well with division into Abuse and Dependence, have now been collapsed into a single Substance Use Disorder category, the logic of which is difficult to penetrate. Added to this is the unresolved debate whether repetitive dysfunctional behaviours eg., compulsive gambling or internet addiction, to say nothing of the fashionable sex addiction, should be classified as disorders thus medicalizing human behaviour to an inordinate extent.

Criticism of Social Anxiety Disorder (SAD, previously Social Phobia)that it is medicalising human shyness is overkill 23, a view that can only be held by someone who has never treated SAD cases(a problem with understanding all psychiatric illness).

SAD is far more than just ordinary shyness, rather a pervasive anxiety under scrutiny with significant social, emotional, behavioural and occupational hazards. It is often poorly recognised as most cases present with depression or alcoholism, secondary to the primary disorder. Just go to an AA meeting and ask those present to put up their hands if they went into life with severe social anxiety.

On the distaff side, the SAD classification led to the promotion of Paxil for treatment of SAD, another bank vault for pharma. This shows how easily the issues can be blurred. Most SAD patients present with depression and alcohol abuse which can respond to antidepressants. It is perfectly reasonable to put distressed and agitated SAD patients on such medications when they present.

However, the correct treatment is psychological which can be done when they are no longer depressed or overwhelmed. It cannot be said that the public image of psychiatry is in the ascent. The disclosure that some prominent researchers have their hands deeply in the drug companies' pockets is less than a good look. Add to this psychiatry's mandate – its exclusive control of illnesses of the mind –is fragmenting to an unprecedented degree. Turf wars with neurology and psychology were but kindergarten squabbles compared with the present situation. Witness the disparate agencies which have not just a foot, but an arm and leg, in promoting (and, in the process, facilitating) the raging epidemics of autism and ADHD. Future generations will not thank us for this unwanted legacy. Less surprising is the passivity with which the profession as a whole deals with the situation. There is a good deal of posturing, leavened with oily dollops of political correctness, from the official bodies. Any steps to kick in on problems — notably rampant over - diagnosis of certain conditions and misuse of drugs — are timid and ineffective. All to often, when psychiatrists present in the media, it is evident they are pushing an ideological barrow, rather than representing the profession as a whole. A recent example: witness those rushing to pin diagnoses on Donald Trump In clear contravention of the Goldwater Rule (it is unethical for psychiatrists to make diagnoses of public figures).24

There are some chinks of light in the ever - deepening gloom. New drugs, such as ketamine, have genuine potential as antidepressants. The hallucinogens may revolutionise the management of obsessive - compulsive disorder and traumatic anxiety, if not alcoholism and drug abuse. Transcranial magnetic stimulation (TMS) is becoming a useful alternative to ECT. Vagal nerve stimulators may allow chronic depressives to come off medication. Deep brain stimulation is being seriously considered. Perhaps the most notable change is the use of cognitive behaviour therapy for a wide range of conditions, even psychotic delusions, something unthinkable a few decades ago. And after nearly a century of ignominy (thanks to Kraepelin including it under schizophrenia), catatonia has been recognised for the pervasive and treatable condition it is. To those who care deeply about the profession and its history over 150 years of determination to classify and treat some of the most debilitating conditions known, for all the difficulties, missteps and mistakes enroute – it is deeply dismaying, if not depressing. What is needed is nothing less than a thorough review of the framework in which psychiatry operates and a clear plan for the future. Allan Horwitz is to be congratulated on a fine book that deserves to be read by everyone concerned about the state of psychiatry, especially trainees who will constitute the next generation of psychiatrists and have to deal with the consequences of DSM's trail of disaster and folly.

This book should have as wide reading as possible in the hope that it will spur individuals and organisations to repair the growing catastrophe. But don't hold your breath that this is going to happen soon.

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1 The name Psychiatry came from Johan Reill in 1807.

2 De Saussure R. The influence of the concept of monomania on French medico-legal psychiatry (from 1825 to 1840). J Hist Med Allied Sci. 1946 Jul;1:365-97.

3 Bergsholm P. Is schizophrenia disappearing? The rise and fall of the diagnosis of functional psychoses: an essay. BMC Psychiatry. 2016 Nov 9;16(1):387.

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5 For a review of these issues, focussing on the Antipodean scene, see: Laffey P. Histories of Psychiatry after Deinstitutionalisation: Australia and New Zealand. Health and History, Vol. 5, No. 2, (2003), pp. 17-36.

6 Rosenhan DL. On being sane in insane places. Science. 1973 Jan 19;179:250-8.

7 Rosenhan DL. On being sane in insane places. Ibid.

8 But, as Susan Cahalan has now shown, it was one of the greatest scientific frauds of the century; see: Susannah Cahalan. The Great Pretender: The Undercover Mission that Changed Our Understanding of Madness. Canongate, 2020; https://www.spectator.co.uk/2020/01/how david-rosenhans-fraudulent-thud-experiment-set-back-psychiatry-for-decades/. Accessed 4 February 2020. The damage however was done.

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15 For a review of the inanities, if not iniquities, involved in the psychoanalysis of schizophrenics, see Edward Dolnick. Madness on the Couch. Blaming the Victim in the Heyday of Psychoanalysis. Simon &. Schuster, 2007.

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20 It was thus predicted that there would be massive cases of vicarious PTSD in New York after 9/11 when in fact it turned out to be quite the opposite.

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# THERE IS NO PLANET B

CONFERENCE REPORT

## Conference on Climate Change, Sustainability & Health Inequalities

BAPIO Women's Forum in collaboration with Milton Keynes University Hospital (MKUH) held a conference on 'Climate change, sustainability and Health inequalities' in May 2022. This article details the highlights of the conference and the key messages of the interdependencies of women's health, tackling inequalities and the impact on the climate.

Keywords
Climate crisis, climate change, gender equality, health inequalities

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## Background

Climate change has a clear impact on the social and environmental determinants of health including affecting clean air, safe drinking water, sufficient food, and secure shelter. Globally climate change is expected to cause nearly 250,000 additional deaths per year between 2030-2050 and this is likely to have a significant impact on the healthcare sector. It is also known that women and children suffer the most health risks caused by climate change.

Born from the need for fairer gender representation for medical professionals from ethnic minorities, the BAPIO Women's Forum (BWF) was founded in 2012. In 2021, the new BWF executive committee decided to take a fresh look at the injustice and inequalities that are still very prevalent in our healthcare system. These inequalities affect not only healthcare professionals from minority backgrounds, but also have a similar impact on patients. It is our belief that gender equality is one of the keys to climate change action as they both are very closely related. The UK Climate Change Commission (UKCCC) advises on how the impact of climate change will perpetuate existing health inequalities in the UK.

Recognising the potential strength in the voice of a voluntary, professional organisation like the British Association of Physicians of Indian Origin (BAPIO), the Women's Forum hosted a conference, in May 2022, focusing on the linked issues of Health Inequalities and Climate Change. The inspiration for the conference was the research demonstrating the interdependency of inequalities in healthcare and climate change. The conference also reached out to hear the daily experiences of minority ethnic women from the BWF.

## A sustainable conference

One of the attributes of a professional is their commitment to lifelong learning. It is as important to keep up to date with the emerging evidence in their chosen specialities, as it is to maintain clinical skills and competencies. With rising awareness of health inequalities and climate change, it is important that healthcare professionals (HCPs) learn to adapt their practice to tackle the challenges faced by disadvantaged groups and adopt sustainable healthcare practices, considering the impact on the climate. Unfortunately, equality, diversity and inclusivity (EDI) training and the resources needed for climate impact and sustainability in healthcare are not easily accessible. Most HCPs do not have the access to practical solutions or the relevant educational resources. Very little is taught in the current undergraduate medical curriculum. Acknowledging this knowledge gap, the BAPIO Women's Forum hopes to increase awareness and work on developing accessible resources. The conference was supported by the communications team at Milton Keynes University Hospital (MKUH).

The BWF executive was keen that the conference should run sustainably;

- working with small 'green' businesses, promoting social responsibility and access to using recycled materials.
- Committing to the philosophy of 'lift as you climb' in providing opportunities to female HCPs, the conference paired young female conference chairs with more experienced ones to provide mentoring and support.
- Hosted at the Hotel La Tour, Milton Keynes which prides itself in being 'green' and helped to make the conference zero-waste and zero-plastic.
- Delegates wore their own work lanyards rather than creating specific ones for the conference.
- QR codes were displayed for the program to reduce paper and feedback was collected electronically.
- Delegate bags were made from jute and included carefully chosen items such as recycled wooden pens, plant pots with seeds, pencils that contained seeds, wooden pencil holder and a recycled notebook.

Social media

Leading up to the conference, the main goal of social media posts was to promote the event whilst raising awareness on the relationship between climate change and healthcare. We felt this was relevant following the burden of COVID-19 on healthcare and our environment. We marketed the event across Twitter and Instagram using #BWFClimate22 and #MKUHClimate22 hashtags. The programme was divided into four sessions with a focus quote e.g. "There is no planet B". Different shades of the colour green were used across all posts to adhere with the themes of climate change, sustainability and health.

@BAPIOWF Twitter and Instagram were frequently used as the day progressed. A tweet consisting of photos, a session quote, affiliated organisations and a key message was the format used for every speaker. This generated many retweets from their respective peers and organisations, and the conference gained traction. Fortunately, the traction spilled over to other platforms such as LinkedIn and Instagram where there was a greater following for some of our speakers.

Key Messages

Vasudhaiva Kutumbakam

The meaning of the phrase is 'the world is one family'. Considered to be the most important moral value in Indian society, this phrase was originally found in Maha Upanishad (500-1000 CE) and can be found engraved in the entrance hall of the Parliament of India. We all need to work together to address climate change as this affects all parts of the globe. While individual actions are commendable, we can truly make positive changes towards climate change when we acknowledge that collective efforts are key to success. In keeping with the Indian and BAPIO tradition, earthen lamps were lit by Dr Jyothi Srinivas and Dr JS Bamrah with the chants.

asato mā sadgamaya,
tamaso mā jyotirgamaya,
mṛtyormā'mṛtaṃ gamaya.

From evil lead me to good,
From darkness lead me to light,
From death lead me to immortality.

We do not inherit the earth from our ancestors. We borrow it from our children

Emma Moir set the scene with the goals of a greener NHS, highlighting that climate change is a major threat to our health as well as our planet. The environment is changing, that change is accelerating, and this has direct and immediate consequences for our patients, the public and the NHS. The Greener NHS program works with NHS staff and Trusts across the country sharing ideas on how to reduce the impact on public health and the environment, save money and reach net carbon zero. In October 2020, the NHS became the world's first health service to commit to reaching carbon net zero.

Camilla Kingdon, reminded the delegates that the United Nations (November 2021) lists the 'Right of children to breathe clean air'. Nearly 90% of the global burden of disease associated with climate change is borne by children under 5 years of age. The RCPCH declared a climate emergency in 2020 and has published a strategy for tackling this issue as a priority.

Joe Harrison, a passionate advocate for addressing climate change has led his organisation in adopting policies on energy efficiency (solar panels on roofs), reducing food waste and supporting staff in using electric vehicles.

What you do makes a difference, and you have to decide what kind of difference you want to make

Medical students Hannah and Jim presented their data on the importance of education on sustainable healthcare within the medical curriculum. Almost all medical schools in the UK have signed up to the Planetary Health Report Card (PHRC) and are committed to the goals of enabling future doctors to address climate change in healthcare.

Greener NHS have introduced Clinical Fellows scheme in sustainability. Veena Aggarwal, a Sustainability fellow shared her personal contribution in this role.

Children across the world are concerned about the huge amount of waste generated every day and the effect of climate change on our world. Catriona Mellor explained her worldwide study on eco-anxiety that confirmed the stress on children and the need for us to demonstrate our commitment to addressing this issue. Inhalers in paediatrics make up a large proportion of waste with most NHS staff and parents unaware of how to dispose of it in an environment friendly manner.

Trainee doctor Zoe Rooke presented their survey findings and their collaboration with pharmacy to set up a disposal scheme in their department.

The NHS is one of the largest employers in the world with 1.4 million staff. Data from pre-pandemic 2019 states that 1.4 billion gloves were used in the NHS. This has likely more than doubled during the COVID-19 pandemic. Tim Simmance, Regional Net Zero lead, encouraged clinicians to work with procurement departments to reduce waste generated, while considering new environment friendly materials of use in the NHS.

Doctors for Extinction Rebellion include thousands of NHS staff who highlight the climate crisis with many campaigns and action plans.

The future will be green or not at all

Medical students and Junior doctors presented on a recent MKUH staff survey that highlighted 90% of staff are concerned about the climate crisis and waste in the NHS. There was a clear need for Trusts to communicate with their staff on new developments (e.g. charging for electric cars). Staff requested easy access to information on understanding how to calculate their own carbon footprint and other relevant resources. In view of this, an electronic resource of the 6 main topics is being developed that will be shared with MKUH staff and University of Buckingham Medical School (UBMS).

Rosie Spooner, a trainee in paediatrics has completed a year as Fellow in Sustainability and gave several examples of Quality Improvement Projects (QIPs) that can be undertaken by different HCPs in the NHS.

A private entrepreneur using ocean waste to develop Personal Protective Equipment (PPE) including scrubs for NHS staff explained the process and brought samples to showcase their work on developing a circular economy that reduces PPE waste. This generated quite a bit of interest and many delegates are planning to consider introducing these PPE in their Trusts including MKUH.

Professor Gatrad, founder of WASSUP (World Against Single Use Plastic), has worked for the last two decades on reducing single use plastic. He developed a program to teach school children on plastic waste.

There is no Planet B

Bola Owolabi, inspired the delegates about the Core20PLUS5 approach, which was developed to focus on 20% most deprived population by the Index of Multiple Deprivation – the 'Core 20' of the national population, 'PLUS' stood for Integrated Care System (ICS) determined groups experiencing poorer than average access, experience or outcomes from healthcare and the '5' represented the clinical focus areas with the greatest opportunities to narrow the health inequity gap. These 5 areas were maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension.

Dame Parveen Kumar emphasised the need to focus on the unmet needs in women's health and encouraged the delegates to persist towards our goal of gender equality.

Gurch Randhawa gave an overview of children's health in London and Luton (CHILL) study focusing on air pollution affecting children. The study organisers used a video message designed by children to recruit >3000 children for their project.

We are all in this together

Ian Sinha presented the evidence exploring the effect of air pollution in children leading to respiratory conditions such as asthma in the UK.

Ella Adoo-Kissi-Debrah, who lived near the South Circular Road in Lewisham, south-east London, died in 2013. Ella was the first person in the UK to have air pollution listed as the cause of death on their death certificate. The air pollution is worse in poorer areas in developed countries adversely affecting people in low socio-economic areas.

Shivani Misra talked on the major issue of diabetes affecting certain demographics and the role of HCPs in identifying and treating these groups sooner, especially among south Asian populations in the UK (Indian, Pakistani and Bangladeshi nationals).

Partha Kar showcased the issue of racism, colourism, and gender bias within NHS staff and the importance of speaking up and actively challenging such behaviours or culture.

Conclusion

Ramesh Mehta, President of BAPIO gave his commitment to showcase the climate crisis in all future conferences. He reiterated that the climate crisis was a health crisis and health care workers should be equipped with the knowledge of the problem and ways to reduce the impact for future generations. 'While we can all help individually by reducing plastic waste, recycling and supporting local businesses it is really important that we collaborate with others to work together.'

'By polluting the oceans, not mitigating CO2 emissions and destroying our biodiversity, we are killing our planet. Let us face it, there is no planet B.'
Emmanuel Macron, President of France

Further reading


- https://www.theccc.org.uk
- https://www.ipcc.ch
- https://ukcop26.org
- https://www.england.nhs.uk/greenernhs/
- https://sustainablehealthcare.org.uk/susqi
- https://climate.nasa.gov/causes/
- https://footprint.wwf.org.uk/#/
- https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/health-inequalities
- https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities
- https://www.england.nhs.uk/about/equality/equality-hub/resources/
- https://unfoundation.org/blog/post/five-facts-about-gender-equality-and-climate-change/
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- https://wasupme.com
- https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/
- https://www.qmul.ac.uk/chill/
- https://phreportcard.org


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